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Henry Ford Hospital: Options and Opportunities in the 1980s
Douglas S. Peters, MHA* and Bruce VV. Steinhauer, MD**

Mr. Peters:

My purpose in this presentation is to create awareness and stimulate thinking about our future. In order to do this, I have organized my remarks in three areas: a brief review of the past decade at Henry Ford Hospital; a discussion of some external conditions, including initiatives by other health care providers; and finally, some ideas about the future directions of this institution.

Henry Ford Hospital can be described in terms of a group practice, a health care provider, an academic health center, and a community resource. These roles are interrelated functions of our institution. In these remarks I will be inviting your attention to our role as a health care provider.

Historical Perspective

A brief review of the past decade at Henry Ford Hospital offers some perspectives about why and how we have arrived at our current position. In the early '70s the institution had serious internal operating problems. Many of you will recall that billing, accounting, and related financial systems were in such a state of confusion that a certified audit was unobtainable for a three-year period. The nursing staff consisted essentially of aides, few LPNs, and a handful of RNs. The physical facilities were in need of repair, upgrading, renovation. The morale of the professional staff and support staff was reported to be at an all-time low. In addition to these and other internal problems, social and economic crises in Detroit represented serious threats to the viability of this institution.

From this environment a strategy developed to regroup and move forward. The concept dealt with developing suburban and urban patient access and a “center of excellence.” Some argued for HFH to relocate to the suburbs with the population flight; others argued that we should develop excellence on the main campus to attract patients downtown, past all obstacles (psychological, geographic, and economic) to be served here.

The strategy which emerged combined both of these thoughts. The main campus was redeveloped to emphasize primary, secondary, and tertiary levels of care, research, and education. Ambulatory care centers in the suburbs were created to provide convenient access for former and new HFH patients as well as to develop a pattern of patient referrals to support the programs of the main campus. At the same time we tried to establish better relationships with the community around the main campus, and a series of urban outreach programs and community initiatives began.

I think the most significant consequence of these efforts is the enthusiasm, confidence, and momentum that we have going into the '80s. Let us review some of the external factors and conditions which we anticipate in the decade ahead.

External Environment

The major health policy issues seem to revolve around cost, technology, entitlement, decision-making, and structure. I wish to expand on these issues by reviewing some local problems of economy, population, and health manpower.
Economy
Obviously, the economic strength of Detroit should be a concern for all of us. Unemployment is very high, and by the end of the present year it is estimated that over 50,000 auto workers will be without health care benefits. Most projections reflect a tough situation through 1981 and well into 1982.

Population
Population is expected to increase about 4% overall by 1990, with an increase in the 65 and over age group and a slight decrease in the pediatric-adolescent age group. A continuation of urban to suburban movement is projected.

Manpower
Many believe that we will experience a surplus in physician supply. There has been a strong trend towards group practice. In 1978, Michigan data reflected that 65% of MDs and DOs were operating in some form of group practice. This trend is expected to continue. Nursing resources will become increasingly scarce. An increasing proportion of graduating nurses will opt for nonhospital nursing roles, and an increasing level of competition for career opportunities away from nursing is expected.

The implication of these circumstances, within the context of cost, technology, entitlement, structure, and decision making, appear to be the following:

- We anticipate a shift of large numbers of people from private to public financing of health care.
- A reduction in tax revenues in the state of Michigan is likely.
- We see a reduction in Medicaid appropriations. Ironically, this shift from private to public financing with a corresponding reduction in government appropriations places the burden on private hospitals and physicians, at the same time as other sources of funds are being reduced.
- The demand for state rate regulation and tighter reimbursement limits will grow.
- We will see more hospitals in Michigan in bankruptcy.
- Demand for services for the elderly, especially those emphasizing alternatives to inpatient care, will increase.
- Reduced demands for pediatric and obstetric services appear likely in the second half of the decade.
- Reduced numbers of young people entering the labor force will accentuate personnel shortages and drive up our cost of labor.
- Second opinions and pre-admission testing programs may become mandatory.
- Appropriateness review of hospital clinical services and many additional criteria will be applied as measures of hospital performance. For example, a statement in the present health plan for Southeastern Michigan by the Comprehensive Health Planning Council indicates that, by 1983, 20% of all surgery performed in southeastern Michigan must be performed in an ambulatory setting. Rather arbitrary, but it is there as a measure, an evaluator, a regulator.
- We will see a continuation of more aggressive involvement by major business interests to influence health policy. A classic example is the Ford Motor Company leadership in establishing bed reduction legislation in Michigan, in promoting prepaid practices (HMOs), and related efforts to contain health care expenditures.
- We will be dealing with more sophisticated, more demanding, and more fickle patients. If our service and cost levels are not consistent with expectations, other providers will receive their support.
- Finally, I think it is obvious that we will have a great deal more competition among providers. In an area with a stable population and a potential surplus of physicians, this competition will become intense.

