

TOWARD A Healthy Nation

HOW THE **AFFORDABLE CARE ACT** WILL AFFECT the relationship between hospitals and communities.

THE HEALTH CARE INDUSTRY is currently undergoing a period of rapid transformation as it faces the dual impacts of the Affordable Care Act and an increasing reliance on electronic medical records. These two factors are helping professionals to focus on population health, even as they reveal the wide disparity between the haves and have-nots. The discipline of planning is uniquely positioned to close the gap between health care providers, cities, and a healthy future for all.

Is health inequality the new wealth inequality?

The facts are sobering. More than two-thirds of Americans are overweight or obese; heart disease is the number one killer in America; and more than 29.1 million Americans have diabetes. But when it comes to population health, even more alarming than these statistics is the growing health care gap between rich and poor citizens in the U.S.

Between 1990 and 2010, 148 nonprofit hospitals, along with 53 for-profit hospitals, closed in the largest American cities. According to a PBS program broadcast during that period, more than 70 percent of blacks and Latinos live in these big cities or their inner-ring suburbs, which means this trend has a disproportionate effect on the health of minority patients. Their neighborhoods also face “food deserts,” areas with too little access to healthy foods like fruits and vegetables. Further, recent research compiled by the *Milwaukee Journal Sentinel* and *Pittsburgh Post-Gazette* shows that the premature death rate is 39 percent higher in poorer counties than wealthy ones, and disability and diabetes rates are higher in low-income regions as well.

While illness is a widespread problem, it is becoming increasingly clear that its effects are felt unequally, in proportion to individuals’ income and place of

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residence. Access to health care, healthy food, and outdoor amenities like parks and walking trails generally are more available in wealthier communities.

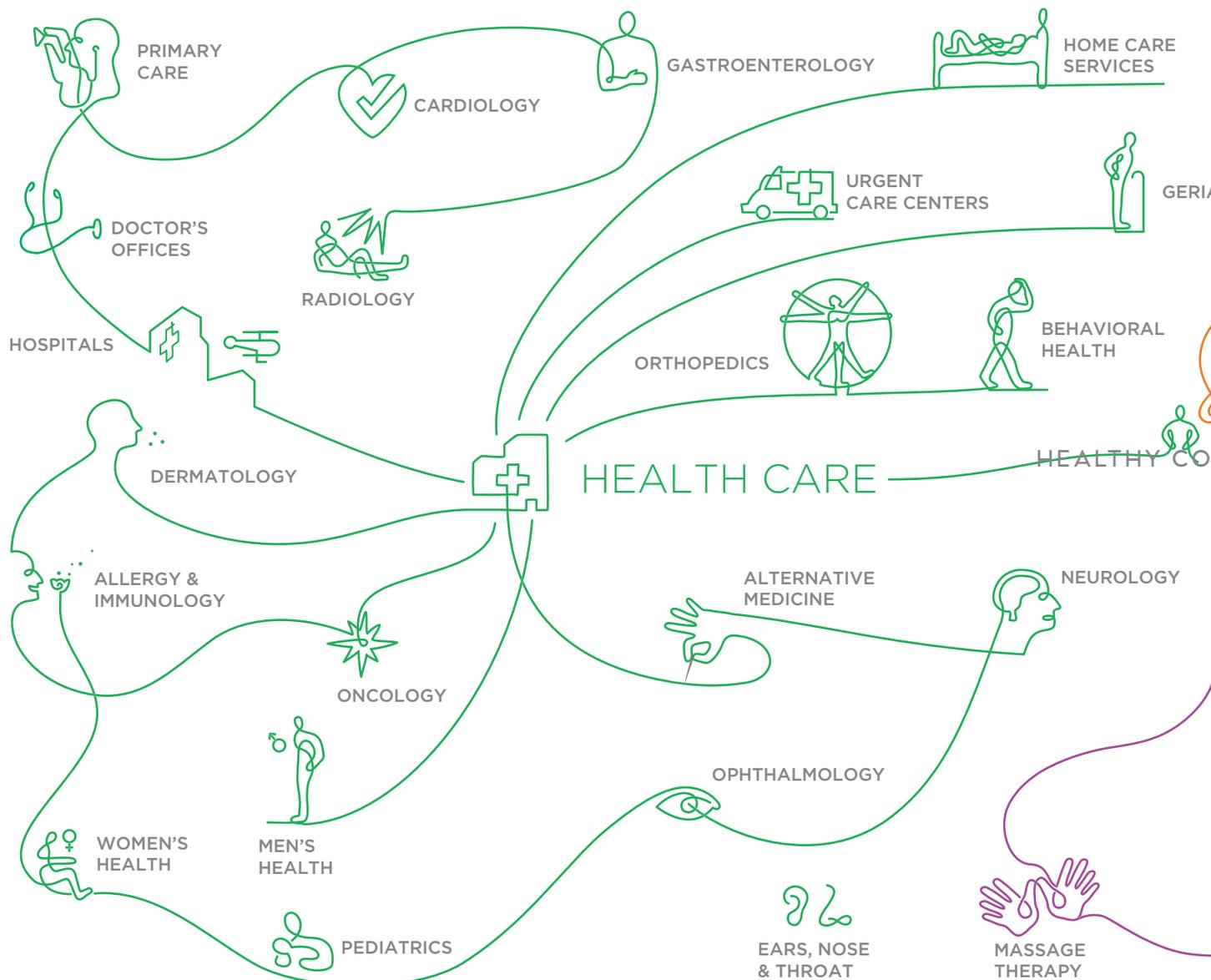
Specialization in the medical profession has hindered community health, too. For many years, doctors entering medical school have trended toward more lucrative specialties, and away from primary care. That means fewer generalists are available as the first line of defense against illness, and those remaining may be located

