



Detroit Wayne County
HEALTH AUTHORITY
It's about access...for all.

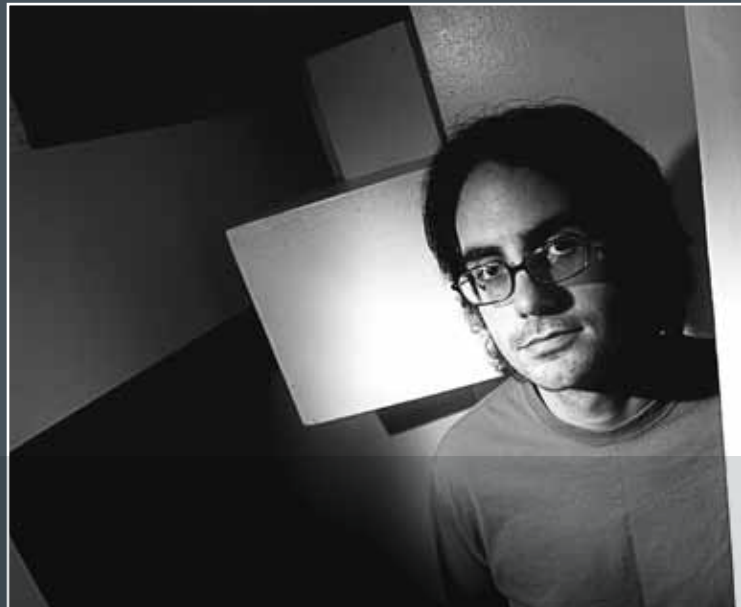


2009 COMMUNITY REPORT

The Uncompensated Care
Emergency Strikes Hospitals

TABLE OF CONTENTS

Board of Directors	2
Message from the Chairman	3
Message from the Executive Director	4
Mission / Vision / Values	5
An Historic Summit of Health Systems	6
2008-2009 Safety Net Report	14
Extending Our Reach Through Community Engagement	22
2008-2009 Progress Report	26
Financial Statement	32
Thank You to Our Supporters	36



BOARD OF DIRECTORS

Gail Warden *Chairman*
President Emeritus
Henry Ford Health System

JoAnn Watson *1st Vice Chair*
Detroit City Council Member

Tim Killeen *2nd Vice Chair*
Wayne County Commissioner

Judge Sandra Cicirelli *Secretary*
18th District Court

Ron Gettlefinger
Retired President
United Auto Workers

Reuben Munday
Partner
Lewis & Munday, P.C.

Dr. Cynthia Taueg
Vice President
St. John Providence Health System

Chuck Gayney
Retired Director
United Auto Workers

EX-OFFICIO MEMBERS

Adam Jablonowski
Executive Director
Wayne County Medical Society

Rose Khalifa
Executive Director
Metro Solutions

STAFF

Chris Allen
Executive Director/CEO

Janette Davis
Chief Financial Officer

Faith Polk
Medicaid Program Administrator

Dennis Archambault
Director of Public Affairs

Joslyn Pettway
Director of Primary Care Initiatives

Kathleen Zalewski
Business Manager

Michele Calloway
Outreach Manager

Erin Barthel
Government & Community
Relations Coordinator

Lorraine Hinton
Executive Administrative Assistant

Marcia Hendrick
Executive Administrative Assistant

Joyce Smith
Administrative Assistant

Andrew Pritchard
Administrative Fellow

Elizabeth Longley
Strategic Development Consultant

Mia Puryear
AmeriCorp Volunteer –
Medicaid Outreach

MESSAGE FROM THE CHAIRMAN

The Detroit Wayne County Health Authority completed another successful year of helping more people in Detroit and Wayne County gain access to quality health care.



Gail Warden

We are making great strides in fulfilling the mission given to us by Governor Jennifer Granholm and the leadership of Detroit and Wayne County in 2004 – “to coordinate efforts to meet the health needs of the uninsured and underinsured residents in the City of Detroit, Wayne County and other Michigan counties by assuring access and improving the health status of all people.”

This is a tall order for any organization, particularly one forced to find creative, entrepreneurial sources of funding to fulfill a public mission. But the Health Authority has proven that it is up to the task with ever expanding activity in public program enrollment, community health services, and health resource collaboration.

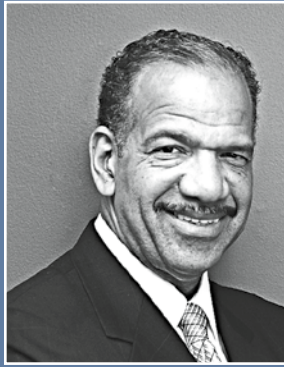
The Health Authority has established remarkable initiatives among health systems, Medicaid health plans, federally qualified health centers, and behavioral health providers, furthering the quality and access of care for the uninsured and underinsured. These initiatives show the ability of the Health Authority to create collaborations across institutional lines.

Looking forward to the implementation of national health care reform, the Health Authority is prepared to lead the community in this transition. While health reform promises to ensure access to health insurance coverage to more people than ever before, it also will challenge the health system to meet significantly increased needs. The health care safety net will be needed more than ever. Although we are fiscally challenged, like all health and human services in this country, we will prevail in the important work of ensuring access for all.

I would also like to recognize the contributions of founding Board member and Treasurer Sister Mary Giovanni, who resigned this year. As Treasurer of the Health Authority Board, she assumed responsibility for the difficult task of financing a mission without a defined source of revenue. Sister Giovanni is a quick study; one who could read a financial ledger sheet and read between the lines of a policy briefing. She demonstrated keen financial governance to help weather the difficult initial years and guided the Health Authority to a more fiscally stable condition today. Sister Giovanni has had the strength and courage to report the brutal facts of those early years and urged the state and other financing partners to support the Health Authority viability. She believed the work of the Health Authority is too important to our community and our society as a whole. The Board will miss her greatly.

Gail Warden
Chairman

MESSAGE FROM THE EXECUTIVE DIRECTOR



Chris Allen

Challenging times always create opportunity, but we need to be creative and enterprising to see opportunity through the barriers of adversity.

The Health Authority was established at a time of great challenge for the safety net. Detroit Receiving Hospital was threatened with extinction. State, county, and municipal leaders saw the wisdom of creating a health authority to strengthen the safety net as a way of preventing the region's emergency/trauma hospital from peril in the future.

The Health Authority has seized the opportunities available to it, from a highly successful Medicaid Match program with an innovative web-based enrollment system to initiatives that

create collaborations between health systems, health centers, and other health providers to strengthen the safety net.

This was a dynamic year for health care and the Health Authority. As we witnessed the “audacity” of President Obama’s efforts to drive health care reform beyond the many hurdles that his predecessors stumbled on, the Health Authority demonstrated its role as a convener by assembling three new committees: the Uncompensated Care Committee, comprised of health system executives, the Medicaid Health Plan/Federally Qualified Health Center Committee, and the Integrated Behavioral Health Initiative.

We have long felt that much can be accomplished with available financial and human resources that exists in our health and human services system to strengthen the safety net. We have proven this point with these committees. For example, health system executives remarked to me how momentous it is that the major health decision-makers have come together for the first time to create solutions regarding access for the uninsured. Meeting regularly as sub-committees and the committee as a whole, the Uncompensated Care Committee worked on the difficult issues of reorienting the

uninsured from emergency departments to community health centers, creating an uncompensated care fund, and developing a network of specialty physicians available to treat the uninsured. I am deeply grateful to the vision, leadership, and hard work of Nancy Schlichting, CEO of Henry Ford Health System, in taking on this challenge.

The relationship between Medicaid health plans and federally qualified health centers has been enhanced greatly by a year-long initiative designed to provide the health plans with a high quality primary care referral source and provider the health centers with Medicaid reimbursement, allowing them to treat more uninsured people.

One of the frontiers in medicine continues to involve creating a productive inter-relationship between providers of medical and mental health care. We’ve known that there is a relationship between psycho/social health and physical health – whether it’s the physical manifestation of emotional distress or the emotional distress that comes from a medical condition. We know that patient care is most effective when these resources are integrated. Our Integrated Health Initiative has brought together more than 30 leaders in the primary care and behavioral health fields and promises to create a new health care delivery model.

As we close our books on 2008-2009, we anticipate moving into new ventures to sustain our operations and grow the initiatives we’ve established. Health insurance reform will extend coverage to many more people – but they need to be informed, enrolled, and ultimately served. There is much work to be done in the safety net to ensure that this occurs. The Health Authority intends to lead the safety net through coordinating existing resources and providing new services where necessary.

To that end, we look to “The Future of the Safety Net Planning Summit,” which will convene the leaders of safety net organizations to discuss current challenges and project the post-health reform safety net. The Health Authority will use this summit to develop its 2010-11 operations plan.

Our community deserves an essential safety net – whether that is preserving health, housing, education, or other necessities of life. We’re committed to creating a strong, integrated safety net that ensures access for all. We appreciate your support in the past and ask you to reaffirm your support in the days ahead.

Chris Allen
Executive Director

MISSION

To coordinate efforts to meet the health needs of the uninsured and underinsured residents of the City of Detroit and Wayne County by assuring access and improving the health status of all people.

VISION

To create an organization recognized locally, statewide and nationally for its ability to develop and sustain an effective safety net delivery system for the uninsured and underinsured populations of the City of Detroit and Wayne County. This will be accomplished through: the coordination of primary care and preventive health services; the establishment of “medical homes” providers to assure continuity of care to residents regardless of where they live; the maximization of private and public resources; and the cooperation and collaboration of all stakeholders on both health services and public health issues.



Clockwise from left: Nancy Schlichting, president and CEO, Henry Ford Health System; The committee in discussion; Ken Matzick, president and CEO, Beaumont Hospitals



This year, the health systems of Southeast Michigan, representatives of state government, the state hospital association, and insurance industry came together to form the Uncompensated Care Committee, at the request of the Health Authority.

The committee, chaired by Nancy Schlichting, president and CEO of Henry Ford Health System, was charged with developing methods of relieving the growing uncompensated care burden while enhancing access to appropriate care for the uninsured and underinsured.