Initiatives
I'd like to describe a few actions to indicate what other providers are doing in response to these same pressures and conditions. Perhaps the most significant response is the development of what we call multi-institutional arrangements, and a second action has to do with diversification strategies. I refer to a variety of relationships and linkages among hospitals that for many years stood isolated from one another. Our field had once been described as a cottage industry where each hospital stands independent from the others and is self-sufficient; but with this array of pressures and regulations it is an obvious choice for institutions to come together. The manner of relationships ranges from informal to merger.

In Michigan, over 35% of all hospitals are in one form or other of multi-institutional arrangement. In southeastern Michigan there are 76 hospitals, and over 50% are controlled or influenced by multi-institutional relationships.

Among the largest of these are: 1) the Sisters of Mercy Health Care Corporation; this organization is the largest Catholic hospital system in the U.S. with 22 hospitals and over 5,400 beds in three states; 2) the Detroit Medical Center with five hospitals, 2,100 beds, and the Health Care Institute; 3) the St. Clair Health Services Corporation, which includes St. John Hospital, an ambulatory care center, a clinic on another site, an alcohol rehabilitation unit, and an array of management services in affiliated hospitals; 4) William Beaumont Hospital Corporation with two hospitals, 1,100 beds, three ambulatory clinics, and management services in 15 other hospitals; 5) the People's Community Hospital Authority (PCHA), with five hospitals, 1,200 beds, and two ambulatory care clinics.

These are significant organizations, and we should be prepared to work with them in the years ahead and expect to compete with them, too. It is important to understand
why all of this is happening and the benefit in these arrangements.

It is assumed that such multi-institutional arrangements can have an impact on the quality of care; that we can pool and share resources to broaden the availability of technology beyond the level of single institution resources. There are potential economies of scale in the application of shared services and purchasing arrangements. There is certainly an advantage in recruiting and retention of unique professional resources. There are benefits in exercising political clout when institutions of this size and scale come to bear on the legislative process.

Diversification is another strategy that health care organizations have been developing with greater frequency. Diversification refers to a variety of ventures aimed at broadening the economic base of the institution. The HMO program reflects this strategy, and there are many other examples. The Cleveland Clinic has a newspaper column on cancer; it appears in the Ann Arbor News. Beaumont Hospital sends radio messages on health promotion across the state. Harper Hospital in the Renaissance Center has taken an old idea — executive medicine — dressed it up and put it in a new location in an attempt to compete for patients. There are many examples of this strategy — health and nonhealth related.

**Henry Ford Hospital**

How does all of this affect us? I think of organizations as being categorized into three groups: Those that make things happen, those that watch things happen, and those that wonder what happened. Henry Ford Hospital should be in the first category. We start the decade of the ‘80s with a strong base. Our reputation for quality in patient services should not be compromised. We are financially strong. We have a Board of Trustees with a strong interest in the success of this institution. Our physical facilities are contemporary. The scope of our activities, their breadth, and diversity give us certain advantages as we compete with others. Our “human resources” are a significant source of strength.

Essential to our future and continuing success is the development of significant linkages with other hospitals and medical groups: The cost of technology, the volume of patient activity to carry out tertiary care missions, and the characteristics of the population make it critical to establish linkages, relationships, and arrangements with other providers of health care.

