TOWARD A NEW URBAN HEALTH MODEL: MOVING BEYOND THE SAFETY NET TO SAVE THE SAFETY NET—RESETTING PRIORITIES FOR HEALTHY COMMUNITIES

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ABSTRACT Parkland Health and Hospital System has been successful by every measure of comparison among its peer institutions, yet it recognizes the imperative of adapting to changes in the regulatory, legislative, and market environments. Given its mandate and a desire to preserve its multiple missions and its partnerships with a highly rated medical school, the playing field for achieving robust survival is very uneven. This article describes the evolution of one of the best “sick care systems” in the United States into an integrated, excellent health care system for the 21st century. The problems faced by the safety net in many urban areas of this country are similar. Many problems are structural in nature and will, therefore, require structural solutions at the local, state, and national levels. Parkland will continue and will be needed for many years as the tertiary and quaternary center of a comprehensive service network made up also of a series of outreach Community Oriented Primary Care clinics and special populations projects. In addition, we hope to help create a community-oriented managed-care plan that encompasses the desire to work with both denominator and numerator populations in a real partnership with many other stakeholders.

INTRODUCTION

The Parkland Health and Hospital System (PHHS) is one of the nation’s largest and busiest public teaching hospital and health systems and has been serving as a safety net for the people of the Dallas area for over 104 years. The University of Texas Southwestern Medical Center at Dallas, with a faculty that can boast of four Nobel Prize winners in medicine and more National Academy of Science scholars than all six other Texas medical schools put together, has provided house staff supervision and direct patient care for nearly six decades. This

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"closed" faculty relationship has been one of our major strengths and, as is true of many other attributes of being part of an academic health center, one of our major weaknesses as well.

The PHHS enjoys a close working relationship with Children's Medical Center of Dallas in a collaborative model and with Zale Lipshy University Hospital, a small, but elegant, facility built to support the faculty's referral practice.

The PHHS has been successful by most industry comparisons, not only with other public teaching hospitals, but also with nonprofit systems of similar size and complexity. The prestigious Foster McGaw Award, sponsored by the American Hospital Association and the Baxter Foundation, was awarded to Parkland in 1994 for excellence in community service, and *US News and World Report* has listed Parkland among the nation's top 40 hospitals in multiple categories for the last four years.

With the only Level 1 Trauma and Level 1 Burn units in northern Texas, Parkland is "top of mind" and ranked first through third for its tertiary care provision by consumers in the area.¹ The rankings are subdivided by ethnicity; Parkland is generally ranked number one in such survey instruments by African-American and Hispanic patients, but is ranked lower by white populations except for trauma and burn care. With a number of "niche markets" built around tertiary and quaternary "centers of excellence," the PHHS enjoys utilization by a significant number of commercially insured patients.

The storm clouds of market-based reforms, as well as legislative health reforms, suggested that the successes of even an excellent "sick care system" would not secure vitality and viability for the future. For the last decade, the PHHS has been in the evolutionary stages of moving beyond the role of the safety net into a true health care system.

CHALLENGES OF BEING A MANDATED/ MISSION-DRIVEN PROVIDER

Under Texas statute, the Dallas County Hospital District (the parent of PHHS), which was created by local referendum, is mandated "to provide for the establishment of a hospital or hospital system to furnish medical aid and hospital care to the indigent and needy persons residing in the hospital district," which is coterminous with the jurisdiction of Dallas County. A hospital district can provide, arrange, or purchase these services.

Over the years, PHHS has expanded its obligations to the community by accepting the regional responsibilities of a Level 1 trauma facility and burn unit, a Level 3 neonatal intensive care unit, and a number of other highly tertiary and quaternary services critical to the broader North Texas community. Further, PHHS has a mission much broader than care of the indigent; it includes care for

all patients, as well as teaching, research, and community service. Many of these added responsibilities define the institution and are as much a part of the fabric of its covenant with the community and with individual patients as is its mandate. The products of these activities are highly valued and costly to produce, yet are underfunded by formal state and federal mechanisms and are too often ignored by managed-care insurers.

Currently, Dallas County has approximately 430,000 residents who live below 150% of the poverty level, which, by PHHS policy, qualifies them for tax-supported care. In addition, one in four Texans is uninsured, and even though they work and do not qualify for tax-supported care, they routinely depend on the safety net for services. The percentage of uninsured among the ranks of PHHS patients is therefore twice as high as for the general population.

