CURRENT EFFORTS TOWARD IMPLEMENTATION OF AN URBAN HEALTH STRATEGY: THE HENRY FORD HEALTH SYSTEM

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ABSTRACT The Henry Ford Health System is one of the nation's major comprehensive nonprofit health systems. Though it serves seven counties in southeastern Michigan, it is based in the heart of the city of Detroit. Detroit, like many of the nation's largest cities, has high rates of poverty, single-parent households, unemployment, and violence. The health status of the population is well below national norms and Healthy People 2000 goals. Through the combined efforts of public and private organizations and the people of southeastern Michigan, Detroit is experiencing a renaissance. Henry Ford Health System is contributing to this renaissance and is working to define its role in improving the health status and quality of life of Detroit's residents. The system's current strategy centers on moving beyond civic projects and philanthropic efforts to the incorporation of care for the uninsured and underinsured in its core operations and plans for growth. To make this change, we have developed a systemwide process that focuses on designing and implementing new delivery models, on partnership development with a variety of organizations, and on managing the care of populations. Our efforts are a work in progress, but they are having an impact on our patients, our organization, and our community.

OVERVIEW OF DETROIT AND THE HENRY FORD HEALTH SYSTEM

The Henry Ford Health System (HFHS) is one of the nation's major comprehensive nonprofit health systems. The roots of the HFHS date back to 1915, when the Detroit automobile magnate, Henry Ford, established Henry Ford Hospital in the city of Detroit. Henry Ford Hospital opened as a unique and innovative institution that was designed to serve the working man. The concern of Clara Ford, Henry Ford's wife, for the quality of patient care and of Henry Ford for efficiency and cost effectiveness of delivery laid the foundation of our current health system. Over the past 80 years, Henry Ford Hospital has grown from 48

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beds and a staff of 10 to HFHS, with its 6 hospitals, 35 clinics, and a staff of 20,000.

Detroit is typical of many of the nation's large industrial cities:

- Half of all children live in one-parent households.
- Half of all children are raised in poverty.
- 75% of the population is African-American.
- Only half of Detroit's working age population is employed.
- 15% of the population is uninsured; 12% is covered by Medicaid.

During the first half of the century, the city's population grew dramatically as workers from eastern Europe, the American South, and the rural Midwest were drawn to good wages and secure jobs in the auto industry. In 1950, Detroit was home to over 1.8 million people. As with other cities, the urban core began to decline in the 1960s, but this problem was exacerbated in Detroit by the loss of thousands of manufacturing jobs. Not surprisingly, demographic trends reflect problems associated with economic decline and social tension. Today, the city's population is just over 1 million people. Married couple families have declined from 58% of all households in 1970 to 29% in 1990, with half of all children in Detroit living in single-parent households.

During the past four decades, many middle-class whites and some middle-class African-Americans have left the city, leaving behind a largely low-income African-American population. Almost one of every three Detroiters (32.4%) fell below federal poverty guidelines in 1990; 47% of all children were being raised in poverty. Even though 76% of the population in the city of Detroit is African-American, its white non-Hispanic population (222,000) is larger than the total population of any other city in Michigan. The city also contains neighborhoods with Arabic, Hispanic, and Asian populations.

Though Detroit's economy and labor market have shown some improvement in the past few years, decades of decline have taken a toll. Between 1970 and 1990, 133,000 manufacturing jobs were lost. Replacement jobs have tended to be in the service sector, at lower wages with few fringe benefits. Only half of the city's working-age population is employed, and the buying power of Detroit households dropped by 25% between 1969 and 1989. In 1990, over half of Detroit's households had an income of less than $25,000 per year.

The health status of the residents of the city of Detroit lags far behind Healthy People 2000 targets and the US population as a whole. The crude death rate is 1,183 per 100,000, as compared with 873 for the United States. Only 66% of children 2 years old have been immunized. Though teen births remained high in 1993, 223 per 1,000 live births, they had declined slightly since 1990. Infant

mortality rates have also improved, but remain high at 17.2 per 1,000 live births, compared with 8 per 100,000 for the United States.