We should continue to diversify to broaden sources of income and support for the central missions of the institution. Many of you are aware that we have formed a subsidiary corporation, Henry Ford Hospital Services. This is a resource to generate benefits from multi-institutional relationships and diversification. Through this corporation we are providing the chief executive officer for the St. Vincent Hospital, a 600-bed hospital in Toledo, Ohio, and several other management services.

These directions require that we evaluate our current organization. I can foresee that we will be dealing with different forms of corporate structure of Henry Ford Hospital in the next decade in order to gain advantages of flexibility, reimbursement from third party insurers, and to stimulate further sources of capital.

Our “game plan” for the decade ahead is to continue the evolution of the main campus as our tertiary care center, with the satellites and the linkages among other providers assisting to create a more comprehensive pattern of health delivery. Strategies of diversification and corporate restructuring will enhance our ability to implement and generate capital for these programs. We must be more efficient and cost competitive to prevail in the environment ahead.

We need to work together to make these decisions. Decisions require physician leadership, trustees and management staff, and maintaining perspective. John Gardner has observed, “Responsible men and women concerned to achieve goals have to cope with two contrasting attitudes on the part of their fellow citizens. One is a violent, explosive impatience to get all things done instantly and bitter disillusionment if that doesn’t happen; the other is a disinclination to take any action at all, sometimes from disagreement with objectives, more often from apathy. Both attitudes pose serious threats. We can be brought down by the aspirations or by our incapacity to aspire.”

Let’s keep our momentum, and our perspectives about the future, and continue to create an institution we can all be proud of.

**Dr. Steinhauer:**

Now that we have entered the 1980s, I want to discuss a question which concerns us all. Where is Henry Ford Hospital going? Perhaps to define our future goals, we should consider briefly what we’ve done in the past.

When I joined the Ford Hospital staff 15 years ago, its purpose was clear: it was a group practice in an academic setting with modest clinical research efforts. A recent survey I carried out evaluated how much primary care the Hospital has done between 1917 and 1979. In 1917 we had four physicians, and primary care was one fourth of our endeavor. Now, at 418 physicians, primary care still constitutes about 26% of our efforts, even though we’ve grown...
to four health care centers and increased our size a hundred-fold.

Such growth in the medical care system has caused some loss of intimacy in our group practice and has created some profound stresses on our organizational style. A recent California study related the number of employees to inpatient and outpatient care at small, medium-sized, and large hospitals. By the standards of that study, Ford Hospital with 6,000-plus employees is superlarge. In the smaller hospitals, bed turnaround time was 23 minutes, and in the larger hospitals, the figure increased to about 108 minutes. Again, many of these larger hospitals are still much smaller than Ford Hospital. The study also found that arrival time for outpatients from information desk to clinic increases progressively with hospital size. The time span between the first outpatient clinic examination until all tests were completed was two days in small institutions, rose to six days in medium-sized institutions, and increased to 18 days for large institutions.

Why Satellites?

To circumvent these and other problems, we developed a strategy which included the development of three satellites—at Fairlane, West Bloomfield, and Sterling Heights—to provide good medical care at locations convenient to the population in those areas. We discovered that patients are generally unwilling to travel long distances to see a doctor. So why not go to the patients?

It was hoped that these centers would supply approximately 40% of our inpatient. However, while outpatient volume has increased, inpatient volume hasn't fared as well. The lack of increased inpatient volume from the satellites may be due to several factors, such as the efficiency of satellite doctors in skillfully treating patients who might otherwise require hospitalization. The travel inconvenience for the physician when he or she admits a patient to the main campus and must then travel back and forth to visit that patient may influence a decision to admit. Many patients have been admitted to subspecialty inpatient units, but the count is not accurate.

We also felt that the satellites would provide the specialties on the main campus with good clinical material. There were approximately 35,000 visits to the central campus from Fairlane and West Bloomfield in 1979, and if we assume that 73% of the care there is secondary or tertiary, about 6% of all our secondary or tertiary care at the main campus now comes from the satellites. At the same time, the satellites have broadened the economic and sociologic basis of our practice, which is particularly useful in fields like allergy, dermatology, and plastic surgery.