Despite an overbedded hospital industry in Dallas, it is not unusual for Parkland to be at functional capacity on the wards and completely full in all of its various intensive care units. In fiscal year 1997, Parkland had 39,180 admissions, 13,558 births, over 1,000 neonatal intensive care patients, 751,636 outpatient visits (on campus and in the community clinics), and 145,633 emergency department visits. The hospital's length of stay has been reduced to 4.6 days, and ambulatory surgery has nearly tripled over the last decade. PHHS handles 71% of all major trauma in the county and case manages the care of roughly 60% of the patients living with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) at some time during their illness; too often, after they experience a loss of health insurance.

The unique features of a mandated/mission-driven provider also include the costs associated with the care of large volumes of low-income and minority populations who need wraparound social services, the "stand-ready" or nonproductive costs for tertiary services, and the costs associated with funding over 500 house staff officers and fellows, as well as substantial support for the clinical research of our faculty. We cannot choose to avoid the population we were created to serve. We must provide a health care system founded on competence, beneficence, nonmaleficence, and the maximizing of patient autonomy and social justice. Stewardship demands sound business principles, but clearly, PHHS is much more than a business.

The local tax support for PHHS has been relatively flat for the past five years despite a growing gap between tax revenues and the costs of care for county-eligible patients, including uncompensated care (bad debt from the uninsured and charity). The anticipated gap will approach \$70 million in the 1998 fiscal year. Expansion of Medicaid and a well-funded and appropriately directed disproportionate share adjustment (\$61 million in 1997) has allowed a substantial

bottom line over the last several years. However, Medicaid revenues have already been affected adversely by reforms that created a more competitive environment for the routine deliveries. Anticipated reductions in Medicare's support of direct and indirect medical education, and Medicare and Medicaid reductions in disproportionate share adjustments, suggest that the unlevel playing field in an imperfect marketplace² will only become more irrational.

Federal and state reimbursement policies and a more favorable regulatory environment for the commercial insurance and managed-care industries that address these issues are critical to the survival of safety net institutions and academic health centers in general. However, we could not wait for such efforts to come to fruition given the failure of achieving universal health care reform in 1994 and the many strong special interests opposing our arguments. Therefore, we began to address what was in our power to address at the local level; this led to a strategic resetting of priorities, as discussed below.

DEVELOPING PARKLAND'S COMMUNITY ORIENTED PRIMARY CARE PROGRAM: A LOCAL SOLUTION

Parkland Health and Hospital System is making the transition by utilizing the Community Oriented Primary Care (COPC) model and its own nonprofit health maintenance organization (HMO). The model we seek is adaptable and, importantly, depends on the community to assist in the solution of nonmedical problems that determine health in a far broader way than the traditional medical system can.³

In its simplest form, COPC represents a fusion of clinical medicine and public health. Fully realized, the concept blends curative and preventive medical services, demography, epidemiology, community organization, and health education for a defined population.⁴ The COPC program consists of six elements: assessment of community needs and assets, community prioritization of health care issues, a community health care system, incentives, evaluation, and financing. Taken together, these components are seen as the means to achieve the goals established by Parkland's COPC health policy.⁵

Typically, community priorities are directed at issues that have direct bearing on health status, but have little to do with the means of the medical care system. In one community, these include such topics as educational opportunities, access to meaningful employment, and a decrease in teenage pregnancies and teenage violence.

Parkland's professional staff has learned from the community prioritization process that it is not possible to be effective in improving the health of the community by imposing solutions. As Berger and Neuhaus,⁶ followed later by

Kretzman and McKnight,⁷ have pointed out, institutions cannot empower. Experts may have unique knowledge, but they do not have expertise in another person's life, family, or community. To be successful in a community requires identifying the community's capacities, listening to the residents' concerns, and working with the residents on their issues. All communities, even the poorest, have opinions and ideas about problems and solutions, and, more importantly, all have significant strengths. Clearly, a relationship-centered interaction occurs between the professional and community components of this partnership; the interaction is based on trust and based on promise keeping (a covenant)—actions, not just rhetoric.

Parkland and its COPC program serve more than 300,000 individuals in Dallas County yearly. The majority of the patients served are minorities, such as Hispanics, African-Americans, and new refugees. Services are provided through a system of health centers. Currently, nine centers are in operation. From these health centers, care is extended in nontraditional settings at 22 homeless shelters, 15 schools, 2 churches, and 3 senior citizen centers via multidisciplinary teams that are a rich mix of midlevel practitioners in addition to primary care physicians.

The health centers are staffed by physicians who belong to a group practice, Community Health and Medical Primary and Preventive Services, Incorporated (CHAMPPS). The physicians are board certified and have clinical faculty status at University of Texas Southwestern Medical School. Several of the 65 physicians have advanced degrees in public health. In addition, special efforts are made to match physicians ethnically to the communities served; 47% of the physicians are African-American, Hispanic, or Asian, and 59% are women. Roughly half of the physicians are bilingual.