“Clearly there is a responsibility that providers in this community have to try to innovate in this area,” Schlichting says. “My goal for this group was to think differently about the challenges that we have in providing care for people who don’t have insurance or are underinsured. Our goal was to have a positive impact in this area, to find new ways of addressing what have been challenges in our community for some time. But the growth of the uninsured population in the last few years has been extraordinary. That’s why there is such a sense of urgency around this issue – and accomplishing something is so important.”

The committee focused on three areas:

- **Federally Qualified Health Center (FQHC)-Hospital Workgroup:** Chaired by Jesse Thomas, president of Molina Healthcare of Michigan, The FQHC-Hospital workgroup was charged with building more effective relationships between hospitals and local FQHCs. The workgroup was specifically charged with examining opportunities for increased cooperation around appropriate emergency department utilization. The workgroup was inclusive of emergency department physicians. A primary goal of the workgroup was to recognize that existing relationships between hospitals and FQHCs must be strengthened. Secondly, a goal was to gain consensus around options for redirecting non-emergent care to a more appropriate and cost effective primary care medical home setting. This included securing workgroup commitment for a hospital system pilot to co-locate an FQHC within an emergency department or adjacent to one.
- **Physician Workgroup:** Chaired by Ken Matzick, president and CEO of Beaumont Hospitals, this workgroup was charged with examining ways of working with physicians to improve quality, cost, and access for safety net services. The primary goal of the workgroup was to improve access to specialty care for uninsured and underinsured patients. Essentially, under this model, specialty physicians agree to treat uninsured patients at no cost on a limited basis throughout the year.
- **Finance Workgroup:** Chaired by Jay Rising, executive vice president, Detroit Medical Center, this group was charged with estimating the uncompensated care burden experienced by health systems, assess coverage expansion options and alternate methods of leveraging federal matching funds; assess opportunities and current limitations on funding; and review federal requirements for funding and coverage expansion.



Determination and innovative ideas will resolve safety net issues

The health care safety net is a complex web of several health and human service providers that provide services for the uninsured and underinsured at various levels. Health systems are the largest components of the safety net, absorbing millions of dollars in uncompensated and charity care, community health center and free clinic support, and other financial and in-kind support for the safety net.



A closer link between emergency services and community health centers

Building more effective relationships between hospitals and local Federally Qualified Health Centers (FQHCs) was a major objective of the Uncompensated Care Committee. Jesse Thomas (above), president and CEO of Molina Healthcare of Michigan, chaired the sub-committee that addressed this issue. Specific recommendations of the committee included:

- Distribute a list of available FQHCs to relevant hospital staff.
- Integrate “point of care” counseling into the emergency department patient care process.
- Hospitals should collaborate with existing FQHCs to help address existing capacity and system issues.
- Create a co-location pilot program involving one hospital and one FQHC.

An important partner in the safety net

“Health systems represent a major component of the safety net,” notes Chris Allen, executive director and CEO of the Health Authority. “This initiative has shown how creativity and commitment by the provider community can result in innovative solutions. Under the leadership of Nancy Schlichting and the collaboration of regional health systems, we have forged a plan that will ensure that many uninsured and underinsured people with urgent health problems have a medical home to treat them in a timely, appropriate manner and not in an emergency room. At the same time, emergency department volume will decrease, allowing providers to care for truly emergent patients and reduce uncompensated care costs for hospitals.”

A critical aspect of change involves Federally Qualified Health Centers (FQHCs) and “look-alike” health centers, free clinics, and other community health centers that can be medical homes for more people in medically underserved areas through partnerships with health systems, according to Schlichting. “We have a superb model for that at Henry Ford Health System with our 30-year partnership with CHASS (Community Health and Social Services Center, Detroit); that relationship allows Henry Ford Medical Group physicians to provide primary care. We have mid-level providers who are Henry Ford employees. All the specialty care needed for those patients is referred to the Henry Ford Medical Group.

“That’s an economic burden, frankly, but the Henry Ford Medical Group takes that on as part of their charitable mission. It is very important in terms of the quality of care – this creates continuity in the relationship. It has allowed those patients to have a true medical home, because they know they will get ongoing care for all their health care needs provided by a very high quality group of physicians and nurses. That relationship is one that we hope we can create with all the health systems and federally qualified health centers.”

Health system committee recommends proactive approach to placing non-emergent patients in primary care facilities

The Uncompensated Care Committee and its workgroups met throughout 2009, culminating in three sets of recommendations listed below:

- Hospital-FQHC Workgroup: Integrate FQHC staff in the emergency triage process to identify and appropriately place non-emergent primary care patients; develop and distribute a contact list and access information about all FQHCs for use by appropriate hospital staff; integrate “point of care counseling” in emergency departments to support referrals to community-based medical homes and to educate patients on appropriate use of emergency departments; collaborate with existing FQHCs to help address existing capacity and system issues, including graduate medical education and clinical rotation opportunities at FQHCs and look-alikes. Develop and implement a co-location pilot between an FQHC and hospital emergency department; and, adopt other cost-effective emergency department redirection alternatives; integrate Voices of Detroit Initiative (VODI) “point of care counseling” in emergency departments.

- Physician Workgroup: Create a voluntary network of specialty physicians who agree to serve the uninsured; coordinate specialty outpatient clinics to provide physicians with an alternate practice site; create a network of physician consultants to help in the secondary care of the uninsured.
- Finance Workgroup: Pursue an approach that expands Medicaid coverage in compliance with early adopter providers in federal health care reform; substantiate the rationale of private employers’ benefit from Medicaid coverage expansion; and refine benefit costs, and develop funding and management systems to support Medicaid coverage expansion.

For further information on the implementation of these recommendations, contact Joslyn Pettway, director of Primary Care Initiatives, at 871-3751 or jp Pettway@dwcha.org.

Bringing the medical home close to hospitals

While the concept may seem easy enough, developing the model for referring patients with primary care and chronic care problems to a medical home required considerable thought and consensus-building. The sub-committee recommended establishing “point of care counseling” in emergency departments to help direct patients to the right setting.

Traditionally, many uninsured and underinsured people wait until their medical conditions become so acute that they need emergency care. “In an emergency department, the average cost per visit is around \$500, while a primary care visit in a community health center would be somewhere around \$40 or \$50,” says Thomas. “If the care that didn’t need to be in the emergency department was redirected to a less expensive environment, the uncompensated care expense would go down.”

UNCOMPENSATED CARE COMMITTEE MEMBERS

Nancy Schlichting

President and CEO, Henry Ford Health System, Chair, Uncompensated Care Committee

Ken Matzlik

President and CEO, Beaumont Hospitals, Chair, Physician Work Group

Jesse Thomas

President, Molina Healthcare of Michigan, Chair, FQHC-Hospital Workgroup

Jay Rising

Executive Vice President, Detroit Medical Center, Chair, Finance Workgroup

Dennis Herrick

Senior Vice-President and CEO, Beaumont Hospitals;

Kevin Seitz

Executive Vice-President, Health Care Value Enhancement, Blue Cross Blue Shield of Michigan

Dr. Paul LaCasse

President and CEO, Botsford Hospital

Michael Duggan

President and CEO, Detroit Medical Center

Gary Ley

President and CEO, Garden City Hospital

James Connelly

Senior Vice President and CFO, Henry Ford Health System

Spencer Johnson

President, Michigan Health and Hospital Association

David Seaman

Executive Vice President, Michigan Health and Hospital Association

Peter Schonfeld

Senior Vice President, Policy & Data Services, Michigan Health and Hospital Association

Denise Holmes

Associate Dean for Government Relations and Outreach, Michigan State University – Institute of Health Studies

Brian Connolly

President and CEO, Oakwood Health

Doug Welday

Chief Financial Officer, Oakwood Health

Dr. Patricia Maryland

President and CEO, St. John Health

Bob Hobin

Chief Strategy Officer, St. John Health

Patrick McGuire

Chief Financial Officer, St. John Health

Stephen Fitton

Bureau Director, State of Michigan Medicaid Services Administration

Garry Faja

President, St. Joseph Health System, Trinity Health

Adam Jablonowski

Executive Director, Wayne County Medical Society

Robert Frank, M.D.

Executive Vice Dean, Wayne State University School of Medicine

Chris Allen

Executive Director and CEO, Detroit Wayne County Health Authority

Janette Davis

Chief Financial Officer, Detroit Wayne County Health Authority

Richard Bohrer

Rear Admiral (Ret.) U.S. Public Health Service, Former Assistant Surgeon General and Director, Community Health Center Program; Co-chair, Primary Care Network Council

Neal Colburn

Consultant, Michigan Primary Care Association

Joslyn Pettway

Director of Primary Care Initiatives, Detroit Wayne County Health Authority

“We have to ensure that there is adequate primary care capacity at Federally Qualified Health Centers and that FQHC scheduling allows for emergency department patients quick and easy access,” Thomas says. “We want to have very effective community outreach and education to help change the culture of going to an emergency department of a hospital for episodic care when there are more appropriate providers of care in the community.” The sub-committee also recommended co-locating FQHC satellites in emergency departments.

Medical homes are designed to promote disease prevention as well as managing chronic conditions so they don’t become emergent health problems. One of the challenges of managing diseases such as diabetes, hypertension, and asthma, is having specialists willing to accept uninsured and underinsured patients. The Physician Workgroup examined ways of creating a network of specialists that would serve patients throughout Wayne County.

“In part, it’s a solution to our emergency room problem, where those patients will show up with advanced disease and we’ll have to take care of them anyway, so how can work toward meeting their needs at earlier stages of disease where the burden is less on everybody,” explains Matzek.

“The pathology of this population is rife for chronic disease,” he says. “Those diseases, if unmanaged, result in devastating medical problems that end up requiring specialty care or emergency care. Active management is

the key. A lot of it is educational, in terms of lifestyle, diet, routine care... a lot of things have to be connected to adequately manage a chronic illness to prevent it from following a course resulting in a worse condition. If a diabetic goes untreated and loses kidney function, poor circulation resulting in amputation – those things are devastating.”

