

INSTITUTE FOR POPULATION HEALTH - DETROIT

The health of the people is really the foundation upon which all their happiness and all their powers as a state depend.

- Benjamin Disraeli



**IMPROVING SERVICE DELIVERY AND
OUTCOMES AND MAXIMIZING FINANCIAL
AND HUMAN RESOURCES UTILIZATION**



PUBLIC HEALTH: ESSENTIAL SERVICE

Less than four cents of every healthcare dollar spent in the United States is invested in the nation's public health system. Experts agree this is an inadequate amount. Failure to provide sufficient funding for public health services allows preventable diseases to progress to more critical stages, leading to higher levels of intervention and greater investments of medical, financial and societal resources in the end.

Lacking a systematic, strategic funding structure, public health agencies at the federal, state and local levels struggle to meet opposing mandates. On one hand, they must balance ever-dwindling budgets; on the other, they must spin straw into gold—do more with less to keep those under their care healthy and whole.

Public health departments, in municipalities that have been hardest hit financially and are in closest contact with the populations in greatest need of their services, are facing this challenge most acutely. Fettered by bureaucracy combined with legacy costs and work rules required by contracts negotiated during more prosperous economic times, too many cities are making painful decisions to cut public health services severely or eliminate them completely. Funding issues aside, the need for public health programs and services continues unabated, creating an opportunity to identify, design and inaugurate new approaches to ensure this indispensable service is not diminished.

Success through Innovation

As the City of Detroit teetered on the brink of bankruptcy in 2012, the Institute for Population Health (IPH), an innovative alternative to closing the Department of Health and Wellness Promotion, was established. With the approval of Detroit's mayor and Michigan's governor, IPH assumed responsibility for mandated and non-mandated public health services for Detroit residents during the city's financial crisis. A non-profit organization, unaffiliated with city government, IPH not only streamlined the administration and provision of public health services, but also posted superior results in almost all program categories and ended its first year of operation with a financial surplus.

TRADITIONAL APPROACHES JEOPARDIZE PUBLIC HEALTH SERVICES

A Heritage of Promoting Health and Wellness

The City of Detroit had been protecting its citizens' health and well being for close to 200 years—as the prospect of bankruptcy loomed in 2011. As early as 1827, the Common Council had recognized government's role in fulfilling this essential function by appointing a panel of physicians to report on policies "conducive to the health of the city." And while titles changed—from Board of Health to Health Department to Department of Health and Wellness Promotion—the organization's mission remained virtually unaltered: "to improve the health and quality of life" for Detroit residents.

In fulfillment of that goal, the city's health department responded to numerous health challenges since its inception: sheltering and treating smallpox and, later, tuberculosis patients; inoculating the first generation of youngsters against the polio virus; assisting individuals infected with HIV/AIDS. As public health's role in creating a vital and vigorous community gained greater recognition and support, departmental responsibilities expanded to provide a variety of essential services: immunizations, control of sexually transmitted and other infectious diseases, health education, hearing and vision screenings, dental services, food protection, and pre- and post-natal services for low-income mothers and their infants.

Strong Leadership in Perilous Times

Mindful of the department's rich history of service to Detroit residents and its significance to their wellness and well being, then-Mayor Dave Bing appointed Loretta V. Davis as the city's Health Officer and Director of the Department of Health and Wellness Promotion (DHWP) in 2011. A seasoned public health executive, Ms. Davis had led Wayne County's public health department and earlier served as Director of the Division of Health, Wellness and Disease Control for the Michigan Department of Community Health. By the time she took over, however, the department's annual allocation from the City budget had shrunk to \$4.1 million—slightly more than one-tenth of the \$37 million allocated for the protection and improvement of Detroiters' health a decade earlier.

What's more, the City of Detroit was on a collision course with fiscal disaster. Drastic measures were in order. One of the first steps came with the approval of a financial stability agreement with the State of Michigan. Supported by Mayor Bing and narrowly approved by the City Council, the agreement was designed to avert the country's largest municipal bankruptcy and avoid appointment of an emergency financial manager by the governor. Under the terms of the agreement, considerable power, over the City's fiscal operations and decisions, was vested in a financial advisory board, along with the authority to consolidate, eliminate or otherwise dispose of city departments.

Detroit's top leaders struggled, looking for solutions that would maintain the municipality's autonomy and enable city services to be provided to residents.

Mayor Bing made budget cuts that would have been unthinkable in more prosperous times, funneling available resources into six areas of "critical importance." Public health was not on the list.

