University of Michigan  
Michigan Healthy Community Initiative  
Overview and Task Force Charge  

Overview  
The United States faces a great challenge: how to promote health and healthy living in the face of tremendous social and cultural pressures that foster unhealthy living and poor health, and how to contain healthcare costs that have risen to crisis levels. The ramifications of meeting this challenge — or failing to do so — for the health and well-being of the populace, in current and future generations, are far-reaching.

To help address this challenge, the University of Michigan is launching a grand experiment — a multifaceted approach to promoting the health of the University community and developing more cost-effective delivery of healthcare, as a model for other institutions. We will seek to advance public discussion and social commitment to change in this key area by harnessing the intellectual capacity of the University to develop, test and study efforts to improve the wellness of our employees, students, retirees and dependents.

The University is particularly well-positioned to tackle the challenge of improving health. A large employer with a relatively stable employee base, the University has its own health care delivery system and managed care plan in the setting of a great medical school; it possesses a remarkable resource in the knowledge and talent of health science faculty concerned with the determinants of health and the delivery of health care; and it espouses a mission of education and research that, for its numerous health sciences schools and colleges, is dedicated to improving health. Indeed, there may be no institution better situated to model new strategies for improving the health of employees. Through this new presidential initiative, we will draw upon and coordinate these many assets, with the long-term goal of developing, studying and disseminating new models for more effective promotion of health and for understanding and acting upon linkages between promotion of health and greater optimization of investments in healthcare.

As a multifaceted effort, this initiative will involve a variety of U of M offices and agencies, each of which has core responsibilities with respect to health promotion, healthcare benefits, healthcare delivery, or education. At the center of this initiative will be a new presidential task force — the Healthy Community Task Force. This task force will serve as sounding board and, as appropriate, coordinating body for a variety of projects and policies developed by University administrative units under the aegis of this initiative. It will, more importantly, develop ambitious and creative recommendations for the promotion of healthy living within the University community, study their effectiveness, and disseminate what is learned. More details of the charge are given below.
For nearly three decades, major national health institutions, including the Centers for Disease Prevention and Health Promotion and the Institute of Medicine, have emphasized the critical role of individual behaviors in health outcomes. CDC estimates that changes in individual health behaviors are needed to avoid half of preventable morbidity and premature mortality; CDC places more than half of contemporary deaths into the category of premature and preventable.

The constellation of determinants of health is extraordinarily complex. While it is unarguable that individual behaviors like cigarette smoking, excessive caloric intake, and lack of physical exercise account for large proportions of the nation's disease burden, none of these behaviors occurs in a vacuum. Smoking and diet are heavily influenced by our social environment — the behaviors of our peers, pervasive advertising, role modeling in movies and on TV, the economics of producing cigarettes and restaurant meals, and so on. Lack of exercise reflects a fundamental transformation in the nature of work over the past century, the availability of inexpensive automated travel (most notably the automobile), the pervasiveness of passive forms of entertainment (TV, the Web, movies), and the development of community layouts not conducive to walking. Affluence itself contributes in a major way to many of the unhealthy behaviors that now plague our health and our health care system.

Fortunately, attempts to encourage Americans to alter behaviors deleterious to their health have paid off. The proportion of adults who smoke has fallen by half since the Surgeon General identified smoking as the most significant cause of lung cancer in 1964. Campaigns to control blood pressure and reduce cholesterol have produced substantial reductions in the populations at high risk. Concurrently, age-adjusted heart disease and stroke death rates declined by more than half. Seat belt use has increased dramatically over the past three decades. Complemented by technological safety improvements in both cars and highways, this behavior change has caused traffic-related deaths, measured per mile driven, to plummet. Workplace safety initiatives have reduced the workplace death rate significantly, while ergonomic improvements in the workplace have diminished injury-related morbidity.