Creating a regional network of specialists to treat the uninsured

The workgroup studied the “Physicians Who Care” program, sponsored by St. John Health for its patients. Specialty physicians agree to see a certain number of patients free of charge. The hospital provides diagnostic services.

“I fundamentally believe that the main problem in health care is the lack of organization of health services,” says Michael Kobernick, M.D., director of Emergency Services for St. John Providence Health System. “The converse of that, if you organize services you can provide better care and create cost savings.” While medical director for St. John’s community health

services, Dr. Kobernick developed an idea to ask specialists to see a few uninsured patients for no fee; provided malpractice coverage and other paper work so that once the patient is seen the physician has all the resources they need.

He would like the Health Authority to create a network not only of specialists willing to see the Medicaid and uninsured population, but primary care physicians as well. “Internally, through the Health Authority, we’d develop that network list. An example would be that Beaumont has orthopedics available and St. John has nephrology available – I would see the Health Authority’s function to provide the overall coordinating services for all of the specialties. It could easily be expanded to provide a regional network resource. If you took a network model HMO concept and you did that



Above: Jay Rising, executive vice president, Detroit Medical Center

with primary care – the Health Authority could keep a list of all primary care physicians available to see uninsured patients in the community. We could then parcel them out equitably so nobody could say that they were getting more than their share. You could begin to see in a bigger picture that we could do the whole thing.”

Health care reform promises to help a lot of people by extending the Medicaid entitlement to hundreds of thousands of people. Single adults who fall under 133 percent of the federal poverty level would be entitled to Medicaid. “These are people who aren’t disabled and may be under 50 percent of the poverty limitations but we treat them,” explains Jay Rising. “They have surgeries, they have treatments, they have serious medical conditions – we treat them. That’s the focus I pushed the Physician Workgroup to address.

“If you are above existing levels of eligibility, but become disabled and have inpatient hospitalization, there are ways for you to have a spend-down to be able to qualify for Medicaid. It’s the folks who aren’t disabled who can’t do this. That’s where the federal government is going, it seems. That’s what we’re trying to focus on. Is there a way the state can do this also? Is there a way to fill that gap between now and whenever the federal plan goes into effect.”

This likely will increase demand for health services in areas that are medically underserved now, in a state that is reducing Medicaid payments to providers, causing some to stop treating Medicaid patients at all. With an estimated 11,000 new Medicaid enrollees added each month now, additional Medicaid enrollees will compound the challenge to providers.

Hospitals bear the burden of the uninsured

“It’s acutely important to understand the size of the burden and what solutions exist, with government support, to relieve that burden,” notes Rising. “It’s an additional cost of doing business. It’s something that makes us less competitive. Hospitals are always concerned about this, because they don’t have payers who are willing to keep increasing the reimbursement. The payers are feeling the pressure from the private sector (businesses that buy the health insurance premium) so we’re really conscious about how we can mitigate the cost of uncompensated care.

The solutions won’t be easy to achieve, with or without health reform legislation; but they are achievable.

“It depends on your will,” Schlichting explains. “The state budget could do more. There’s always give and take in any

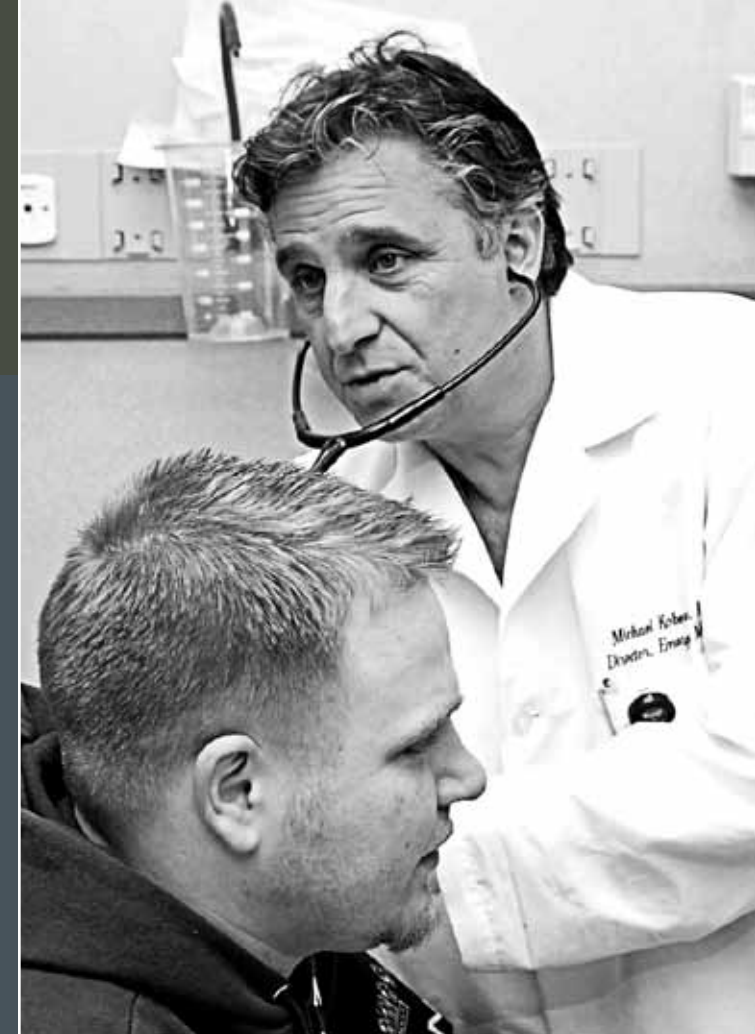
budget. If you don’t believe that eligibility should exist, and there’s not a group of people advocating, it will never happen. We think that we’re the appropriate people to be advocating for these patients. These patients don’t have a voice in this state. If health care providers don’t step up in partnership with the Detroit Wayne County Health Authority to advocate for appropriate coverage, I don’t know who is going to do it.

“If we always know the answer before we ask the question, we’re never going to do it. In this state, in my opinion, we assume we can’t do something before we try it. No is the easy answer. Finding the path is harder.”

The Uncompensated Care Committee completed its work in December 2009, with a vow to continue in an oversight capacity as task groups implement the committee’s recommendations in 2010. The committee’s work represents a significant milestone in strengthening the safety net.

Notes Thomas: “Historically, this discussion would not even be taking place in Detroit/Wayne County. There would be a growing fragmentation (of care), and uncompensated care and charity care would escalate. (Uncompensated care in Southeast Michigan grew from \$300 million in 2007 to \$800 million in 2008.) The Health Authority, in its wisdom, has pulled the principals together – the health system CEOs and CFOs, health plan executives and FQHCs.

“It has been refreshing to have all of the stakeholders at the table. . . . You can begin to make progress despite how difficult the lift is – changing policy and changing culture is a heavy lift – when you stand close together and you lift where you stand, you can lift mountains of opposition, indifference and suspicion. The outcome of this, in my mind, is a commitment to stand close together and lift where we stand.” ■



Helping recruit ‘physicians who care’ for specialty charity network

St. John Providence Health System has maintained an effective network of specialty physicians willing to provide free care for the uninsured. Through the Uncompensated Care Committee, a good idea is becoming better, as a regional version of that network is underdevelopment. Michael Kobernick, M.D., Director of Emergency Services for St. John Providence (pictured above), is providing the medical coordination for the regional network.

Above: Dr. Paul LaCasse, President and CEO, Botsford Hospital

SAFETY NET 2008 2009 REPORT

The inter-local agreement that created the Detroit Wayne County Health Authority (Health Authority) charged the organization with monitoring health care for the safety net population. In 2008, the first steps in establishing the Safety Net Resource Center were taken, and in the same year the first annual Safety Net Report was published as part of the Health Authority's annual report. In order to aid safety net organizations in addressing barriers to care in a structured, comprehensive way, the Health Authority will continue to work toward strategies for monitoring the state of the safety net. These annual reports serve as the first stage in that effort.

The 2009 Safety Net Report provides updated statistics for the key indicators used in the 2008 report. These indicators were gathered from a variety of sources, including the Michigan Department of Community Health (MDCH), the U.S. Census Bureau, and the Administration for Health Research and Quality (AHRQ). Together, these numbers provide a description of the "state of the safety net" and indicate that health disparities continue to exist within Wayne County, as well as between Wayne County and the rest of the state. While the need for effective monitoring strategies remains, the availability of these indicators also raises important questions about how to effectively track changes in conditions that affect the health of people in the safety net population.

The Health Authority believes that collaboration between key stakeholders is critical to maximizing the impact of the Safety Net Resource Center Initiative. This report goes beyond providing a description of the health care safety net, and begins laying the groundwork for an ongoing safety net monitoring project. This proposed monitoring project, which is modeled after the AHRQ's national Safety Net Monitoring Initiative (AHRQ-SNMI), relies upon the abilities of a core team of stakeholders to pull together the best available data.

To that end, this report calls for the establishment of a safety net monitoring taskforce, comprised of key stakeholders, which will work in collaboration to maintain an ongoing, standardized system of data collection and reporting. A safety net monitoring task force would determine which indicators are most valuable, what additional data

would be relevant to this initiative, and how that data can be collected on an annual basis.

This collaborative initiative will allow for the gathering and reporting of data to facilitate more precise planning of community interventions, data-driven program development, and a greater capacity to advocate on behalf of community members within the safety net population.

Overview

In 2009 the health care safety net for Detroit and Wayne County has seen both progress and setbacks. In terms of progress, new access points such as Western Wayne Family Health Center – Taylor and the relocated Waller Health Center in Detroit, as well as the S.A.Y. free clinic in Highland Park have opened, and will increase access to safety net health services. In addition, the American Recovery and Reinvestment Act (ARRA) has resulted in federal funding for safety net resources. At the same time, state budget shortfalls led to Medicaid funding cuts that will likely result in reduced access to services among community members who rely on safety net services. Federal stimulus grants have resulted in an increase of \$6,489,829 in funds for Disproportionate Share Hospitals (DSH) in the State of Michigan. In Wayne County, a total of \$11,476,850 was awarded to health service organizations. This money led to an estimated 67.97 jobs being created or saved in the county. (See table 1.)