far from the populations that need them most.

But a major reason why Americans are unhealthy is our streak of fierce independence. Generally speaking, as a society, we tend to look out for ourselves at the expense of caring for the greater collective good. As urban designers, planners, architects, business leaders, and city officials, we should rethink this model. We need a mind-set that focuses on overall population health and remedies its unequal distribution.

Planning for Healthy Communities

A TRULY HEALTHY NEIGHBORHOOD combines health care, economic activity, and healthy lifestyles to combat the negative health outcomes caused by inactivity and chronic illnesses such as obesity, diabetes, and heart disease.



SOURCE: NBBJ, ILLUSTRATION BY FELIX SOCKWELL

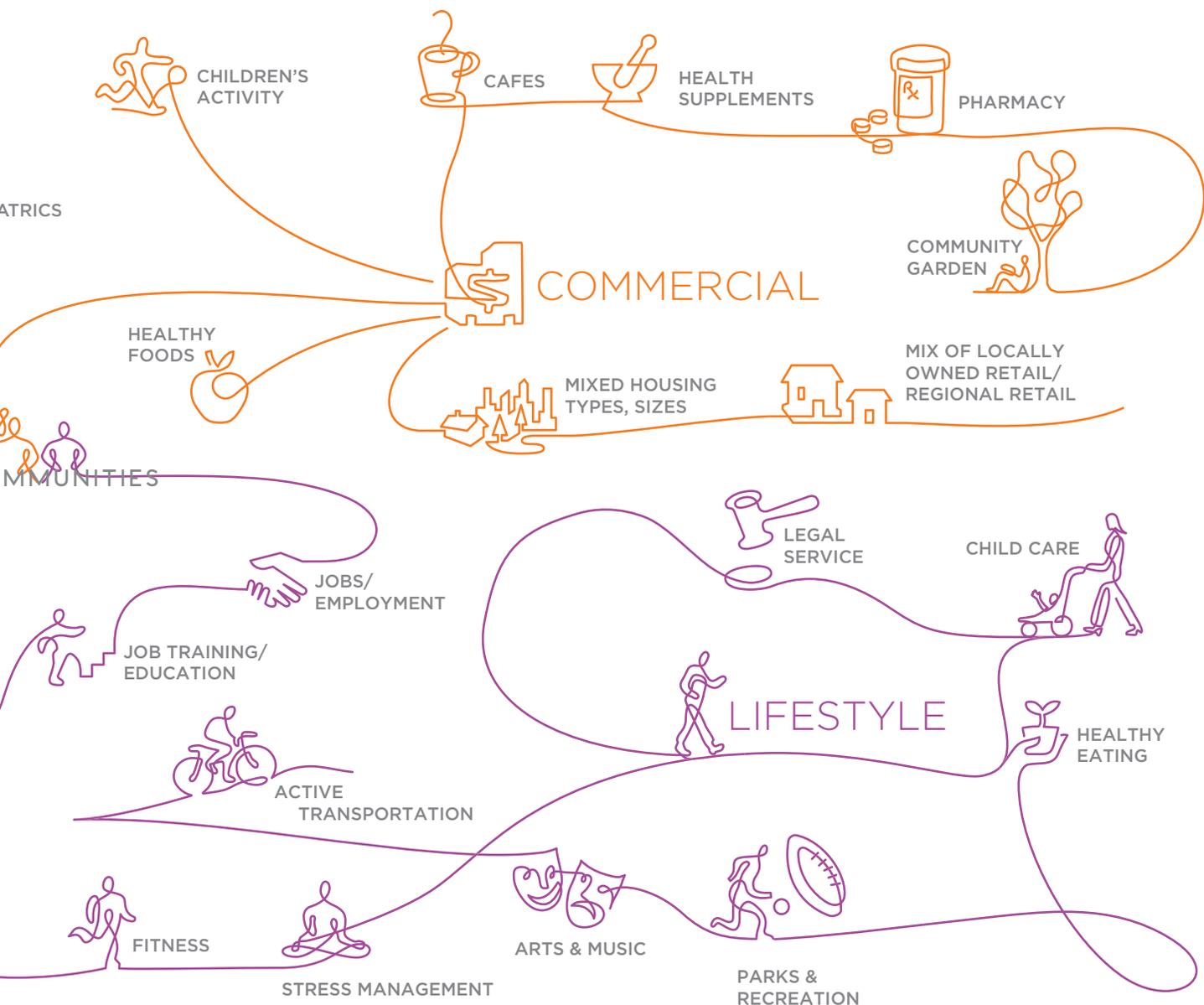
Affordable care and big data

With the passage of the ACA, federal and state governments, via Medicare and Medicaid and many commercial insurers, are changing the payment process for health care. The old model—which paid doctors and hospitals a fee for a specific service—is now being replaced with a value-based payment model that pays for the outcome. To a degree, this change creates incentives for health care organizations and insurers to keep their patients and subscribers

healthy, thus preventing them from relying on expensive tests and procedures or extended hospital stays for revenues.

When done effectively, this is a win-win scenario: The individual remains healthy and the provider remains financially healthy. The overall health of the communities in which hospitals reside will now be reflected in their bottom lines.

At the same time, the increasing amount of demographic and patient data available in electronic medical records now enables



health care professionals to identify patterns in population health much earlier and more accurately than ever before. This wealth of data has fundamentally shifted how hospitals and health care professionals engage with their patients, their neighborhoods, and their communities. They are evolving beyond their traditional mission, as they become civic stewards that build healthy communities.

A recent workshop report on population health from the Institute of Medicine—a division of the National Academies of Sciences, Engineering, and Medicine—notes that as health care reform moves forward, the next step will be to create a community-integrated, learning health care system that uses population health strategies capable of rapidly deploying best practices for both prevention and treatment. The ACA creates an opportunity to integrate population health into the health care system, to elevate the priorities of prevention and health equity, to align clinical care and community health, to empower consumers and communities to improve health outcomes, and to provide companies incentives to improve workplace wellness.