Violence and substance abuse contribute to the city's health problems. The rate of violent crime is 12,000 per 100,000 residents. In 1993, 45% of deaths for persons under age 44 were caused by homicides. Homicides accounted for 20% of the years of life lost below age 65.

Until the 1920s, infectious and parasitic diseases accounted for the majority of deaths. Since then, chronic diseases, such as heart disease, cancer, and stroke, have become the predominant causes of death, today accounting for about three in four deaths. In 1992, the top five causes of death for Detroit residents were cancer, heart disease, homicide, stroke, and pneumonia/influenza. Detroit ranks second among the large cities of the country in death rates for chronic diseases.

In the midst of this turmoil, HFHS has worked to survive as a high-quality, cost-effective provider that supports its communities and their residents in improving health status and quality of life. The essential priority of HFHS, providing exceptional-quality, cost-effective care, is strengthened by excellence in education and research. The services of the system include disease prevention, diagnosis, treatment, research, education, medical equipment, and long-term and home health care services. HFHS also provides a variety of financing products, including the largest health maintenance organization in Michigan, Health Alliance Plan, with over 535,000 members. HFHS offers 24-hour emergency services in eight locations.

HFHS also serves southeastern Michigan through four affiliated community hospitals, one psychiatric inpatient hospital, and a major chemical dependency treatment facility. The Henry Ford Medical Group is one of the nation's largest, with 1,000 staff physicians in 40 specialties. Another 1,800 private practice physicians are affiliated with the system, including more than 600 physicians from Horizon Health System, the osteopathic arm of HFHS. The medical group operates 30 medical centers in seven counties, which record more than 2.5 million visits annually.

Henry Ford Hospital and the HFHS corporate headquarters are located in the heart of Detroit. Attached to the hospital is the system's largest, multispecialty medical center. Six other medical centers, two of which specialize in serving geriatric patients, are located in Detroit to bring primary and multispecialty care to patients near their homes and jobs. As described below, HFHS partners with other organizations for the provision of health services through school-based health centers, family practice centers, community health centers, and various

health networks. We estimate that, in any given year, 20% of Detroit's residents receive care through HFHS-owned or HFHS-partnered services.

The HFHS has been struggling to develop a strategic planning process to guide decision making for urban health initiatives. For the most part, various initiatives have been opportunistic: they tend to be undertaken because a person or institution external to the organization solicited our participation or because someone within the system identified a need and developed a program. For example, a foundation may ask HFHS to join with other types of providers on a neighborhood improvement program, or a system hospital may "adopt" a school and provide tutoring, health services, and mentoring for the children. Regardless of origin, the HFHS initiatives are oriented to community service.

While these activities have benefited both HFHS and the community, this approach to decision making has had its limitations. Chief among these limitations are the following:

- Integration of these initiatives into core operations rarely occurs, thus the initiatives die when the funding ends or staff leave.
- Organizational resources are not fully leveraged to optimize participation.
- Activities have been viewed as philanthropic endeavors and not as fundamental to our mission.
- Activities have had no connection to strategic objectives.

THE PRIMARY CARE INITIATIVE

In the early 1990s, HFHS had an opportunity to review its approach to the provision of health care services in an urban setting in partnership with other large health systems in Detroit. At that time, HFHS participated in the Primary Care Initiative, which was developed by Detroit Health Systems and was supported by a grant from the McGregor Fund. The purpose of the project was to study existing models of primary care in urban settings, particularly those that involved partnerships between large health care systems and community-based organizations, and to plan for the establishment or expansion of several partnership models through the participation of large, integrated health systems serving Detroit.