Balanced budget requirements, and the resulting pro-cyclical nature of state spending, mean that the state government is forced to cut funding to social programs just when they are needed the most. ARRA has supplemented the state of Michigan's support of Medicaid programs to the tune of \$973 million.

Table 1: ARRA Grants for Health Safety Net and Related Programs

Recipient Organization	Amount (\$)	Jobs =/+
Arab Community Center for Economic & Social Services	657,977	28.73
Cass Community Social Services	53,049	0
Community Health and Social Services	1,130,138	4.16
Covenant Community Care	839,966	3.8
Detroit Area Agency on Aging	567,640	0
Detroit Community Health Connection	1,259,014	1
Detroit Healthcare for the Homeless	885,939	10.37
Henry Ford Health System	4,213,560	17.91
Michigan Health Academy	184,097	0
Sinai Hospital of Greater Detroit	50,000	0
Western Wayne Family Health Centers	1,635,470	2
Totals: 11	11,476,850	67.97

source: <http://www.recovery.gov/Transparency/RecipientReportedData/Pages/RecipientReportedDataMap.aspx>

Nevertheless, state budget negotiations for FY2009-2010 resulted in Medicaid reimbursement cuts. While these are expected to save the state \$16 million over the next year, they will have a compounded impact on the Medicaid programs when federal matching dollars are factored in. According to the Michigan Health and Hospital Association, each dollar the state spends on Medicaid programs, is matched with \$2.33 from the federal government. Based on these estimates, a decrease in \$16 million in state Medicaid spending will result in a total loss of \$53,280,000 for Medicaid programs.

New and ongoing economic challenges in Detroit and Wayne County have resulted in a high rate of eligibility for Medicaid programs, and demand for safety net services has likely never been greater. Furthermore, Federally Qualified Health Centers (FQHCs) and other safety net organizations (SNOs)



Above: Chris Allen with John Cafazza, Jr., Director of the Bureau of Primary Care Office of State and National Partnerships. Mr. Allen and Kim Sibilisky, Executive Director, Michigan Primary Care Association (MPCA), met with Mr. Cafazza to discuss "Improving Access to Quality Care: Expanding Federally Qualified Health Center Services in the Greater Detroit Area," a plan developed by the MPCA and the Primary Care Network Council.

SAFETY NET 2008 2009 REPORT

that receive Medicaid funding typically extend services to the uninsured population as well. For that reason, uninsured individuals who do not qualify for Medicaid are also adversely affected by these cuts.

Additional access points and shifting sources of funding are likely to have a lasting impact on safety net services. As SNOs in this region work to strengthen the health safety net, it is important to establish a set of measures against which to gauge successes and short falls. This report expands on the 2008 report by identifying sources of information on the safety net indicators recommended by the AHRQ-SNMI. While not all of these indicators are available at local level on an annual basis, there are publically-available sources for enough of them to serve as a starting point for an ongoing monitoring project in Wayne County. The next section of this report provides an overview of those resources, along with a preliminary SNO “report card” based on those indicators.

Follow up to 2008: Monitoring improves results

Last year’s report drew largely on data from the U.S. Census and MDCH. Source data was drawn from both ongoing collection initiatives and cross-sectional reports. While this mix of sources can provide a good sense of the safety net at a given point in time, the inclusion of cross-sectional information limits its usefulness as a model for ongoing monitoring.

It should be noted that all data included in this report is collected and reported on by governmental agencies or other independent agencies providing information which is freely accessible to the public. In that regard, this report seeks to present the most precise information available without conducting additional data collection, or purchasing information from private sources.

Table 2: Five-year rolling average: Average low birth weight rate

Source: MDCH: Natality Statistics

	2001-2005	2002-2006	2003-2007
Michigan	8.2	8.3	8.4
Wayne County	10.5	10.6	10.6
Dearborn	6.5	6.5	6.7
Detroit	13.5	13.6	13.6
Ecorse	12.2	12.7	12.4
Hamtramck	9.7	9.9	9.6
Highland Park	15.4	16.0	16.7
Inkster	12.5	12.8	12.2
Taylor	7.7	7.8	8.0
City of Wayne	6.5	6.9	8.0

Table 3: Five-year rolling average: Infant Death Rate

Source: MDCH: Infant Mortality Trends

	2001-2005	2002-2006	2003-2007
Michigan	8.0 ±0.2	7.9 ±0.2	7.9 ±0.2
Wayne County	11.0 ±0.5	11.1 ±0.5	10.8 ±0.5
Dearborn	4.4 ±1.3	4.9 ±1.4	5.5 ±1.5
Detroit	15.7 ±0.9	15.6 ±0.9	15.2 ±0.9
Ecorse	16.5 ±8.6	15.5 ±8.3	20.7 ±9.7
Hamtramck	6.5 ±3.5	6.8 ±3.6	5.7 ±3.2
Highland Park	16.2 ±7.6	16.2 ±7.6	17.4 ±8.0
Inkster	8.8 ±3.8	9.9 ±4.1	10.0 ±4.2
Taylor	9.0 ±2.8	10.1 ±3.0	9.2 ±2.8
City of Wayne	4.5 ±3.6	6.8 ±4.5	9.1 ±5.1

Key indicators cited in the 2008 report that were taken from ongoing data-collection initiatives included five-year rolling averages of infant mortality and birth weight, age-adjusted death rate, death rates for specific conditions, emergency department activity, ambulatory care sensitive hospitalization trends, Medicaid enrollment, and FQHC capacity measures. The following tables provide updates for selected indicators from the 2008 report:

Tables 2, 3 and 4 provide updates for selected indicators from the 2008 report.

Table 4: Age-adjusted Death Rates for Selected Wayne County Cities

Source: MDCH: Mortality Trends

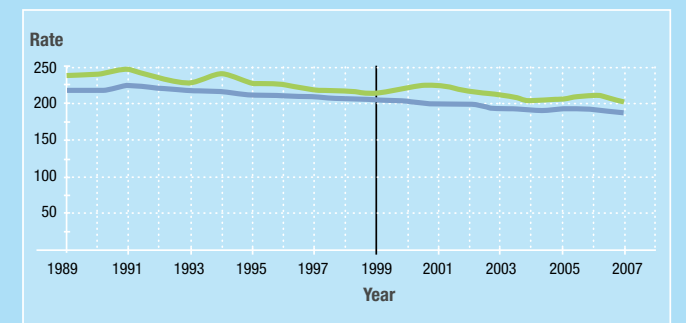
	Heart Disease			Cancer			Diabetes Mellitus		
	2005	2006	2007	2005	2006	2007	2005	2006	2007
Michigan	231.1 ±2.9	226.7 ±2.9	222.6 ±2.8	190.7 ±2.7	190.8 ±2.6	187.1 ±2.6	26.7 ±1.0	26.7 ±1.0	26.3 ±1.0
Wayne County	295.9 ±7.5	286.5 ±7.5	282.5 ±7.3	207.1 ±6.4	212.0 ±6.5	201.5 ±6.2	28.7 ±2.4	29.8 ±2.4	30.5 ±2.4
Detroit	359.5 ±13.3	339.4 ±13.1	344.8 ±13.3	216.9 ±10.4	232.3 ±10.8	226.1 ±10.7	29.8 ±3.9	33.5 ±4.1	31.8 ±4.1

There are important differences between cities in Wayne County, and in comparison to the rest of the state. However, these numbers did not fluctuate greatly from 2006 to 2007.

Death rates for these conditions did not change greatly between 2006 and 2007. However, in Michigan and Wayne County there has been an overall decreasing trend in death rate from heart disease and cancer over the past 20 years. The death rate for diabetes over that same period has remained relatively constant. These trends are depicted in tables 5, 6 and 7.

Ambulatory care-sensitive hospitalizations are those which could have been avoided had timely ambulatory services been provided instead. Table 8, on the following page, shows reported rates of ACS hospitalizations from 2000-2007.

Table 5: Cancer Age-adjusted Death Rates, Wayne County Residents, 1989-2007

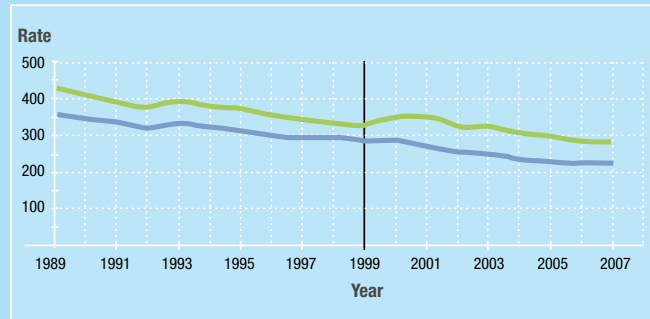


Source: 1989-2007 Michigan Resident Death Files, Vital Records & Health Statistics Section, Michigan Department of Community Health

Wayne
Michigan
ICD-9/10 Rev Change

SAFETY NET 2008 2009 REPORT

Table 6: Heart Disease Age-adjusted Death Rates, Wayne County Residents, 1989-2007



Source: 1989-2007 Michigan Resident Death Files, Vital Records & Health Statistics Section, Michigan Department of Community Health

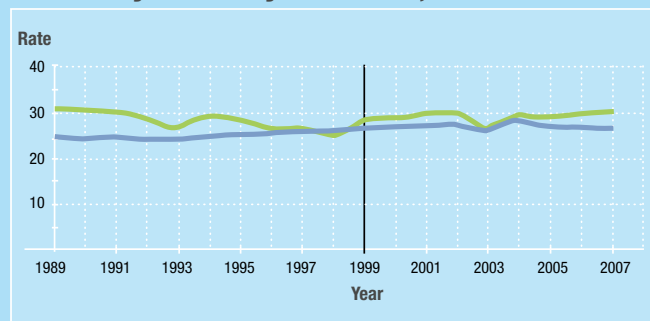
Wayne
Michigan
ICD-9/10 Rev Change

Table 9 was created using information in the Michigan Primary Care Association’s report, 2009 Guide to Michigan Community Health Centers . It gives an overview of changes in capacity at FQHCs, “look-alike” health centers, and other health centers, compared to numbers reported in the 2008 report. Overall, the number of access points and services has increased in the past year. There are two additional access points, more on-site access to behavioral health services, and nearly 3,000 additional people are receiving dental services through these health centers. However, the total number of reported medical users has declined. This decrease is due in part to the fact that the number of medical users at Health Centers Detroit was not reported. Upon request, this health center provided an estimate of 13,100 users. When this figure is included, the estimated decrease in users is 2,522. While that represents a decrease of only around 3%, any decrease in utilization of these centers is surprising given the economic situation in Wayne County over the past several years.