This suggests a critical consideration: Health care organizations cannot safeguard community health unilaterally. They are not yet equipped to deliver a total population health approach, nor should that be their sole responsibility. While health care providers can and should encourage patients to eat differently, they typically cannot change the supply of healthy food in a community. Neither can they determine where people choose to live, or the many social determinants that affect health.

It is the job of public health groups, private companies, and ordinary citizens to partner and collaboratively devise solutions. Planners, as the grand conveners, can and should advocate for a new method of community building that centers on healthy community design and on changing behaviors to a health-conscious mind-set. Streets designed for active mobility and commuting are as essential as providing parks and play areas that support increased aerobic activity. And more flexible land-use zoning that encourages a mix of uses, perhaps including community gardens and the sale of locally grown fresh food, is equally important in the formula for healthy communities.

Planners' expanded role

While health care providers and the World Health Organization have redefined health in recent years as a state of complete physical, mental, and social well-being—not merely the absence of disease or infirmity—planners need to understand health more holistically as well.

In other words, there is a huge, untapped opportunity for planners, as community representatives and advocates, to work in a much deeper and more integrated fashion with hospitals, health care systems, and developers to create healthy communities. The American Institute of Certified Planners Code of Ethics demands that planners become more sophisticated about these issues.

How to proceed? We start with a dialogue that engages planners, health care professionals, developers, policy makers, and community members. This discussion should focus on three main avenues to achieving a healthy community:

CORPORATE CITIZENSHIP. One key to innovation in healthy community design centers on the work of the private sector. Many private institutions and companies understand that employees are

not only interested in highly engaging and flexible workplaces, they also want healthy work environments and civic spaces that foster active work, passive recreation, and a balance between the two. This approach should also apply to mixed use, health-centered development initiatives.

Amazon, the online retailer, has been exemplary in this regard. For years it has spurred the development of Seattle's South Lake Union neighborhood, which has resulted in a walkable community next to downtown, centered on public transit, and filled with amenities including a Whole Foods grocery.