The COPC health care team includes an array of health professionals: dentists, nurse practitioners, physician assistants, nutritionists, health educators, outreach workers, translators, psychologists, and social workers. All are integral to the health care team and enhance the program's ability to respond to the health needs of the community.

The scope of primary care services includes pediatric, adolescent, adult, and geriatric medicine, as well as maternal health services. Outreach preventive programs for cancer and AIDS also have been implemented. Parkland provides needed inpatient or outpatient subspecialty services at the central campus in partnership with the faculty of the University of Texas Southwestern Medical Center at Dallas or through the services of the Children's Medical Center of Dallas. The COPC program also cooperates with existing public health programs to address immunizations, sexually transmitted diseases, disease surveillance, health education, maternal and child health, and health maintenance examina-

tions for public school students. The city of Dallas and the city of Garland also contract with Dental Health Program, Incorporated, a nonprofit agency, to provide dental care at two health centers. The City of Dallas Health Department also provides women, infants, and children (WIC) services at COPC health centers. The Dallas County Health Department provides sexually transmitted disease surveillance and services at several COPC health centers. Services provided by both the city and county health departments are integrated so that they appear to the patients to be one seamless system of care. The Maternal Health and Family Planning Program network, operated by the Department of Obstetrics and Gynecology at the University of Texas Southwestern Medical Center at Dallas, also co-locates their services in the majority of COPC sites, and the COPC program provides pediatric services in their freestanding locations. Of the over 13,500 women who deliver babies at Parkland each year, 94% receive prenatal services through this system, with Parkland funding the prenatal care component. As a consequence, infant mortality rates in our system are among the lowest, if not the lowest, among the nation's teaching hospitals that tend to care for sicker patients. The gap between white and African-American infant mortalities has virtually been closed by our combined efforts.

Parkland entered into a series of partnerships with private health care providers to expand the COPC program. One of the community's nonprofit teaching hospital systems, Methodist Health System, donated a hospital they were closing to Parkland to establish a COPC health center on its campus. This prevented the community from losing its health care infrastructure completely. Another nonprofit teaching hospital system, Presbyterian Health System of Dallas, has joined with Parkland to establish a COPC site in an underserved neighborhood close to their primary campus. Despite the pressures of competition, a number of Dallas-area nonprofit hospitals have chosen to collaborate with us for the community's benefit.

The COPC program has developed a particularly special relationship with the Dallas Independent School District. COPC staffs the school district's school-based clinic and provides clinical services at 10 youth and family centers located on school campuses, and at 5 sites served by "traveling teams" that provide care in 5 middle schools and high schools. In addition, Parkland has joined in a unique partnership with the C. V. Roman Medical Society, the local affiliate of the National Medical Association. The society applied, with Parkland's assistance, to the Robert Wood Johnson Foundation and received a grant that will permit Society doctors to follow and care for their unfunded patients at COPC health centers. This last effort has also established a system that provides for volunteer credits to further enhance patient and community participation. These credits

can be used to purchase prescriptions or pay for services or can be given away to help another person in need (often within the volunteer's church congregation).

Feedback is a key factor to ensure that the health policy is implemented properly; financial rewards encourage continuing high-quality performance. The staff is informed of progress toward achieving health-outcome objectives, and surveys are being developed to evaluate patients' perceptions of quality. A tripartite incentive pay program links clinical performance to health outcomes, merit, and productivity for the physicians and midlevel practitioners.

Measurements of health outcome and data on the cost of health care services are used to evaluate the effectiveness of the health policy. Evaluation is based on the assumption that the delivery of preventive health care will influence positively the health status of the community, and that improving a community's health status will reduce health care costs. The evaluation process tests the validity of those assumptions, as well as the program's performance. Because the health-outcome objectives have time frames of one to three years, the program's short-term performance must be assessed by process audits as a proxy.

Health outcomes are calculated based on pre-established morbidity and mortality rates for the given health problem in each outcome objective. The data for the health outcomes are obtained from the program's and Parkland's medical information systems. The measurement for health outcomes is obtained by comparing the morbidity or mortality rates in a given health center's population with the morbidity or mortality rates in the community served by that health center.