BOLD INNOVATION AND SOLUTIONS REQUIRED TO AVOID A SHUT DOWN

A New Approach to an Old Problem

Asked by Mayor Bing to offer a viable alternative to eliminating the department, Loretta Davis, the city's Health Officer, understood that a traditional approach to providing public health services in Detroit would no longer work. Mayor Bing said, "We owed the taxpayers an opportunity to receive the best service possible."

Ms. Davis responded to the challenge by proposing a transfer of DHWP's programs and operations to a "public health institute." Relatively new to the public health arena, these organizations are structured as non-profit entities, and currently operate in 30 states, including Michigan, and the District of Columbia. A few major American cities, such as New York and Philadelphia, have adopted this delivery model for their public health services as well.

**“Don't let politics
get in the way of
doing what is right
for your residents.”**

- MAYOR DAVE BING

The institutes' primary purpose is to improve the wellness of residents of the communities in which they operate. They reach this goal by fostering innovation, creating partnerships, and leveraging resources. Their services typically include:

- » Population-based health programs
- » Health policy development, implementation and evaluation
- » Training and technical assistance
- » Research and evaluation
- » Health information
- » Health communication and social marketing
- » Fiscal management



Advantages: Streamlining Administration, Management and Service Delivery

In Detroit's case, this approach offered several advantages over the structure that had been in place throughout the twentieth, and into the twenty-first, century, while also preserving an essential public service. The pluses included:

- » Uncoupling from the legacy costs and outdated work rules required by contracts
- » Reducing administrative overhead
- » Overcoming bureaucratic barriers

Moreover, and from the standpoint of clients and the city as a whole, a Detroit-based public health institute could operate more nimbly and increase focus on, as well as substantially improve, customer service. Freed from the internal politics, organizational inertia and red tape of city government, the organization would be better positioned to manage and use—not return—grant funds, as had happened much too regularly under the City's traditional public health management structure.

As envisioned by Ms. Davis, the proposed Institute for Population Health (IPH) would be designed to "advance positive outcomes in populations and communities." Its founding principles would include leadership and service, ethics and integrity, excellence and professionalism, innovation and entrepreneurship, and health equity.

Acceptance and Activation

Although approved by Mayor Bing, endorsed by Michigan Governor Rick Snyder, and supported by the Michigan Department of Community Health, Loretta Davis and her team faced multiple obstacles in establishing a public health institute in Detroit. They were operating without resources, as funds were not available to cover planning expenses, and working against the clock, with intense pressure to make a swift and seamless transition.

And, because 200 city positions would be eliminated if the change took place, the labor unions that represented DHWP employees predictably and vigorously opposed the plan. Several Detroit City Councilmembers joined the fight, challenging the authority to transfer public health services to a non-profit without the Council's consent.

Preparations moved forward, however; required approvals were secured; and the Institute for Population Health (IPH) was established. The

Michigan Department of Community Health transferred \$42 million in state and federal grant funds to IPH, which previously had been given to the city's health department. In exchange, the Institute would provide mandated and non-mandated public health services to Detroiters. IPH was allowed to retain and reinvest revenue generated through fees paid for client services under the terms of the agreement as well.

Ms. Davis, who had inspired and guided the development process from the outset, was named IPH's founding President and CEO. She led an executive staff that included, among others, Chief Operating Officer Betty Pash, who had formerly served as Deputy Director of the Michigan Department of Community Health, and been a part of the team that developed the plan to launch the IPH in Detroit.

Fulfillment of Promises

The Institute for Population Health opened its doors to the residents of Detroit on October 1, 2012, following an intense six-month period of planning and preparation. The transition took place without disruption to the delivery of public health services in Detroit. Like its predecessors, IPH offered a full menu of programs, including:

- » Environmental Health
- » Lead Poisoning Prevention
- » Communicable Disease
- » Children's Special Health Care
- » Emergency Preparedness
- » Environmental Safety
- » Family Planning
- » Food Safety
- » HIV Prevention
- » Immunizations
- » Maternal-Infant Health
- » Pediatric & Adult Dental
- » STD Prevention
- » Tuberculosis Prevention & Control
- » Vision & Hearing
- » Women, Infants & Children (WIC)

Focused on stabilizing and improving public health services in Detroit, the Institute's first year of operation was marked by administrative efficiency, flexibility, innovation, and service provision. Employees were trained in proven customer service techniques. They were also challenged to move beyond the role of "case finders" and practice holistic engagement to discover additional factors that affect clients' health and well being.