A third justification for the satellites is that ambulatory care is a worthwhile end in itself. Henry Ford Hospital has been committed to this concept from the beginning, and our organizational system encourages it. The tri-county area of southeastern Michigan does not have as great a surplus of doctors as some urban areas. Therefore, it is our responsibility and opportunity to replicate ourselves to a greater extent than if we were in Denver or Albuquerque or San Francisco.

Other justifications for the satellites include: Keeping pace with the competition provided by other group practice health care facilities in the metropolitan area; decentralizing our organization to reduce the risk that the main campus will become too large to be efficient; and contributing financially to our total effort.

The satellites have also provided a modular opportunity for innovation without bringing the whole institution into peril with experiments. Central appointments were first tried at the satellites and probably have been worthwhile. An organized occupational health service was first tried at Fairlane.

Still another experiment is the prepayment program. By testing this program in the satellites, we learned that patient accessibility to physicians is vital. If we fail to meet the needs of patients in a timely manner, we know it and we know it soon, because they have already paid for the service. How far the prepayment plan will go isn't clear yet.

Prepayment programs also influence referral patterns to some extent, and regional hospitalization may play an important role. If we could admit some patients to regional hospitals for primary types of illnesses, these patients would be more likely to return to Ford Hospital when they ultimately have a more serious illness or need more extensive treatment. At present, if a patient decides not to go to Ford Hospital and then has to be referred to another hospital for further treatment, he or she follows the referral pattern of the regional hospital. In this way that patient is lost to us.

Before we started the satellites, we also investigated some organizational alternatives to our current approach. One possibility was the office building concept: Eliminate the Medical Director, hire a first-class administrator for each satellite, and have the professional component for each department run through the main campus. We didn't do that because we wanted to create some of the group practice feeling at the satellites that prevails at the main campus.

Our organization has required a considerable number of adaptations in order to provide effective medical service in this complex urban environment. During the '70s, Henry
Ford Hospital undertook one of the most complex maneuvers in recent medical history in this country, and the result has placed considerable strain on the organizational pattern in this institution. I still think the clinical Department Chairmanships, which are at the soul of this Hospital, will continue to be the center of our lives as clinicians. Those of us who have other administrative tasks in medicine recognize this, but we recognize also that the complexity of our effort requires a lot of different players in different situations.

The Satellites in the 1980s

The future looks promising for both the West Bloomfield and Fairlane satellites. Both experienced growth in their surrounding areas in the '70s. Bloomfield's prepayment program grew faster than anticipated, and during the 1980s, I think the shell space there will be filled. There will also be increasing pressure for some degree of subspecialization at Bloomfield. However, its growth potential is limited by the lack of regional hospitalization, particularly in the prepayment area. Obstetrical services, for example, excellent as they are at the main campus, cannot be sold to a broad population base from that long a distance. Ideally, Bloomfield should have its own hospital. However, we are not precluded from inter-institutional relationships by the ultimate existence of a hospital at West Bloomfield in some context or other. Fairlane will probably have higher technology during the '80s, with mammography and possibly echograms, and also some further subspecialization, such as oncology and cardiology.

Both West Bloomfield and Fairlane appear to be growing by increasing penetration of their immediate areas rather than by a widely dispersed increase in growth. A survey of zip codes of patients shows a higher percentage in immediately surrounding zip codes rather than more and more zip codes. Perhaps people are less and less willing to go far for a doctor. The willingness to go far to a doctor is specialty dependent. People are unwilling to go very far to see a pediatrician, somewhat more willing to travel to see an internist, but they will travel unlimited distances to see a neurosurgeon or ophthalmologist.

Our new satellite in Sterling Heights will soon be in operation as well, despite problems we encountered in getting certification of need for such a facility. The downriver area also represents a good opportunity for us. We are seriously contemplating some type of involvement there. Its advantage over other parts of the tri-county area is that it is not as intensely over-doctored. It certainly is undercommitted in some subspecialty areas.

Five years have made quite a difference. Now, many institutions are doing what we have done. What Oakwood Hospital in Canton Township is doing right now is similar to what Ford Hospital has done. For example, they are starting a free-standing 24-hour Emergency Room. The success of West Bloomfield and Fairlane has made it increasingly difficult to start a new enterprise in the same area because we have shown that we can succeed in this type of effort. For that reason, I believe that further satellites probably will require more inter-institutional alliances among the hospitals in places like Livonia and Troy.

