



# The Journey from Medical Care to Health Care: Lessons from the Field

By Christopher J. King, Ph.D., FACHE

## From Past to Present

In 2002, the Institute of Medicine's landmark publication, *Unequal Treatment: Confronting Racial and Ethnic Differences in Health Care*, served as a cue to action for instituting best practices to eliminate variation in patient outcomes by race, ethnicity, gender, primary language and other socio-demographic factors. Consequently, the term "health disparities" became well socialized in the industry, as hospitals and health systems across the nation adopted evidence-based practices to address the issue. From "REAL" data collection to mandating employees undergo annual cultural competence training, efforts primarily focused on interventions within the walls of clinical settings. While this work is warranted and progress has been made, it's clear there's so much more to do.

In the spirit of population health management and reducing costs, the industry has evolved over the past couple of decades. We now recognize clinical care is a small component of total health and

individual or population health is mostly shaped by the structural and social conditions of the environment. Gainful improvements in health outcomes will require us to crack the code in applying a more holistic approach to how systems of care are organized, delivered and financed. We must adopt unconventional practices that operationalize medical care as a component of health care.

This evolution in thought has changed the conversation. We have shifted from dialogue on health disparities to more complex socio-ecological interactions that are root causes of poor health. Today, concepts such as social determinants of health and health equity are socialized across the industry. According to the Centers for Disease Control and Prevention, health equity is achieved when "every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances." For this publication, I define health equity as distributing resources according to need so all individuals, regardless of their differences, have

access to opportunity – leading to optimal health.

Based on this definition, what does this mean for hospitals and health systems? What role can they play in delivering health care - not just medical care? How will this approach impact the bottom line?

## The Journey to Health Equity: Moving Forward

As the first Assistant Vice President of Community Health for MedStar Health (2000-2015) and current Georgetown University

health systems researcher with a focus on historically marginalized communities, I have had the opportunity to tap into the deeply-rooted tradition of how systems of care are organized and delivered. Through community health needs assessments I have facilitated, it has been a privilege to listen to the narratives and lived experiences of residents across the nation – many of whom have been inappropriately characterized as “non-compliant patients.”

As a result of my work, I recognize that each entity is on a different level of the health equity continuum. For the general audience, I am casting a wide net and sharing a few strategies that have promise to yield transformative outcomes.

### 1) Apply a historical lens in Community Health Needs Assessments (CHNA)

The mandated Community Health Needs Assessment (CHNA) is a resource for grassroots activists, community partners, and key stakeholders; it is not solely for the hospital. Most CHNAs are prospective by design but my work has taught me the value of a complementary retrospective approach. Understanding the history of the community served is one of the best ways to begin the process of undoing systemic injustice and delivering care that is compassionate and tailored to the needs of the population.

A few years ago, I led a CHNA process for the

District of Columbia. We had a unique opportunity to work with a historian who helped stakeholders understand how the structural conditions of local geographies were different by design (i.e. redlining / disinvestment). This level of information added a new layer of insight on historical trends as key drivers of premature death, high readmission rates and high morbidity rates in some locales. The approach helped pinpoint more granular needs and the community-based resources/partners needed

to address those needs. Furthermore, findings were instrumental in crafting a narrative at the intersection of place, health, productivity and economics - bolstering efforts to promote a more equitable distribution of resources moving forward.

### 2) Operate as a socially-conscious anchor institution

According to the Democracy Collaborative, anchor institutions are enterprises, such as hospitals, that are rooted in their local communities by mission, invested capital, or relationships to customers, employees and vendors. One aspect of operating as a socially conscious anchor institution is to know what assets exist in an underserved or underrepresented community. Developing a scorecard of practices that can strengthen the capacity of those assets is prudent for health improvement, community engagement, and strengthening the brand. Examples include but are not limited to: sponsoring local hiring and training programs, refining purchasing and procurement practices, volunteering for board service, offering low interest loans and creating community investment portfolios through endowments.

### 3) Conduct learning journeys

Understanding the lived experiences of patients is key to building trust and delivering experiences that are culturally nuanced. A learning journey is an

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orchestrated experience that gives board members, executives, and/or practitioners an opportunity to see first-hand the challenges patients face in the home and neighborhood level. A few years ago, I facilitated an organization's learning journey. Using hospital data, we identified a census track with substantially high asthma related emergency department (ED) visits.

We visited a large low-income apartment complex within the census track. The majority of patients' primary language was Spanish. Upon entering their homes, we witnessed unsafe living conditions that were not up to code. We were most struck by the mold, mildew, holes in the walls and cockroach infestation. We listened to their stories, then partnered with a legal firm to address the issue. After a couple of months, the management company began making the improvements. Hospital leaders had 'an aha' moment that would inform future dialogue, community benefit resource allocation and community engagement practices.

#### **4) Ensure the structural environment reflects the rich diversity of the community**

Medical experimentation and other historical injustices in medical care have resulted in some populations' profound distrust of the health care system. While these dynamics are deeply-rooted, a few easy fixes can take the industry a step closer to cultivating trust and engaging patients in meaningful ways. In my interactions with community members about their healthcare experiences, I consistently hear iterations of this message .... "nothing in that building looks like me or my community," and "when you feel that way, you do not go to the doctor unless you are in pain – or maybe you go because of your job or something like that."

Taking time to perform an environmental scan of the structural environment and identifying opportunities to create a more inclusive feel is key to

advancing population health objectives. In other words, does the organization reflect the cultural richness of the community? Tangibles include but are not limited to: pictures, educational materials, wall renderings, magazines, music, and workforce composition.

#### **5) Identify local champions and refine how we engage the community**

We cannot do this work alone.

As part of the CHNA process for MedStar Washington Hospital Center, hypertension in Black men was identified as a health priority. Recognizing the important role of the barbershop for Black men, we identified a highly respected owner of a shop housed in the hospital's primary service area. The owner was frustrated with patrons who had passed away over the years due to heart disease and other preventable conditions. He wanted to make a differ-

ence and decided to partner with us and convert his barbershop into a health hub. Our team provided his staff with training on conducting blood pressure screenings. We also provided materials, developed referral protocols and a case manager worked with patrons as needed.

The owner of the shop was the face and brand of the program. It was a win-win. Through his leadership and our humility, we reached hundreds of men. For the first time, many of these men talked about vulnerability and the importance of wellness and preventive services. For the healthcare team, it was a teachable moment on the efficacy of transferring power. And for the hospital, the community developed a more favorable perspective about intent and authenticity.

#### **Conclusion**

We will make significant progress towards population health when we learn to contextualize health

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care through a health equity lens. This warrants a working reflection of our history and awareness of how our history has impacted communities, shaped patients' perceptions and contributed to bias in how patients are treated. A social-ecological approach helps us unearth solutions to undesired utilization patterns such as high readmission rates and preventable ED visits.

Hospitals and health systems cannot be solely responsible for improving the health of the general population; however, they can play an instrumental role in investing in their communities, convening diverse stakeholders to achieve a shared vision, and using their voice as anchor institutions to advocate for a culture of health. How leaders of the

institution choose to operate in this space relies on institutional expertise, capacity and community needs. Whether it's through community engagement, community investment, community-based partnerships, place-based advocacy, population health data analytics, or developing workforce soft skills around empathy and compassion, new and emerging competencies are necessary. These imperatives suggest opportunities to retool or reskill existing roles, as well as create new ones.

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**Christopher J. King Ph.D., FACHE**, is Chair and Associate Professor in the Department of Health Systems Administration at Georgetown University.