The Primary Care Initiative emerged from the idea that partnerships between health systems and innovative, community-based models of care could overcome the shortcomings of each approach working in isolation. Linkages with health systems could, in theory, provide these innovative models of primary care with more stable and highly trained staff, appropriate space, expertise in clinic management and financial services, and linkages to specialists and hospitals. Further,

linkages with community-based programs should help health systems to offer more-flexible, varied models of service delivery that address unique cultural, economic, and social factors that impede the effective use of health care and limit improvements in health status. The purpose of the Primary Care Initiative was to develop plans to improve primary care services by exploring the feasibility of partnerships between health systems and community-based programs to offer guidelines for developing such partnerships and to foster the development of specific partnership plans.

Participation in the project helped HFHS to gain a better understanding of what contributes to successful partnerships and successful programs involving large provider organizations and community-based organizations. The lessons learned can be summarized as follows:

- Successful programs keep a sense of focus in their activities. This focus typically centers on the specific needs of a defined population and on making measurable improvements in the health status of that population.
- Although a sense of focus is required to maintain direction, successful programs frequently broaden primary care concepts. Social and educational services that are provided on site (or facilitated for the patient by the primary care provider) and the use of nonphysician providers are just two examples of how the vision of primary care can be expanded beyond the traditional doctor-patient office encounter.
- Successful programs must be responsive to community needs and preferences. Responsiveness can come from a genuine commitment to meet community needs even if the organization is not located in the community served. However, responsiveness is more likely to be fostered if the primary care services are embedded in the community through the use of linguistically and culturally appropriate materials, governance by community boards, and staffing and management by community residents.
- Successful programs are able to combine a sense of autonomy and flexibility in day-to-day operations with a functional connection to organizations that provide related health and social services. Patients are able to feel a sense of "seamless" service delivery, even if they leave the primary care program for specialty or inpatient care.
- Successful programs have relatively broad funding bases and rely on a combination of service revenues, grant support, and other means to support essential staff and equipment.
- Most successful programs have a dedicated leader or "champion" who is

deeply committed to the success of the program and has a strong personal identification with it, but who can build a leadership team to ensure that the program's survival does not depend on a single individual.

Based on these lessons, the Primary Care Initiative drafted a set of principles for partnerships to improve primary care services and community health status. The principles address three core issues: the domains of responsibility of health systems, the interface between health systems and community-based organizations, and key elements in innovative primary care models. These principles have become known as the "McGregor Principles" and are being used to develop an urban health strategy within HFHS:

- The definition of health includes more than the absence of disease.
- A community's health status is the combined responsibility of health care organizations, the community, and the individual.
- Health care organizations best benefit their community via direct provision of health services, participation in community-based prevention activities, and employment opportunities with their attendant benefits.
- Although there is a causal connection between social problems and health status, health systems can work to improve health status even though social problems remain.
- Improved access to health care can be accomplished through partnerships between health systems and community-based organizations.
- The success of partnerships will depend on growing levels of mutual respect, trust, and commitment to common goals.
- Successful health care programs focus on and respond to identified community needs and preferences.
- Patients should feel a sense of seamless service delivery.

In addition to these partnership principles, HFHS decision making is guided by two other factors. We are interested in initiatives that will support the development of HFHS as a managed-care organization and provide opportunities for long-term growth. We are looking at partnerships, models of care, and financing arrangements that demonstrate promise for the long term. We are looking for ways to make fundamental change in our operations, particularly in the areas of financing and primary care.

URBAN HEALTH STRATEGIC PLANNING

HFHS has been trying to make these principles operational for the past several years. Five strategies drive our approach to urban health:

- We are working to develop a system-wide process to decide collectively what our role should be in improving the health status of the citizens of Detroit and southeastern Michigan. We are moving away from dozens of individualized initiatives, which emerge from each hospital and clinic, to a more centralized planning process with implementation at the local level. There is still room for each facility to initiate a program or respond to a request on its own, but we believe that most of our initiatives should fit with a vision of our role that is developed by the system as a whole.
- HFHS is investing time and energy to identify and test new delivery models, models that will better meet the needs of people with a complex mix of medical, social, economic, and environmental challenges.
- We are investing energy and resources in partnership development. We have identified other partners from the health care sector and many other sectors (social services, public agencies, economic development, etc.) that share our values and commitment to working together.
- The system's urban health strategy is consistent with the principles of good managed care. Accountability for the health status of a population, comprehensive preventive and primary care services, fiscal restraint, and measurement of outcomes are central to our approach.
- Most important, perhaps, HFHS has come to recognize that addressing the health care needs of the city of Detroit is a fundamental part of its growth strategy. Urban health initiatives are no longer a philanthropic endeavor that lies outside our core work. Caring for the underserved population is fundamental; it is a central part of operations. We are working to embed urban health initiatives into the mainstream, not leave them as decorative add-ons that survive or disappear based on grants and the preferences of individual leaders.

TYPES OF URBAN HEALTH INITIATIVES

In general, five types of urban health initiatives are being pursued at HFHS: (1) delivery model initiatives; (2) community health status initiatives; (3) demonstration, research, and education initiatives; (4) community service initiatives; and (5) financing initiatives. It is beyond the scope of this paper to detail specific programs in each of these categories, but brief summaries of a few programs illustrate our efforts.

Delivery Model Initiatives

Delivery model initiatives are a top priority. Three years ago, HFHS received funding from the Kellogg Foundation to establish school-based health services that focus on access to care and healthy lifestyles for children and teens in 13 of

Detroit's public schools. Since that time, additional support has been received from the Kresge Foundation, and federal and state governments have supported violence-prevention programs linked to these clinics. Based on what we had learned during the Primary Care Initiative, we developed a partnership approach to school-based health, involving the schools, parents, other health care providers, public health agencies, and community programs. The school-based health staff contracted with the Henry Ford Department of Pediatrics to provide services in some of the schools, but they also contracted with other health systems, thereby broadening community commitment to the program and increasing its chances of survival after grant funding ends.

HFHS is one of several health systems partnering with the Detroit Health Department to provide professional services at the city's health clinics. Each system has "adopted" a clinic, with health system clinicians working with health department staff to provide primary care services. When necessary, the systems provide secondary and tertiary care at their own facilities for health department patients.

HFHS has formed a relationship with two organizations that serve the Arab American community in southeastern Michigan. The Detroit area has the largest concentration of Arab-Americans in the United States. We are working with these organizations to develop health care delivery models that are tailored to the unique cultural, economic, and medical circumstances of this population. Ismael Ahmed, executive director of one of these organizations, has been named to the HFHS board of trustees.

HFHS formed another type of partnership with Mercy Health System to save an inner-city hospital. Though Mercy Health System generally competes with HFHS in southeastern Michigan, both systems recognized the importance of Mercy-Detroit Hospital to the city of Detroit. At the end of 1990, Mercy-Detroit Hospital projected an annual operating loss of $28 million; last year, the hospital reported a margin of 3.5% on revenues of $107 million. Credit for this turnaround is shared by the health systems and Brenita Crawford, chief executive officer of Mercy-Detroit, who has successfully made operational the concept of being a community-driven provider.

Community Health Status Programs

HFHS is working with many other organizations in southeastern Michigan on our Healthy Cities program, Healthy Detroit. The system is also pleased to be a part of the Robert Wood Johnson Foundation program on the Health and Safety of Children. This long-term project brings together professionals from health care, law enforcement, education, social services, and public service to join with

parents and children to reduce substance abuse, violence, and early sexual activity.

The Child Health Network is a partnership between HFHS and Children's Hospital of Michigan to coordinate pediatric health care services. The network has received a five-year $7.3 million grant from the Centers for Disease Control to improve immunization rates in Detroit. Similarly, the Breast and Cervical Cancer Control Program is a collaborative effort to ensure that all women in the area can have mammograms and Papanicolaou tests, regardless of insurance.