Increasingly, health systems are breaking out of their traditional campus boundaries to create health districts: medical areas that not only serve the sick but also promote the health of the surrounding neighborhoods. MetroHealth Medical Center in Cleveland, under a master plan by HKS, Inc., has recently moved to create smaller facilities and grounds on its main campus that are more accessible to the community and provide public amenities. Its satellite clinics even offer services such as cooking classes, teaching residents of all income levels how to create affordable, healthy meals every day of the week.

Other health care organizations are implementing similar decentralization strategies by dispersing smaller facilities. These facilities still tend to be single-use buildings, however, typically including health and outpatient facilities only, to the exclusion of other complementary community and commercial uses. No matter the scale, the integration of uses such as children's play areas, community gardens, and a mix of neighborhood-oriented services would more definitively implement a healthy community paradigm.

While these efforts should be applauded, our health partners, the health care development and insurance industries, can and should do more. Health care organizations are well positioned to promote exercise, healthy food, active transportation choices, and interactive learning opportunities for employees and patients alike.

For instance, Seattle Children's Hospital offers an incentive for bicycle commuting to and from its Bellevue, Washington, clinic to address street capacity issues and reduce parking congestion on campus. A modest subsidy program encourages bike commuters, and a small bike shop (which replaced three parking spaces) offers free on-site tune-ups to employees.

Yet while the campus has seen a noticeable reduction in daily auto traffic and the changes have surely brought health benefits to its staff, how much more widespread would the positive effects be if similar services were dispersed throughout the community? Planners can certainly help providers weigh the options and implement such programs.

In an ideal world, health organizations would also adopt branding and marketing initiatives to highlight the locations where health and community development coincide, much as EcoDistricts integrate sustainability initiatives with mixed use developments. EcoDistricts hint at the local benefits that communities and health care providers could reap by encouraging a range of health-focused and essential services to occur in one place.

POLICY CHANGES. Smart government should help lead the way toward healthy communities, even without burdening businesses with unnecessary regulations, mandates, taxes, or fees. City planning organizations and governments are well positioned to raise

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PREAMBLE, ZONING ORDINANCE OF THE CITY OF CAMBRIDGE, MASSACHUSETTS

the bar by encouraging innovative approaches to healthy living.

Local zoning codes already provide a model for how municipalities might encourage communities to ensure public health. The zoning code for Cambridge, Massachusetts, which recently passed “net zero” requirements, includes a preamble that reads: “It shall be the purpose of this Ordinance to lessen congestion in the streets; *conserve health*; to secure safety from fire, flood, panic and other danger; to provide adequate light and air; . . . to preserve and increase the amenities of the City” (emphasis added).

The Cambridge example is a good baseline, and it likely resembles many other zoning codes’ “statements of purpose.” But planners can do even more to reflect the urgency of a new health-driven community design concept that speaks more directly to the need to integrate land uses, active recreation, social equity, jobs, and health care uses. Regulations could require that a certain number of open, inviting stairways are included in buildings, that healthy foods are served in cafeterias, and that a certain standard of environmental quality is maintained.

While many cities have goals like Cambridge’s, it is less common to define the specifics of a mix of health care and other commercial uses as a way to create urban form and placemaking opportunities. Health care and jobs, combined with recreation, healthy foods, and affordable housing, would resonate with people of all income groups and illustrate a broader view toward healthy community design.

INCENTIVES. City planning organizations should continue to offer health care providers and developers some incentives for creating new ways to integrate complementary land uses—beyond just health care services—to promote healthy living. By combining uses that support families, a range of multimodal transportation options, and essential services, people may begin to see improved behavioral changes and active living choices.

Development projects that integrate child care facilities, healthy food production and retail, parks, play areas, walking trails, and other active recreational uses could receive credit toward floor area and building height allowances. Incentives could also be designated for transit access, bicycle parking, on-site bicycle tune-up shops, or even buildings that reduce carbon emissions, which is good for the environment and for the health of the community as well.

We already offer incentives for individual buildings: The Bullitt Center in Seattle bills itself as the “greenest commercial building in the world.” As a facility designed by the Miller Hull Partnership to both the Living Building Challenge and active design principles—

including an inviting stairway that encourages tenants to walk to their floors, thus promoting health while reducing electrical loads from elevator use—the Bullitt Center earned significant zoning variances, which allowed it to encroach into required setbacks while eliminating parking requirements.

The next step is to apply these incentives across an entire district. To achieve this broad goal of total population health, a larger, more comprehensive vision, involving collaborations and partnerships and new ways of thinking, beyond the scale of an individual building, will be required.