THE NEED FOR ACCOUNTABILITY: OUTCOME STUDIES

Sophisticated multiyear community assessment is being undertaken by Parkland in conjunction with the University of Texas School of Public Health in Houston to promote accountability in regard to the uses of scarce resources. These studies are done at arm's length from the actual providers or administrators of the system. Preliminary findings from the studies are very encouraging, with reductions approaching two-thirds in emergency room utilization and hospitalization for chronic illnesses such as diabetes, hypertension, and asthma. A significant reduction in emergency department visits can be attributed in part to more-accessible community services and a walk-in clinic for the working poor, which is open until late evenings on the Parkland campus. COPC patients are two times less likely to be admitted through the emergency department, have shorter hospital stays (3.4 vs. 5.37 days on average), and have 50% lower charges (\$4,394 vs. \$8,435 on average).

In Dallas, as in the rest of the nation, the health care industry is changing

rapidly. Changes include horizontal and vertical integration, mergers and consolidations, and changes in the size and staffing of the institutions to rationalize services and cost and improve efficiencies and access to managed-care markets. Previously unattractive payer sources, such as Medicaid, are now being sought by private providers, both nonprofit and for-profit. Competition threatens the collaborative efforts of providers for the community's well-being.

In evaluating strategic options in this changing environment, increased efficiencies and access to new markets should not be the paramount goals; rather, the goal should be the improvement of the health of the community. If this is the real bottom line, collaborative partnerships follow naturally.

A vision will not materialize because of good intentions. Safety net institutions are not immune from the temptation to focus efforts on "increasing market share" in a competitive model instead of improving the community's health status through collaboration. A focus on community service, on stewardship, and on each institution doing its part to help create healthier communities creates a milieu that reminds us of our moral commitments to fairness and social justice. We must continue to serve the most underserved and vulnerable members of this community. We must be a safety net for years to come because of the retractable nature of the illnesses that plague the urban areas of our country.

BACK TO THE FUTURE: RETURNING TO THE COMMUNITY

While the COPC program emphasizes the care of denominator populations and the improvement of the health of the entire community, it can serve as a foundation on which we can superimpose a "third-generation" managed-care strategy. The Parkland Community Health Plan, a nonprofit HMO licensed recently, will share the COPC infrastructure and its nonprofit group practice to care for enrolled populations of Medicaid, Parkland's own employee population, and perhaps some commercial patients who live in the communities we serve. As an entity that is trying to adapt to marketplace reforms and legislative initiatives that will push most Medicaid patients in Texas into managed care, we have decided to get closer to the premium dollar in order to keep resources within our system.⁸ We also intend to explore new and innovative insurance concepts to address the needs of the working poor; these concepts include geographically defined nonprofit plans for the working poor, developed in partnership with small businesses, churches, synagogues, or "citizen cooperatives."

The emphasis on community in both the COPC program and the Parkland Community Health Plan is not misplaced. It was from the community that the first generation of managed care sprang in the late 1920s. Friedman recently provided us with a wonderful review of the history of managed care and inte-

grated health systems in America.⁹ Sometimes, it came from occupational settings. For example, plantation owners in Hawaii, lumber and mining firms in the Pacific Northwest, and railroad companies in Minnesota provided health services to attract workers and to retain them. Physicians were difficult to recruit to such locations, and guaranteed contracts or salaries were required. Among the most notable of these innovators were Henry J. Kaiser and his son, Edgar, who, with the help of Dr. Sidney Garfield, developed a managed-care concept to provide care to migratory construction crews working on the Grand Coulee Dam and later in the shipbuilding yards of Oakland, California, in the 1930s and 1940s. The Kaiser Foundation Health Plan was born from these efforts in 1946.¹⁰ Today, this plan covers more than 9 million people and is found in many states beyond its California home.

Many early managed-care entities were religious or faith based. The Benedictine Sisters in Minnesota created a five-hospital system and sold "hospital tickets" in lumber camps; the tickets were priced between \$1 and \$5 and guaranteed purchasers hospital care for one year.¹¹ In the state of Washington, the Sisters of Providence also sold tickets for hospital care at St. Peter Hospital in Olympia; there, the tickets cost 75 cents monthly.¹²

One of the most enduring of these innovations evolved eventually into the Group Health Cooperative of Puget Sound. Doctors James Reed Yoakum and Thomas C. Kerr established the Western Clinic and Hospital Association in Tacoma, Washington; that clinic offered a prepayment program for loggers and other workers to guarantee them needed physician and hospital care. The physicians felt that prepayment was a better solution than simply "passing the hat" to pay for medical expenses of injured coworkers.¹³