Toward an Ongoing Safety Net Monitoring Initiative

The 2008 report provided an adequate description of the health care safety net in Wayne County. However, in moving toward an ongoing monitoring initiative, there are two specific issues relating to the availability of data that need to be addressed. First, there has not been any statistically significant change in most of the indicators used since the 2000 census. This is true at both the state and local levels. For example, rates for infant mortality have not varied significantly at the state or local level since the 1990s. This raises questions as to the usefulness of standard measures

Table 7: Diabese Melitus Age-adjusted Death Rates, Wayne County Residents, 1989-2007



Source: 1989-2007 Michigan Resident Death Files, Vital Records & Health Statistics Section, Michigan Department of Community Health

Wayne
Michigan
ICD-9/10 Rev Change

such as infant mortality in an annual monitoring report. Secondly, there is a two-year lag in reporting for much of the MDCH data. This means that statistics presented in the 2008 report were based on 2006 data. Likewise, this year’s updates are based on 2007 measures. In other words, if any of the numbers were to change significantly, the current reporting process wouldn’t capture that change for two years. This hampers the ability of the report to monitor the safety net, identify weaknesses, and provide the information necessary for SNOs to respond in a timely fashion.

In order to address these issues, and to establish a monitoring program that is truly useful to area SNOs, the Health Authority will develop a task force comprised

Table 8: ACS Hospitalizations as % of Total: 2000-2007
Source: MDCH: Ambulatory Care Sensitive Hospitalizations

	Detroit	Wayne County	Michigan
2000	24.3	22.2	18.7
2001	25	22.8	18.9
2002	25.9	23.8	19.4
2003	25.1	23.7	19.4
2004	25.8	24	19.5
2005	26.1	24.4	20.1
2006	25.6	24.1	19.8
2007	25.8	24.2	20

Table 9: Federally Designated Clinics Reported Capacity, 2006-2007

Source: MPCA: 2008 Guide to Community Health Centers, and MPCA: 2009 Guide to Community Care Centers

	Type	Sites		Medical Users		Dental Users		Behavioral Health	
		2006	2007	2006	2007	2006	2007	2006	2007
Advantage	CHC/Homeless	*3	*4	8016	7648	1034	3148	R	O,R
AIHFS	I.H.S.	1	1	6159	481	-	40	-	O,R
CHASS	CHC	3	3	11189	11212	1368	1389	R	O,R
Covenant Community Care	CHC	2	2	2340	2321	-	0	R	O
DCHC	CHC	5	6	16203	16903	2114	2914	R	O,R
Health Centers Detroit Found.	FQHC look-alike	**3	**3	13106	-	-	-	R	R
The Wellness Plan	FQHC look-alike	**3	**3	24753	26573	-	-	R	R
Western Wayne Family HC	CHC	1	1	614	1620	-	0	R	O
Total:	8	21	23	82380	66758	4516	7491		

SAFETY NET 2008 2009 REPORT

of Primary Care Network Council members and other stakeholders to do the following:

- Establish specific, shared definitions of what constitutes the safety net, safety net population, and safety net organizations;
- Determine which indicators are necessary for understanding the safety net;
- Determine which of these indicators are available at the local level on an annual basis;
- Determine what additional data needs to be collected to provide a comprehensive understanding of the state of the safety net;
- Develop a strategy for standardized data collection and reporting.

Such a task force is consistent with the best-practice guidelines provided by the AHRQ-SNMI framework. That initiative used data collected between 1999 and 2001 by the Current Population Survey, the 2000 Census, and other provider surveys to report on a total of 118 indicators in the following five categories:

- Demand for safety net services;
- Financial support for safety net services
- Safety net structure and health system context;
- Community context;
- Outcomes and safety net performance

Appendix A provides a complete list of the indicators used in the AHRQ-SNMI, along with an overview of similar data that is collected at the state and local level for Michigan and Wayne County. Appendix B includes the full AHRQ-SNMI of all 118 indicators for Michigan, Wayne County, and the Detroit statistical area.

In terms of usefulness and feasibility, local stakeholders should consider focusing on specific indicators relating to number of access points, number of users at these sites, and measures of service quality. It may also be useful to establish an agreed-upon set of areas in the region where

need is greatest, and focus efforts on tracking progress within these specific areas. The 2009 report, *Improving Access to Quality Health Care* examined a range of criteria to determine areas of greatest need. In looking forward, it would be worth revisiting that report, and working to align the proposals outlined in it with other factors relating to access and quality, as well as with new plans to scale back services and relocate populations living in sparsely-populated areas of the city. As an aid in considering these factors, the map below identifies priority areas for FQHC expansion.

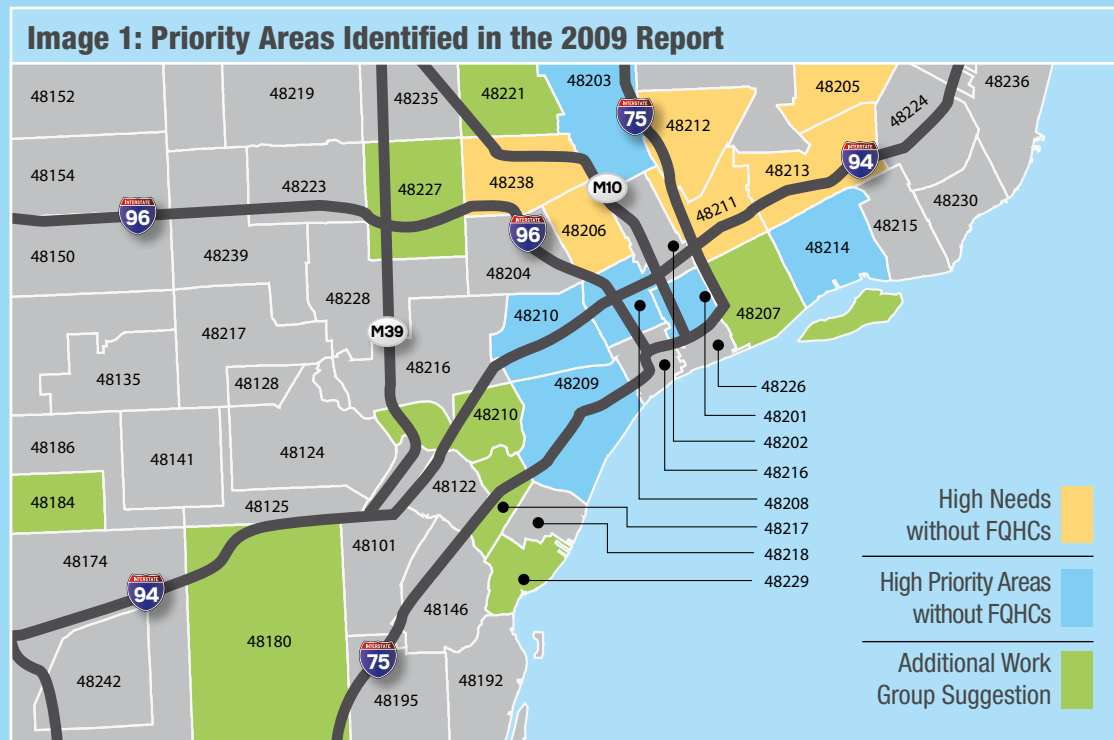
Conclusion

Monitoring the health care safety net in Wayne County remains a work in progress. However, with the establishment of the Safety Net Resource Center in 2008, and improved methods of assembling statistics, this report will become more useful in time.

Safety net monitoring not only provides data for grant applications and strategic planning, it provides groups like the Primary Care Network Council with valuable information to guide its initiatives.

These safety net reports, along with the Safety Net Resource Center website, have given us a start. The proposed task force will enhance our ability to acquire statistical data and implement a standardized system of safety net monitoring. We propose using the national AHRQ-SNMI, as well as the 2009 *Improving Access to Quality Health Care* report, as a foundation for our efforts at the local level. These resources will provide information that will allow us (the local SNOs) to better respond to and serve the safety net population in Wayne County.