Health first, not health care

At the core of the healthy community is a physical environment that is conducive to physical activity, positive behavior, socioeconomic diversity, and clinical health infrastructure. Of these combined factors, the clinical component—what we traditionally think of as “health care”—should constitute only about 10 percent of the healthy community. The physical environment, healthy behavior, and socioeconomic factors should encompass the remaining 90 percent of the elements that define healthy communities.

These elements will likely include pedestrian-friendly streets; walkable mixed use development patterns; access to transit, parks, nature, and civic engagement; and a heightened sense of quality of life. Health care organizations, city planners, public health departments, urban design professionals, developers, and insurers will all play important roles in codeveloping this new paradigm. As the ACA continues to evolve, it will drive these stakeholders to realize the concept of healthy communities throughout the U.S. ■

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RESOURCES

FROM APA

Plan4Health: plan4health.us.

Institute for Medicine and Public Health: medicineandpublichealth.vanderbilt.edu.

The Institute of Medicine: tinyurl.com/paxw4hh.

Centers for Disease Control Community Health Improvement Navigator: cdc.gov/chinav/index.html.

Community Commons: communitycommons.org.

Population Health Metrics: pophealthmetrics.com.

MORE COMMUNITY BENEFITS MEAN HEALTHIER COMMUNITIES *By C.J. Eisenbarth Hager*

Some are calling it the Community Reinvestment Act for nonprofit hospitals. It has been an IRS requirement for years, but few outside the hospital industry have ever heard about it. What is a hospital community benefit requirement? How can it be a useful tool in building healthy communities? And why should planners pay attention to it?

For decades, nonprofit hospitals have been required to provide a “community benefit” in exchange for tax-exempt status. According to the journal *Health Affairs*, in 2011, nonprofit hospitals received an estimated \$24.6 billion in income, property, and sales tax benefits. In exchange for tax advantages, the IRS expects nonprofit hospitals to broadly support the health of the communities they serve—what have come to be called community benefit requirements.

Historically, most nonprofits have met this requirement by providing care for free or at reduced rates to uninsured and underinsured patients. Although charity care has filled a good portion of the hospital industry’s community benefit response, it is not the only allowable strategy. Over the years, the IRS has authorized a variety of activities and investments that would meet the requirements, as long as they improve health.

Thinking broadly about improving health, investments in quality housing, a safe walking environment, public recreation facilities, and access to affordable fresh produce can help a nonprofit hospital meet its community benefit requirements.

Affordable Care Act factor

The Affordable Care Act, passed in 2010, has added more dimension to community benefit requirements. First, nonprofit hospitals are required to perform a community health needs assessment every three years and to match up their investments with the health challenges identified in the CHNA. The IRS regulates this process.

A second nuance introduced by the ACA was the promise of a reduction in the rate of uninsured and underinsured patients. In turn, this would presumably result in a reduction in charity care, making room for other community benefit investments, like affordable housing or healthy food access. The Urban Institute reported a drop in the number of uninsured people by 15 million in the 19 months following the implementation of the ACA’s insurance marketplace. How this plays out at an individual hospital, however, is influenced by a number of factors, including unique local needs.

The changes ushered in by the ACA create an opening for planners with a broad interest in healthy communities. First, planners can help to inform a hospital’s CHNA by offering an array of data and technical expertise about how the built and physical environment can affect health—and providing potential on-the-ground solutions. Improving the walking and biking infrastructure and environment in a neighborhood with high obesity rates, for instance, might make sense from a planning and health perspective.

Secondly, CHNAs can augment other community planning efforts. A general plan or area plan could include a CHNA analysis as a way to understand built environment challenges.

This can work the other way, too: The CHNA can draw upon information in existing planning documents.

Lastly, the community benefit requirement provides another implementation tool. While hospitals can provide direct funding as a way to meet the requirement, hospitals can also offer other resources that will meet its obligation. These include facility use, staff time, and in-kind donations.

How hospitals are responding and partnering to meet the community benefit requirements is still evolving. Now is an opportune time for planners to reach out to local nonprofit hospitals to help meet the health challenges of their communities.

To learn more about the community benefit requirement and how to start a conversation with a nonprofit hospital, read *Connecting the Dots: A Healthy Community Leader’s Guide to Understanding Hospital Community Benefit Requirements* (tinyurl.com/pb6uqc3).

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AS A RESULT, many nonprofit hospitals are changing how they meet the community benefit requirements necessary to maintain their tax-exempt status. Historically most nonprofit hospitals provided charity care to the uninsured and underinsured, but with that need shrinking, they are now making other investments to benefit their communities.