In its first year of operation, IPH posted more than 600,000 encounters with Detroit citizens. Public health programs reached new levels of success through innovative approaches to service delivery. By locating IPH facilities in neighborhoods, particularly the city's North End and northeast, utilization increased in most categories, including:

- » Individuals tested and treated for sexually transmitted disease (+74%)
- » Immunizations administered (+66%)
- » Visits to family planning clinics (+20%)
- » Restaurant inspections (+20%)
- » Follow-up restaurant inspections (+103%)

IPH also recorded an 87 percent reduction in the average number of days taken to investigate communicable diseases (down to 14 days from an average of 104).

New programs were introduced, including Early On, which, in its first year, served 374 families with developmentally delayed children under the age of three. Significant focus was also given to health information planning, policy evaluation and research, which used internal and external data for the purpose of improving the health status of residents of Detroit.

What's more, IPH's clients recognized the changes that had taken place and expressed their appreciation through responses to a client survey, which measured satisfaction with timeliness, helpfulness, privacy, cost and cleanliness. IPH received an overall score of 89 percent, based on the results of 8,300 surveys.

The success of the venture was evident in IPH's financials, as well. Operating expenses were slashed by \$5 million, down from 17 percent for DHWP in fiscal year 2012-13 to 8.5 percent for IPH from October 2012 through September 2013. Cost savings were directed into services and programs to benefit clients.

Based on these results, Detroit's former mayor Dave Bing would advise other cities to be unafraid of change. "Don't let politics get in the way of doing what is right for your residents," he said.

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CONCLUSION

Today, IPH's commitment to improving the health and well being of Detroit's 700,000-plus residents is stronger than ever. While the organization continues to innovate and serve Detroiters' public health needs, the City's post-bankruptcy mayoral administration reconstituted the Department of Health and Wellness Promotion. The Institute for Population Health, under the leadership of Loretta Davis, continues to provide much-needed public health programs and to improve service delivery by leveraging new funding models and public-private partnerships.

Because of the success IPH experienced, Ms. Davis is frequently consulted by other municipalities and public health officials to share her expertise and experience in transforming traditional delivery systems into contemporary models of service excellence and financial stability.



About IPH

The Institute for Population Health (IPH) is dedicated to advancing positive health outcomes in populations and communities. Our actions are guided by our values, which include health equity, leadership and service, and innovation and entrepreneurship. These values are evident in IPH's actions on behalf of the clients we serve and our commitment to improving their health status.

As a pioneer in transitioning traditional public health service delivery systems into financially stable, outcome-focused organizations, IPH also guides public health departments and agencies to innovate new solutions that assist the achievement of their missions and enable maximum utilization of resources for the benefit of their target groups.

Contact

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Behavioral Health

	CURRENT & PREVIOUS DASHBOARDS							
	Pre-IPH	Oct-Dec 2012	Jan-Mar 2013	Apr-June 2013	July-Sept 2013	Cumulative Avg	Change	Progress
Number of HIV Tests Performed	1,303	1,932	2,002	2,183	1,861	1,995	53%	▲
Number of People Who Received Substance Abuse Prevention Services	25,761	15,602	25,658	28,307	20,546	22,528	-13% ³	▼
Number of Substance Abuse Clients Receiving Required Communicable Disease Screening	1,418	1,380	902	1,026	2,042	1,338	-6% ³	▼
Number of Clients Who Received Substance Abuse Treatment	6,529	5,223	4,551	4,981	5,730	5,121	-22% ³	▼

Environmental Safety & Preparedness

	CURRENT & PREVIOUS DASHBOARDS							
	Pre-IPH	Oct-Dec 2012	Jan-Mar 2013	Apr-June 2013	July-Sept 2013	Cumulative Avg	Change	Progress
Number of Restaurant Inspections	536	601	649	651	672	643	20%	▲
Number of Follow-Up Restaurant Inspections	119	184	201	302	279	242	103%	▲
Number of Environmental Inspections	N/A	516	678	187	190	393	No Baseline	N/A
Percent of Staff with Appropriate Emergency Preparedness Training	87	75 ⁴	85	87	91	N/A	4%	▲

³Funding cuts impact services provided

⁴Newly-hired, untrained employees given 1 quarter (90 days) to complete training

Notes:

- Pre-IPH: 10/1/2011-9/30/2012, last quarter before IPH, last month before IPH or contractual target
- Cumulative Avg: Calculated with IPH data only
- % Change: $\left(\frac{[(\text{Cum Avg-IPH}) - (\text{Pre-IPH})]}{(\text{Pre-IPH})} \right) \times 100\%$
- Progress: Determined by "% Change" or compared to the goal for that program
- Data rounded to the nearest number

January 10, 2014