For more information on this report or the Safety Net Resource Center, contact Andrew Pritchard at 313-871-3751. ■



i "Safety Net Monitoring." *Agency for Healthcare Research and Quality (AHRQ) Home Page*. Web. 27 Jan. 2010. <<http://www.ahrq.gov/data/safetynet/>>.

ii "Disproportionate Share Hospitals (DSH) Allotments for Fiscal Year 2009." United States Department of Health and Human Services. Web. 27 Jan. 2010. <<http://www.hhs.gov/recovery/cms/dshstates.html>>.

iii *Recipient Reported Data Map*. Recovery.gov. US Government. 27 Jan. 2010 <<http://www.recovery.gov/Transparency/RecipientReportedData/Pages/RecipientReportedDataMap.aspx>>.

iv State of Michigan. Senate Fiscal Agency. *Senate Fiscal Agency Memorandum*. 9 Oct. 2009. Web. 27 Jan. 2010. <<http://www.senate.michigan.gov/sfa/Publications/BudUpdates/StateBudgetUpdate100209.pdf>>.

v Health Care Association of Michigan. *Some Cuts Never Heal*. Mha.org. 5 May 2009. Web. 27 Jan. 2010. <<http://www.mha.org/mha/pressreleases/2009/Some%20Cuts%20Never%20Heal%20Media%20Statement%20050509.pdf>>.

vi "Community Health Information--Natality." Michigan Department of Community Health. Web. 27 Jan. 2010. <<http://www.mdch.state.mi.us/pha/osr/chi/births/frame.html>>.

vii "Community Health Information--Infant Mortality." Michigan Department of Community Health. Web. 27 Jan. 2010. <<http://www.mdch.state.mi.us/pha/osr/chi/InDx/frame.html>>.

viii "Community Health Information--Mortality Trends." Michigan Department of Community Health. Web. 27 Jan. 2010. <<http://www.mdch.state.mi.us/pha/osr/chi/cr/frame.html>>.

ix "Community Info. Preventable Hosp." Michigan Department of Community Health. Web. 27 Jan. 2010. <<http://www.mdch.state.mi.us/pha/osr/chi/hosp/frame.html>>.

x "Community Info. Preventable Hosp." Michigan Department of Community Health. Web. 27 Jan. 2010. <<http://www.mdch.state.mi.us/pha/osr/chi/hosp/frame.html>>.

xi *2009 Guide to Michigan Community Health Centers*. Rep. Lansing, MI: Michigan Primary Care Association, 2009. Print.

xii "Book 1. Data for Metropolitan Areas: Table A-1." *Agency for Healthcare Research and Quality (AHRQ) Home Page*. Web. 27 Jan. 2010. <http://www.ahrq.gov/data/safetynet/databooks/safetynet_key1.htm#healthcare>.

xiii "Assessing Safety Net Provider Financial Health: A Simple Measurement Tool. Table 1. Measures Selected, Formulas, and Reasons for Selection." *Agency for Healthcare Research and Quality (AHRQ) Home Page*. Web. 27 Jan. 2010. <<http://www.ahrq.gov/data/safetynet/clousetab1.htm>>.

xiv *Improving Access to Quality Health Care*. Rep. Detroit: Detroit Wayne County Health Authority, 2009. Print.

EXTENDING OUR REACH THROUGH

COMMUNITY ENGAGEMENT



The Detroit Wayne County Health Authority has enhanced its Community Outreach program annually through ambitious goals to increase access to care by assisting and facilitating enrollment in Medicaid and other public insurance programs, helping the uninsured and underinsured find medical homes and essential health services, and promote good health.

Community Outreach coordinates and manages activities that assist people potentially eligible for Medicaid in applying for benefits, and links them with medical homes. Ultimately, our outreach efforts help improve access to health care by increasing enrollment of eligible but un-enrolled individuals and families. Community Outreach works with health systems, hospitals and community health centers; public and private entities; and faith and community based organizations in an effort to increase access to health services.

In April 2009, the Community Outreach completed development and implemented HelpEngen, a web-based electronic application tool, to assist in its outreach efforts. HelpEngen integrates Medicaid eligibility assessment, application form preparation, and the collection of supporting documentation for multiple programs into a single, patient-friendly guided interview. HelpEngen is being deployed in health systems, community health centers as well as community and faith based organizations.

Also in April 2009, Community Outreach staff organized free sports physicals at Northwestern High School. The week-long event, in partnership with the clinic at Northwestern High School, performed close to 400 physicals; overall 500 new patients were seen at the school clinic. These remarkable numbers are indicative of the need for physicals and the value of physicals in linking young people to primary health services. Without these physicals, these young people would not be able to play sports and would

likely not see a health care provider. The program is part of community-based physical programs, which include back-to-school physicals in the fall.

In July, Community Outreach staff identified Carter Methodist Church on the Near West Side of Detroit, which has a dedicated but impoverished congregation. Community Outreach, together with other Health Authority staff hosted a “Community Baby Shower and Health Fair” for the congregation and residents in the area. The baby shower was distinctive because it included the fathers as well as mothers. Each father who attended the event and participated in the exercise and informative talk by a pediatrician received a gift. Nearly 70 mothers attended the event, which exemplified community unity with corporate donations, volunteers, and participants representing a diverse socio economical background.

In August, free school physicals were co-hosted by the new Western Wayne Family Health Center in Taylor. The week-long event provided physicals for over 300 students. The event introduced many families to the new health center, which was filled every day. In addition, there were informational booths consisting of health care plans, college representatives and fun activities for the young children.

As with Northwestern, each child examined received a back pack with school supplies donated by the health plans. In addition to promoting healthy living, students were encouraged to consider college education and professional careers. Gifts from colleges and universities were raffled off each day to reinforce the idea.

Community Outreach staff work with hospital and health systems to advise, train and support patient financing departments in their efforts to reduce uncompensated care costs and the conversion of uninsured patients into insured. The work also includes working with hospitals and health systems on community benefit efforts aimed at assisting so that each health organization has met its defined participation in community health needs, promotion of community based eligibility awareness, coordination of

local events and activities designed to connect community residents with Medicaid programs and services.

Moreover, in order to better meet the needs of its hospital and health system partners, the outreach services were modified to include:

- Technical assistance;
- Facilitating eligibility for all publicly funded health insurance programs;
- Data analysis and recommendations of revenue flow related to patients presenting as uninsured or under-insured;
- Automated program screening and assessment, disability liaison, and included coordination of community benefits.

Community Outreach staff also supported Cover the Uninsured Week – Health Expo for the Uninsured; planning and participating in the 2009 Metro Detroit Youth Day; and served on the planning committee and promoted enrollment services for the 2009 Diabetes Expo; planning for childhood obesity awareness for parents and children; as well as membership in Healthy Kids, Healthy Michigan.

The common denominator in Community Outreach events is the ability of staff to identify a needed area in Wayne County and then collaborate with local leaders, corporations, health care plans, and volunteers to advance our mission of access to health care for all. ■

Walk for the Uninsured rises to new level at Belle Isle

On a hot, sunny summer day, about 300 people representing all areas of the health care safety net came out in support of the uninsured and the mission of the Health Authority. Area health organizations were on hand with health information, vision and podiatry screenings were provided, and a massage therapist soothed sore muscles. Keeping with the health theme, Frank Taylor, head chef from Henry Ford West Bloomfield, provided a cooking demonstration, showing how you can cook a fast, inexpensive, nutritious meal. The Walk also launched the “Access for all...Health Care Fund,” which underwrites the cost of providing physical exams for the uninsured at area health centers.



Children in Western Wayne get free physicals

Getting ready for school also means getting a physical, because healthy students are better students. It's also an opportunity to talk with parents about health insurance coverage – theirs and their child's. The Health Authority developed a model for providing student/well child exams for large numbers of young people, with the help of partners from Western Wayne Family Health Center – Taylor and area Medicaid health plans. Services at the week-long program Aug. 17-21 included dental, vision and hearing screening; lead testing; immunizations; and general health and Medicaid enrollment information.

2008
2009

PROGRESS REPORT



The Health Authority was created to “coordinate efforts to meet the health needs of the uninsured and underinsured residents in the City of Detroit and Wayne County by assuring access and improving the health status of all people.” The goals of the Health Authority are:

- Expand the number and location of primary care access points throughout Detroit and Wayne County;
- Assign each enrolled client a primary care medical home;
- Coordinate the delivery of healthcare between and among Health Authority health providers to eliminate fragmentation and reduce costs;
- Provide care management and referral services as a core component of the delivery system;
- Facilitate access to a full range of culturally competent, preventive, medical and non-medical services;
- Design a delivery system that is able to enhance federal and other funding and reduce duplication.

To accomplish these goals, the Health Authority has an infrastructure that includes two 25-member advisory committees. One group is comprised of health care providers while the other reflects a broad base of community leaders and organizations. These advisory groups act as a sounding board to the Health Authority staff, providing valued feedback and input into the goals and progress of the Health Authority.

Programmatic work of the Health Authority’s goals and objectives is accomplished by workgroups, a council and several committees that are comprised of community stakeholders, health system, governmental, and subject experts.

- **Uncompensated Care Committee** – During fiscal year 2009, the Health Authority created the Uncompensated Care Committee which is representative of all of Southeastern Michigan Hospital CEOs and CFOs to examine the issue of escalating uncompensated care costs. The committee was charged with measuring the uncompensated care burden along with recommending policy changes and action steps that will both reduce uncompensated care burdens and provide better access for the uninsured. Three workgroups grew out of this committee (FQHC-Hospital Workgroup, Physician Workgroup and the Finance Workgroup) which made viable recommendations for continuation and implementation to meet the overall objective of the committee.
- **Primary Care Network Council** – Another committee that continues to gain traction, created in early 2005, is the Primary Care Network Council, which is represented by leadership of all various safety-net providers in Detroit and Wayne County, including Federally Qualified Health Centers, “look-alike” community health centers, free clinics, faith-based health centers and others. The initial program was supported by a grant from the McGregor Fund. The Primary Care Network Council (PCNC), comprised of the leadership of safety net providers in Detroit and Wayne County, has continued its work. The PCNC has developed initiatives around safety net expansion, workforce development, and the creation of a safety net resource center. The East Side Planning





Team (ESPT), chaired by Sr. Mary Ellen Howard, Executive Director, Cabrini Clinic; and Herbert Smitherman, Jr., President and CEO, Health Centers Detroit Medical Group, an initiative of the PCNC, was charged with improving the coordination and delivery of primary care services in the near side of Detroit, zip codes 48207, 48213, 48214 and 48215. The ESPT produced a detailed report, “Ensuring Essential Health Services on Detroit’s Near East Side,” with recommendations outlining the establishment of a network of primary care services that result in a medical home for all residents of the near east side of Detroit. The PCNC adopted the following indicators from The Commonwealth Fund definition of a true medical home:

- A regular doctor or source of care,
- No difficulty contacting their provider by telephone,
- No difficulty getting care or medical advice on weekends or evenings, and
- Well-organized and on time doctor visits.

Health Authority staff built on the developmental work initiated prior to 2005 to create *NET works 2010* a vision of a regional network of health services for the medically underserved in southeastern Michigan. To further define the Health Authority’s charge, the founding members adopted the strategic plan, “The PATH Forward.”

