MHA Michigan Health & Hospital Association | Leading Healthcare

To: Members, Senate Health Policy & Human Services Committee

From: Laura Appel, Executive Vice President, Government Relations and Public Policy

Date: February 2, 2023

Re: Public Health and the Shared Responsibility of Hospitals and Health Systems

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Public Health and the Shared Responsibility of Hospitals and Health Systems

The Michigan Health & Hospital Association represents every hospital in Michigan; if your local hospital has an emergency room, that facility is an MHA member. MHA members also include inpatient psychiatric hospitals, inpatient rehabilitation hospitals, long-term acute care hospitals, and in some cases, long-term care facilities which are part of hospital systems.

Hospitals and health systems do not take the lead on public health, but hospitals bear the cost of poor public health. Lack of funding in core public health programs slowed the response to the COVID-19 pandemic and exacerbated its impact, particularly in low-income communities, communities of color, and for older Americans – populations that experience higher rates of chronic disease and have fewer resources to recover from an emergency.[1] In the first days of the pandemic, Southeast Michigan was among the hardest hit areas of the country. Hospitals quickly filled with patients in the emergency department, then in intensive care units, then on ventilators. Nurses, respiratory therapists, physicians, and environmental, food service, and transport workers all grew exhausted with the overwhelming need for patient care. Certainly, the human susceptibility to a novel virus was the primary cause of this distress to the system. The underlying rates of chronic illness and other complicating factors made the initial impact that much worse, imposing a high death rate of patients, an emotional and physical toll on hospital workers, and sudden and extreme financial losses for hospital systems.

Value of Public Health

We are familiar today with health care miracles like transplant surgeries and life-saving trauma care. However, the largest gain in life expectancy in the United States occurred between 1880 and 1920 due to public health improvements such as control of infectious diseases, more abundant and safer foods, cleaner water, and other nonmedical social improvements.

This period is referred to as the First Public Health Revolution and it occurred before the medical interventions of antibiotics and advanced surgical techniques were in place. Improved sanitation, public water treatment, sewage management, food inspection and municipal garbage collection almost

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[1] The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2022. Issue Report from The Trust for America's Health. Retrieved February 1, 2023.

eliminated the aforementioned causes of death. These interventions were implemented across neighborhoods, cities, and counties. This health improvement happened a macro level, not with personal or individual interventions.

The increase in life expectancy was also enhanced by the explosion of vaccine development— *and the public health reforms that got those vaccines in people's arms.* The whooping-cough vaccine was developed in 1914, tuberculosis in 1921, diphtheria in 1923 — followed by the polio vaccine in the early 1950s. Vaccines are administered individually but achieve the greatest impact when an effective strategy produces comprehensive uptake of the intervention.

Hospitals and Public Health

Over time, hospitals and health systems have taken on a greater role in the public health system. When COVID-19 vaccines became available at the end of 2020, hospitals were the first to do the dispensing. The West Michigan Vaccination Clinic in Grand Rapids, a partnership of the Kent County Health Department, (what was then) Spectrum Health, and Mercy Health, delivered more than 200,000 doses of the vaccine between the end of January and April 30, 2021. At its peak, more than 12,500 vaccine doses were provided at the clinic in a single day, with roughly 1,000 shots administered per hour.

Monoclonal antibodies were one of the first effective therapies available for people with COVID-19. These antibodies required intravenous delivery and the infusion took an hour or longer. Hospitalization wasn't necessary, but intravenous care is not the type of offering available from a local public health department.

These are two examples of many successful intersections between local public health, the state health department, and Michigan's hospitals and health systems in recent years. Vaccination remains a strong and close partnership between public health and health systems. Recent evidence shows the most valuable resources in building vaccine confidence are physicians and other clinicians who have the skills to build trust with their patients.

The past few years have exposed challenges for the relationship between public health and health systems as well. Everyone engaged in communicating across health sectors and to the public about the pandemic, it's mitigation, and care for people who fell ill was dedicated to improving a tragic situation that even now persists with more than 500 people hospitalized in Michigan. The MHA quickly learned the footprint of our health systems, which stretch over several counties and are not always contiguous, do not necessarily align well with the state-based Health Care Coalition system which is county-based and divided into eight static districts. Reporting on available supplies by hospital and by state region was difficult to reconcile with large organizations which now inventory supplies by warehouse in multiple locations strategic to hospitals within the system. Going forward the MHA hopes to work with state and local partners to reconcile the public health planning system to the health system model most hospitals are now part of.

In 2021, the MHA initiated a Task Force of its own members focused on public health and how MHA members could best support the reinvigoration of public health policy, improve funding, and public support. As the MHA task force grew over time with the addition of local public health representatives, it became clear that data sharing is not as successful as expected. During the pandemic, hospitals reported the number of available medical/surgical beds, intensive care beds, and ventilators available.

Hospital licensed bed numbers differed from the number of "staffed beds" as the availability of workers rose and fell during the pandemic. To communicate directly with the public health community, the MHA is creating a dashboard on the MHA website with graphics to display available hospital beds by health care coalition region, hospital admissions for flu, COVID-10 hospitalizations, and COVID-19 hospital admissions by age. This is only a first step and a good faith effort to share information in a common language and a usable format between hospitals and local public health departments. The MHA anticipates the development of a robust and greatly improved public health data system, incentivized by the Centers for Disease Control and Prevention Public Health Infrastructure Grant. The Data Modernization component is not yet federally funded but is critical to the goals of improving the foundational competencies of state and local public health.

Emergency Preparedness

One prominent part of public health everyone experiences during a pandemic is the need for emergency management systems. Despite best efforts and positive experiences in many circumstances, it is evident that work is necessary to remove the silos which isolate knowledge within distinct groups, to bolster public health infrastructure, and to better organize the interaction between federal, state, and local governments. The American Hospital Association convened multiple national organizations in 2022 representing chief public health officials, local health departments, hospitals and health systems, fire/EMS and emergency management leaders, public health professionals and health care professionals — to bridge gaps across national preparedness strategies. Together these groups become CLEAR—Convening Leaders for Emergency and Response—and established a field guide for emergency preparedness. Members of the House Health Policy Committee may find this information useful in future policy development around emergency preparedness.

Inequity in Health Status and Health Care Delivery

Health inequities are differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work and age. Health inequities are inherently unfair and must be confronted and eliminated. Hospitals and health systems, and state and local public health representatives are united in this understanding.

The MHA has a second task force specific to health equity. Michigan lawmakers are probably aware of the dismal statistics on severe maternal morbidity/mortality for Black women in Michigan. From 2015-2019, Black women were nearly three times more likely to die from pregnancy-related causes in Michigan (29.8 and 10.7 per 100,000 live births, respectively). The MHA is focused on finding more effective ways to eliminate this specific health disparity of care. Health systems, and their public health partners must work together to reduce the incidence of chronic disease, eliminate the lack of knowledge among all pregnant women related to treatment or follow-up, and confront the conditions which result in delays in seeking or providing care. However, there is ample evidence that social factors, including education, employment status, income level, gender and ethnicity have a marked influence on how healthy a person is. Those working in health and health care are not experts in education, employment, transportation, food security, or the other social factors creating hurdles to good health. Achieving change to improve the health of individuals and in turn, create healthy communities, requires comprehensive and coordinated policymaking beyond public health and health care delivery.