Demonstration, Research, and Education Projects

HFHS is an academic health center with a long tradition in research and training. We have been building those academic programs that will improve health care for the urban population. Interdisciplinary teams are often a key component of high-quality care for the most vulnerable of our urban patients. We have demonstration and training programs on interdisciplinary teams funded by the John A. Hartford Foundation and the Commonwealth Fund. Training programs for medical students and residents in urban health programs are supported by the Robert Wood Johnson Foundation and the Pew Charitable Trust. Henry Ford Hospital and Case Western Reserve University are producing an innovative curriculum for the training of generalists, starting with medical school. This project arose from the recognition that there are too few primary care providers to meet the needs in the city of Detroit, especially a lack of providers who can serve the uninsured population. Medical students are taught the skills to manage the health of the population or panels of patients. These skills are based on epidemiology and are focused on treatment of chronic disease, management of disease processes, and secondary prevention. Our training programs fit with our delivery model initiatives; both recognize that some access problems are the result of delivery models that fail to address geographic, cultural, financial, and social barriers to using health care services. With funding from the Agency for Health Care Policy and Research and the National Institute on Aging, we have established a research center devoted to outcome studies for African-American patients. There are also numerous disease-specific studies designed to improve the care of the urban population.

Community Service Projects

The community service projects are typical of those being done by many urban health centers. We are involved in various neighborhood development and business associations, we support tutoring and training programs for local schools and colleges, and we participate in many civic projects to improve housing and neighborhoods, reduce violence, and help our most vulnerable citizens.

Financing Initiatives

Financing care for the uninsured and underinsured remains a problem in southeastern Michigan. There are no public hospitals and only four public health clinics for 250,000 Detroiters without adequate health care coverage. None of the delivery systems can provide the needed care without charge, but at present, there is no mechanism for providers, health plans, employers, and government to share the costs of care. However, within HFHS, we are evolving a variety of managed-care models. We are developing a Program of All-Inclusive Care of the Elderly (PACE) for dually eligible (Medicaid and Medicare) frail elderly persons. Our health plan and delivery system are participating in Medicare and Medicaid managed care. We have also been awarded a contract from the state of Michigan to provide statewide health care services to Children with Special Healthcare Needs, Kids Care of Michigan. In order to share clinical expertise and control administrative costs related to fulfilling the objectives of the contract, HFHS and the University of Michigan Health System have formed a joint venture corporation to provide the services to this population.

Funding

The HFHS urban health initiatives are funded by a variety of sources. We have been fortunate to receive grants and contracts from public agencies at the federal, state, and local levels, and we have an active philanthropy program. However, our success in securing external dollars is due in part to our willingness to commit internal resources to urban health programs. These resources take the form of direct dollars, but we also commit staff time to develop joint ventures and partnerships and to identify models of care that can provide needed services with very limited funding. Leveraging internal dollars and expertise to push forward our urban health strategy has been essential to our progress.

LESSONS LEARNED

Although we have come a long way in the past 5 to 10 years, there are still improvements to be made. We are trying to build on what we have learned to date. Perhaps our experience will help others to avoid mistakes that we have made. The following are the key points learned:

- Improving our effectiveness as an urban health provider is a work in progress. Programs need regular evaluation to determine their effectiveness. Improving the health status of inner city residents is challenging, and often frustrating, because many of the factors that contribute to poor health are outside our control.
- We are also learning to become more strategic and proactive in our approach.

When opportunities present themselves, we review them to determine whether they meet our strategic objectives.

- We are shaping our urban health strategy with continuous input and feedback from the community.
- A clear and consistent strategy helps with internal decision making, but it also helps community organizations to know what your priorities are. We are learning that it is more important to send a clear and consistent message about what we can and cannot do than to raise expectations and not be able to deliver.
- We must find ways to "mainstream" urban health initiatives into our core operations; they must become a fundamental part of our business. To do this, we need to measure the benefits of the services we provide to patients, to the community, and to our own organization.