In Oklahoma, the Community Cooperative Hospital of Elk City was developed in 1931 and became the first capitated physician/hospital organization in the United States. It was masterminded by Dr. Michael Shadid, an immigrant from Syria.¹⁴ Shadid inspired others to try this innovative concept; among them were the Group Health Association (Twin Cities of Minnesota), which was created in 1938, and Group Health of Puget Sound in Seattle in 1945 (see above). In Two Harbors, Minnesota, in an effort to save a local hospital owned by the railroad system, a largely Finnish community set up an HMO of sorts by hiring physicians and offering a prepaid insurance plan.¹⁵

The concept of communities solving such problems through the creation of cooperatives originated much earlier, in Rochdale, England, in about 1844.¹⁶ With European immigration to North America, cooperatives blossomed across the northern portion of the United States and were manifested as agricultural, dairy, and even sewing cooperatives, mortuary societies, and the Grange movement.

Early community efforts were often funded in like manner when municipal efforts also were inadequate. These pioneering efforts arose from the community to meet the needs of the community. They were not established to control costs *per se*, but represented a new model of delivery. Many of them were, from the beginning, interested more in member and community-based preventive interventions and protection of the safety net than the traditional provision of medical services in the fee-for-service sector. While these forms of managed care seem to be losing ground to for-profit managed-care organizations (MCOs), recent losses on Wall Street and the backlash against managed care may yet provide an opportunity to return to the future.

SUMMARY

PHHS is owned by the community and must be responsive to the community's most vulnerable populations. It serves as the safety net for all residents of Dallas County for critical care, but particularly has addressed its attention over the last decade to providing the primary care and preventive medicine infrastructure in underserved areas of the community. We are striving to create a community-responsive servant organization that is competent to become a partner with the various communities in which our clinics are located.

PHHS intends to promote the values of the early nonprofit HMOs and establish a covenant relation with our patients and the community. It is in the spirit of the third generation of managed care that we must address enrolled populations, while not ignoring the unenrolled populations in the process. We promote value by investing savings in prevention rather than solely increasing executive salaries or stock dividends. PHHS believes strongly that, to be responsive to the community, we must provide care to the individual person in a patient-centered way.¹⁷ We understand that our institution must also nurture a "relationship-centered" partnership with the community. This requires a willingness to engage the community in dialogue. We further believe that Parkland's COPC program and nonprofit HMO represent opportunities for the training of physicians and for conducting relevant community-based health systems and clinical research.¹⁸

PHHS must remain competent and able to measure what it does as a health care entity. It must understand both the limits of its abilities and the competence that exists within power that is within communities to improve health. All must recognize that autonomy will sometimes be in conflict with other values and with the needs of populations of patients. Perhaps one of the major reasons that we are in such a dilemma in the United States regarding health care, and whether or not it should be a right available to all, is in our failure to understand the connection that citizens have to one another.

We believe that our model has great import, not only for the underserved areas of our communities, but also at the national and state policy levels because health care ultimately is delivered as a local service. By using the concept of a cooperative to add to the community-based MCO we are creating, we hope to provide more input for patients, their families, and the community into our system's health care product. Health is not a commodity to be sold, but a state that the patient and his or her family and community experience. Patients are not commodities either; we need their input in the design, operation, and monitoring of the costs, quality, and responsivity of our system.

It is difficult, as an old African proverb has it, "to eat an elephant in one bite." By developing neighborhood cooperatives, it may be possible for patients, physicians, administrators, and purchasers of health care, as well as individuals living in the community, to understand the reasons for sometimes placing community benefit over individuals' desires for services of marginal value. Allocation conflicts will occur; therefore, an appeals or grievance process is necessary. With open communication and outcome information from evidence-based feedback loops, we can strive to improve care and patient behaviors year to year through the utilization of continuing quality improvement techniques.

It is not impossible to construct a managed-care plan that is at least as ethical as any other type of health care delivery previously used, including fee for service. It is, however, unlikely that satisfactory results will accrue over the long term if managed care is only a cover for managed utilization or managed reimbursement. Further, the failure of market-based reforms should rekindle the societal debate needed to create a pluralistic, ethically sound, and economically feasible universal health care plan for this nation. Health insurance, however important, is not enough to create healthy communities. We must achieve social justice and a sense of community in the delivery of health care and human services.¹⁹ The country would be well served if fewer of our citizens chose to "bowl alone,"²⁰ live in gated communities, and commute to work the same way every day so as not to see what the more vulnerable members of our society endure. If we truly reinvigorate our nation with a sense of community, the next health care debate will hold greater promise than the marginal political solutions of the past. It will also more likely lead to the preservation of the ethical and moral underpinnings of the professional's covenant for individual patients and the partnerships between safety net providers and their communities.

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