This plan more closely aligns the work of the Health Authority to the goals outlined in the original Interlocal Agreement between the founding members. Key elements of the plan include:

- Increasing the number of primary care sites;
- Increasing the enrollment in clinics and practices that provide a medical home for the medically underserved population;
- Increasing funding and reimbursement coming into the healthcare safety net;

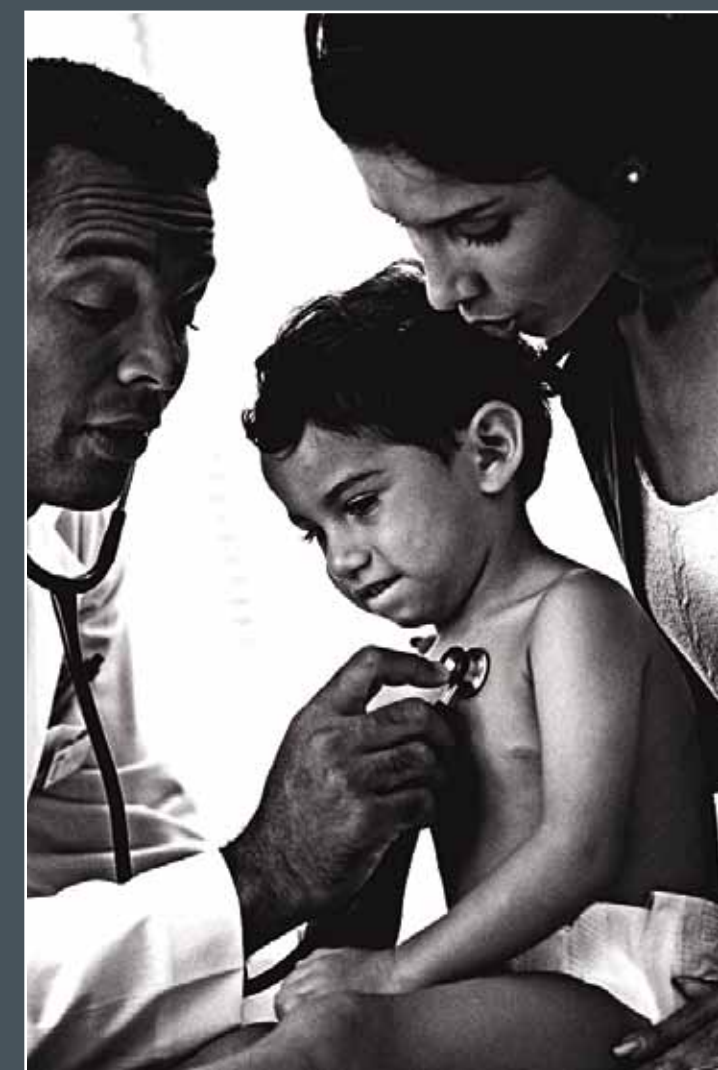
- Building an infrastructure appropriate to the programmatic needs of the Health Authority; and finally
- Increasing the engagement and ownership of all stakeholders.

“The PATH Forward” outlines numerous strategies and activities that we feel are achievable and measurable. The final point is critical: To make it happen requires the engagement of all stakeholders. In that regard, we are increasing/enhancing our communication with various stakeholders through interviews and strengthening our Board, as well as the Provider and Community Advisory Committees, soliciting input and engagement from consumers (i.e. the uninsured), and further communicating with our founding partners.

Major programmatic accomplishments include:

- Access to Health Care – The Health Authority facilitates access to health care services for uninsured and underinsured residents. Through an Interdepartmental Agreement with the Michigan Department of Community Health, the Health Authority conducts Medicaid outreach activities in partnership with area health systems, safety net providers, faith-based and community organizations (FBCOs). The Health Authority’s Medicaid Outreach Activities are designed to facilitate Medicaid and Medicaid waiver program enrollment of uninsured and underinsured Michigan residents. During fiscal year 2009, the Health Authority maintained hospital agreements with Oakwood Healthcare, Garden City Hospital, Accretive Health, Beaumont Hospitals and Trinity Health. The contractual relationship with its health partner requires the Health Authority to facilitate Medicaid Outreach Activities that include, but are not limited to application assistance, training, and providing technical assistance. In addition, the Health Authority provided

Medicaid policy and operational training for the partnered health system patient advocates and provided training and technical assistance to hundreds of community volunteers. Fiscal Year 2009 demonstrated increased and improved access for residents seeking insurance because the Health Authority funded and trained eight community organizations to screen and facilitate the application process and assist in collection of required documents for the uninsured. The Health Authority also provided mini grants of \$15,000 to six FQHCs to assist them in reviewing existing patient population as well as to facilitate enrollment for new patients presenting as uninsured.



- **New/Maintain and Strengthen Access Points** – The Health Authority is assuring access to primary care. To date the Health Authority has provided support and technical assistance for three new Federally Qualified Health Centers (FQHC), a “look alike” community health center, two additional health centers and a nurse practitioner model clinic in a retail setting. The latest coordinated efforts between the Health Authority, Trinity Health Port Huron and Michigan Primary Care Association, is working to increase the number of areas classified/designated as Medical Underserved Area resulting in providers being able to establish FQHCs. In reference to maintaining and strengthening access points; the school-based clinic at Northwestern High School remains open through increased patient population which was the result of the Health Authority’s outreach effort.

- **Enrolling Children in Health Plans** – The Health Authority coordinated efforts to enroll eligible children in state sponsored health insurance programs with the Detroit Public Schools, Department of Health and Wellness Promotions, Think Detroit Police Athletic League, and health system-sponsored school based health centers and other community groups. The effort to enroll children has evolved into a movement to ensure 100 percent of children are insured and have a primary care medical home.

In an effort to increase medical coverage, the following events were held:

- o Northwestern High School Sports and Well Child Physicals - Children that were enrolled in a Medicaid

health plan were encouraged to take advantage of the physicals and other medical and dental screenings, by the end of the week over 500 new patients were seen at the clinic.

- o Community Baby Shower and Health Fair - With a primary focus on ensuring access to prenatal care, family involvement and enrollment in health insurance. There were a total of 72 registered participants including 11 fathers.

- o Taylor –Inkster Back to School physical health fair - In an effort to bring awareness to a new FQHC in Taylor, Michigan, a weeklong back to school physical health fair was held at their facility. Medicaid insurance plans and local colleges supported this effort by providing gift cards

and other gifts. The project exceeded its goal of providing more than 300 children physicals.

- **Integrated Health Initiative** – One of the frontiers of health care is integrating medical and mental health services to improve healthcare. The Health Authority convened a task force of all major providers of community mental health and primary care to discuss opportunities and implement recommendations from Detroit Wayne County Community Health. ■



FINANCIAL STATEMENT

Overview

The General Fund is presented on a modified accrual basis of accounting; a short-term view to tell how the resources were spent during the year, as well as how much is available for future spending. This information is then adjusted to the full accrual basis to present a long-term view of the Health Authority as a whole. The long-term view uses the accrual accounting basis, which measures the cost of providing services during the current year and whether the full cost of providing government services has been funded.

The General Fund modified accrual basis financial statements provide detailed information about the current financial resources. This is important as it demonstrates compliance with various state laws and shows the stewardship of the Health Authority's revenue.

The Health Authority's full accrual statements present information about the Health Authority's total economic resources, including long-lived assets and any long-term obligations. This information is important as it recognizes the long-term ramifications of decisions made by the Health Authority on an ongoing basis.

The financial statements also include notes that explain some of the information in the financial statements and provide more detailed data. The statements are followed by a section of required supplemental information that further explains and supports the information in the financial statements.

Condensed Financial Information

Table 1 on page 34 compares key financial information in a condensed format.

The Health Authority as a Whole

The Health Authority's net assets increased by \$1,112,331 this year. The Health Authority's primary source of revenue is from contributions, donations, and federal grants through the MDCH Interdepartmental Agreement. Medicaid Outreach Services and contracted services are a significant expense of the Health Authority representing 83 percent of the Health Authority's total expenses, with salaries and fringes representing 9 percent.

The Health Authority's Fund

The Health Authority's Board has the ability to create separate funds to help manage money for specific purposes, and to maintain accountability for certain activities. The Health Authority's major fund consists solely of the General Fund.

The fund balance of the General Fund increased during the current year by \$1,121,166. The increase exceeded the final amended budget by \$88,289.

Sources of Funding

For fiscal year-end 2009, the Health Authority's sources of funding came from the community at large and various stakeholders, including: Michigan Department of Community Health/Federal Government, Garden City Hospital, Oakwood Healthcare, St. John Providence Health System, Accretive Health, Beaumont Hospital and Trinity Health.

The Health Authority's final budget provided for excess revenue in the amount of \$1,032,877. Actual General Fund activity provided excess revenues of \$1,121,166.

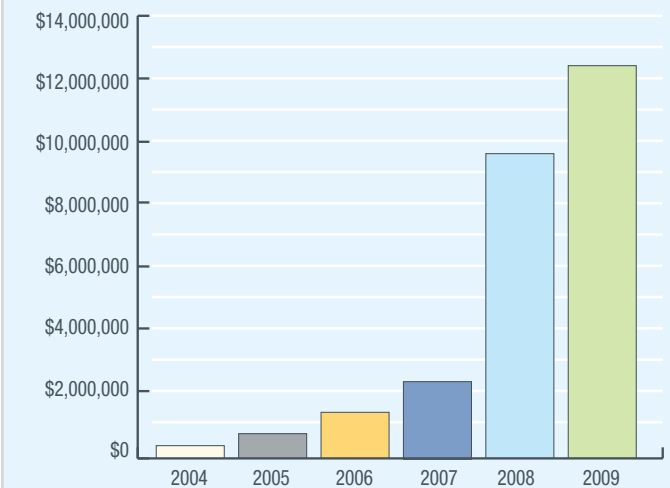
Capital Assets and Debt Administration

At the end of the fiscal year, the Health Authority had \$60,480 invested in furniture and equipment. New depreciable furniture and equipment added during the year amounted to \$6,451.