Trap-lining

This alliance may develop along the lines of what is called trap-lining. This term refers to the practice of large multispecialty institutions like Ford Hospital providing off-campus subspecialty clinical services to smaller 200-400 bed hospitals that do not have such services themselves. Typically, in these smaller institutions, subspecialty services are provided by generalists who do a little subspecialty work in addition. Some of these institutions would undoubtedly like to have subspecialists doing that job. Consequently, some of our subspecialists at the main campus might find, rather than doing more general medicine in order to make an adequate income, they would prefer to do all subspecialty work, but some of it would have to be off campus. This practice is not unprecedented.

At the Lovelace Clinic in Albuquerque, for example, the staff gastroenterologist there does most of the endoscopy in town at other hospitals. Increasingly, referral practice and inter-institutional relationships are following each other. You create alliances in a lot of different ways — administrative, medical — and the referrals derive from that pattern. Trap-lining can help us in that respect also. It is already going on to some extent at Ford Hospital right now. And in the next few years our natural allies in the health care field will be the 200-400 bed hospitals that are increasingly threatened by the large suburban hospital.

Questions and Answers

Question:

Many of us fear that perhaps we are being spread too thin in these various areas. Are we going to have the talent to maintain this huge institutional care at the central campus at a high level of efficiency and excellence? I would just hope that as all these avenues outside the institution are approached, and as we get involved in them, we won't forget that this is really our lifeblood right here. We should do all we can to maintain this central institution at a high level of efficiency.

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Dr. Steinhauer:
Medical talent is becoming a little easier to recruit than it was a few years ago. Perhaps that reflects the changing ratio of physicians. For the first time people are actually calling us for jobs, and that is happening at the central campus too.

Mr. Peters:
One of the advantages we see in our subsidiary corporation involvement with other institutions, in other settings, is the opportunity to learn, perhaps in a more manageable, smaller, definable setting, some techniques and opportunities to bring experiences from those settings to our own here. Diversification does create some risks in ways you have mentioned, but it also creates the opportunity to cultivate management talent and bring it back home later.

Question:
An alternative plan you did not discuss is the Kaiser-Permanente system, which relies on separate, free-standing clinics and hospitals in a system or network. In that regard, do you envision developing such a system in which our satellites would be coupled with a local hospital?

Dr. Steinhauer:
We have thought about that. I think the problem is that the state legislature in Lansing doesn't agree with that hypothesis. I know you are not referring exclusively to HMOs, but the national HMO law does provide for an institution to build anything it pleases. It can build a hospital, it can theoretically ignore certificate of need legislation. But the Michigan Legislature has so far determined that it is not going to pass enabling legislation to permit that to happen.

Mr. Peters:
Our relationships with other institutions will take a variety of forms. They probably take on a very informal appearance at the outset, but in the long run of the decade we are looking at, only a few systems may survive. I mentioned five major systems now operating, and for political, economic, regulatory pressures that we face, many hospitals will simply disappear as single entities. We would like to relate to some of those in that mid-range category.

Question:
The quality of medical care depends upon a lot of things, such as staff physicians to take care of the patients, and we make allowances for these outreach hospitals. What effort are we making to try to determine the quality of house staff? What is being explored in terms of some quality control of the laboratory data, x-rays, chemistry, etc, apart from the economic aspects?

Mr. Peters:
At this moment we are so far away from having any significant relationship with any institution that we haven't developed those questions. Right now, we are talking about providing physical facility planning, business office support, evaluations of nursing service, personnel management, and other management services functions. The discussions that we've had with others have been founded in management relationships, in which Ford Hospital provides administrative services as an entry point. In the case of Toledo's St. Vincent Hospital, the Chief Executive Officer, Mr. Al Johnson, came from Ford Hospital; he has that responsibility and all that it implies. So, indirectly, it's fair to say that we have helped in identifying resources for that institution. Dr. Steinhauer and others will become involved in discussions that bring clinical relationships into the picture. I think we will be careful in our relationships and in how we structure our negotiations with those institutions, including the quality of care and staffing.