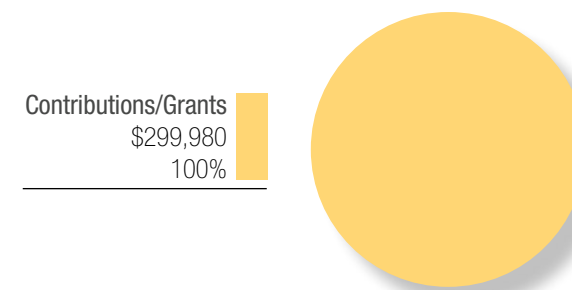
Contacting the Health Authority's Management

This financial report is intended to provide our stakeholders, benefactors, etc. with a general overview of the Health Authority's finances and to show the Health Authority's accountability for the money it receives. If you have questions about this report or need additional information, we welcome you to contact Executive Director and CEO, Chris Allen at (313) 871-3751. ■

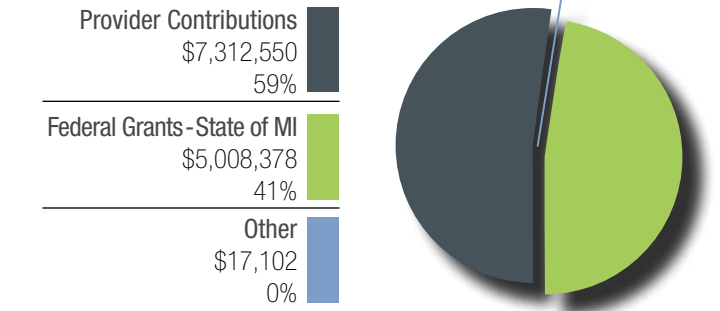
Annual Statement of Revenue



2004 Pre Development Percent of Revenues and Sources



2009 Actual Percent of Revenues and Sources



Audited Statement of Revenues and Sources

	Pre Development 2004	Actual 2005	Actual 2006**	Actual 2007	Actual 2008	Actual 2009
Contributions/Grants	\$299,980	\$635,020	\$535,380	\$205,602	\$87,500	\$0
Provider Contributions		150,000	445,091	1,112,075	5,715,959	7,312,550
Federal Grants - State of MI*			293,858	838,385	3,758,436	5,008,378
Other		6,325	4,909	2,552	8,910	17,102
TOTAL	\$299,980	\$791,345	\$1,279,238	\$2,158,614	\$9,570,805	\$12,338,030

Baseline excludes in-kind and other fiduciary support; **2006 does not include HRSA \$492,080; *Interdepartmental Agreement with MDCH for Outreach

FINANCIAL STATEMENT

Table 1: Condensed Financial Information

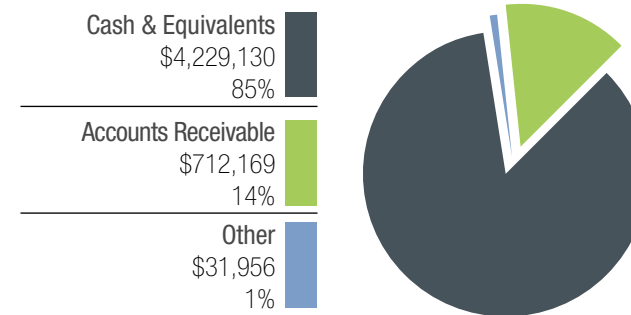
	September 30, 2009	September 30, 2008
Current Assets	\$4,973,255	\$2,621,884
Capital Assets	\$60,480	\$69,315
Total Assets	\$5,033,735	\$2,691,199
Current Liabilities	\$2,433,363	\$1,203,158
Net Assets		
Invested in Capital Assets	\$60,480	\$69,315
Unrestricted	\$2,539,892	\$1,418,726
Total Net Assets	\$2,600,372	\$1,488,041
Revenue		
Contributions, Donations and Grants	\$12,388,030	\$9,570,805
Expenses - Operations	\$11,255,699	\$8,542,035
Change in Net Assets	\$1,112,331	\$1,028,770

Table 2: Balance Sheet – Governmental Fund

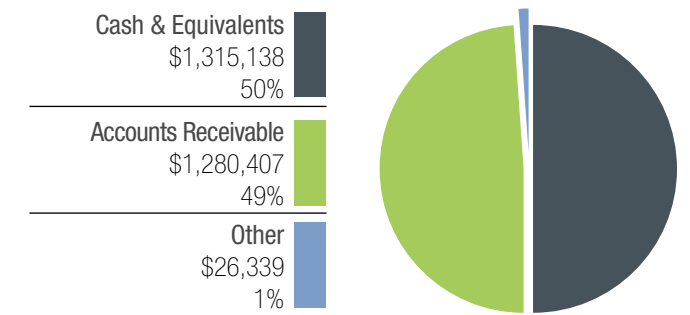
ASSETS	GENERAL
Cash and Cash Equivalents	\$4,229,130
Accounts Receivable	712,169
Prepaid Expense	30,424
Miscellaneous Receivable	1,532
Total Assets	\$4,973,255
LIABILITIES AND FUND BALANCE	
LIABILITIES	
Accounts Payable	\$2,118,830
Accrued Payroll	27,314
Due Back to Funders	287,219
Total Liabilities	\$2,433,363
FUND BALANCE	
Unrestricted	\$2,539,892
TOTAL LIABILITIES AND FUND BALANCE	\$4,973,255
Total Governmental Fund Balances	\$2,539,892
Amounts reported for governmental activities in the Statement of Net Assets are different because Capital Assets used in governmental activities are not financial resources and are not reported in the funds.	
The cost of capital assets are	\$112,357
Less accumulated depreciation	(51,877)
Subtotal	\$60,480
Net assets of governmental activities	\$2,600,372

Governmental Fund Analysis

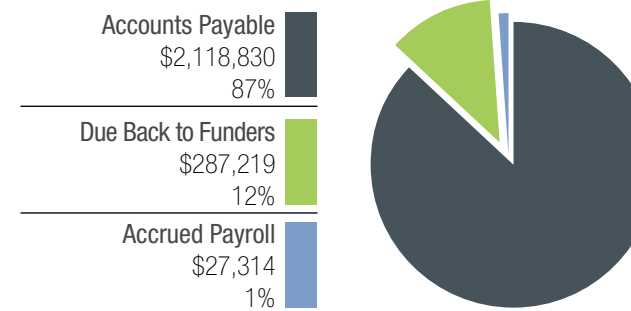
2009 Summary of Assets



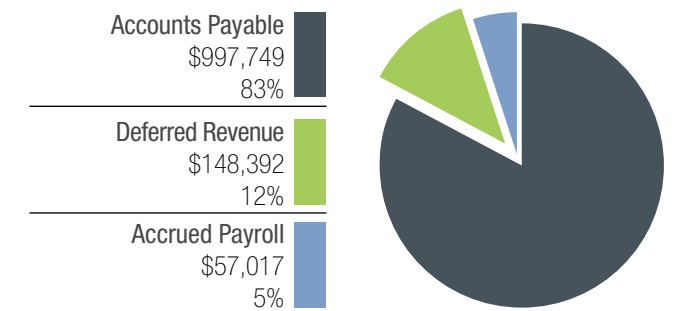
2008 Summary of Assets



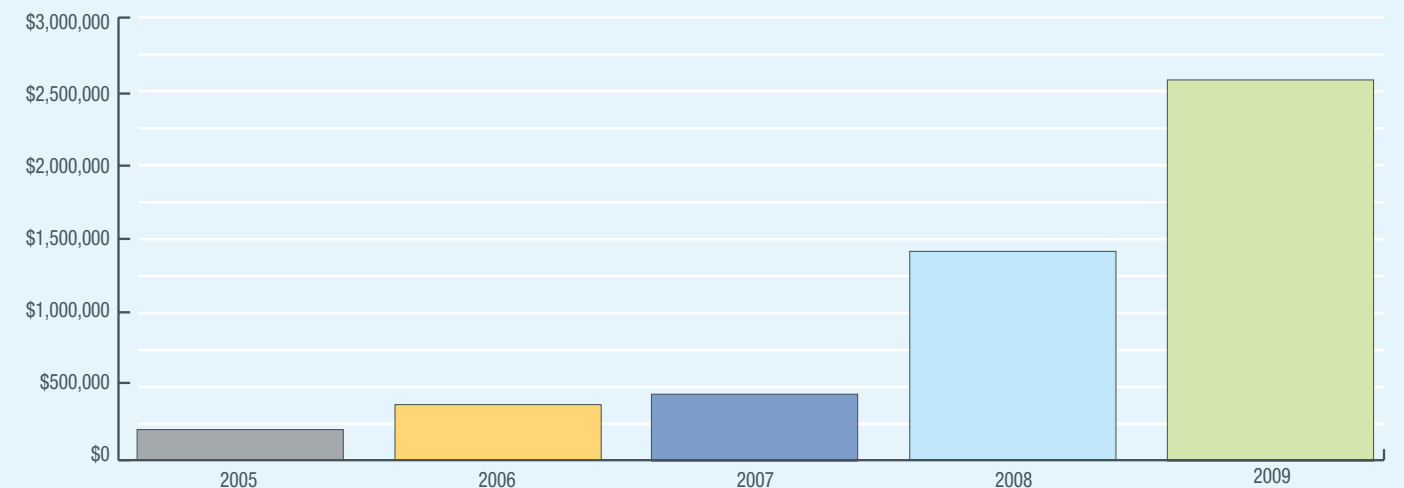
2009 Summary of Liabilities



2008 Summary of Liabilities



Summary of Unrestricted Fund Balance



THANK YOU TO OUR **SUPPORTERS**

Accretive Health, Inc.

Beaumont Hospitals

Department of Health and Human Services

Garden City Hospital

Michigan Department of Community Health

Oakwood Healthcare Inc.

St. John Providence Health System

Trinity Health





Detroit Wayne County
HEALTH AUTHORITY
It's about access...for all.