Still, much remains to be done. Obesity rates are skyrocketing. Over a fifth of adults still smoke. Perhaps 15 percent of consumers of alcoholic beverages are problem drinkers. Homicide and suicide continue to be leading causes of death. More than 40,000 lives are lost annually on the nation's highways. Of equal if not greater concern than the overall numbers are the disparities in the distribution of disease burdens by socioeconomic status. Poor and less educated Americans suffer from behavior-related illness in far greater proportions than do the affluent and well educated. Disparities by race and ethnicity, while narrowing, remain large. Within our own University of Michigan community, assuming that employee behavior is consistent with that reflected in national data, it is highly likely that the burdens associated with obesity, alcohol abuse, and smoking are borne disproportionately by some groups of University employees.

The challenge

To many students of health promotion, the workplace constitutes a uniquely valuable setting for encouraging improvements in health behaviors. Employees spend the largest proportion of their waking hours at work. Further, employees are readily accessible to employers wishing to disseminate health-enhancing messages; they are subject to
workplace policies (e.g., no smoking in workplace buildings); peer effects of co-workers influence them; and they frequently confront work-related decisions that affect their personal bottom lines (e.g., I will pay more for company-sponsored life insurance if I smoke). As noted above, the University of Michigan possesses a wealth of resources with which to develop effective workplace interventions. Moreover, the University setting provides educational opportunities to improve students’ understanding even before they enter the workforce.

There are particular challenges, such as: institutions and factors beyond the workplace have immense influence on individuals’ behavioral choices; employees and other members of the community have numerous personal goals besides better health, and their autonomy must be fully respected in any strategy; institutional resources are not unlimited, and investments in promotion of health represent both real and opportunity costs for the institution. Part of the function of this effort will be to take into account, and to better understand, how various such issues factor into the development of an effective health promotion strategy at an institution such as ours. Ultimately, there may be no better single point of entry into the constellation of health determinants than the sort of workplace represented by the University, or a better laboratory in which to proceed to develop a model for broader use. Even modest gains in healthful living for our community would represent a tremendous start for deeper understanding and further action.

Charge to committee

The committee is tasked with identifying, evaluating, and recommending adoption of interventions representing cost-effective investments in the health of the UM workforce. In so doing, the committee is encouraged to develop creative approaches to promoting health within the University community, and to consider specifically ways in which the programs and resources of the UM Health System can be employed to further this objective.

The committee is also tasked with advising the University administration and UM Health System administration on ideas and projects, brought to the committee, that are relevant to the University’s overall goals of promoting healthy living, improving healthcare delivery, and endeavoring to control healthcare costs.

The Michigan Healthy Community Initiative is intended to advance public discussion and encourage social commitment to change by conceiving of health as a community process within the special context of the University workplace. As such, the committee will invite community contributions to its deliberations. Of great interest will be how effectively, how seamlessly, and to what consequence, the University can integrate the promotion of healthy living with the provision of health care coverage and service delivery. The linkages between healthy living and health care are not well elucidated and the opportunity to link the two explicitly creates the possibility of an exciting and valuable synergy.

The initiative builds upon the interest and commitment of the President, the Provost, the Executive Vice President for Medical Affairs, the Executive Vice President and Chief Financial Officer, M-Care, the UM Health System, the health science and other schools, Human Resources, and others. All of these will constitute important resources for the work of the committee. The committee's specific charge is to:
• Develop models of how to enhance healthy living and health care delivery that effectively use the University’s financial and human resources toward the goal of benefiting the University community.

• Promote and support healthy living in a multi-cultural context for University of Michigan students, staff, faculty, retirees, and dependents. This may involve, for example, utilizing on- and off-campus educational services, incentives in health care benefits, and rewards for meeting behavioral health targets.

• Evaluate the impacts of interventions on health behaviors within the various components of the University’s workforce and retiree population.

• Evaluate other consequences, both fiscal and social, including among the former impacts on absenteeism and on-the-job productivity and, among the latter, employee attitudes toward the interventions and toward work satisfaction itself.

• Describe how, if at all, interventions influence insurance costs and coverage for individuals, families, and the University as a whole.

• Regarding the previous three items, and more generally, encourage ongoing scholarly research on and evaluation of initiative interventions as they are developed and implemented, drawing on faculty and staff expertise from across the University.

• Provide for broad communication about the nature and consequences of any interventions, disseminating what is learned and contributing to policy discussion at the state and national levels.

The committee will keep the President and executive leadership informed about its progress and advised on emergent proposals. Given the scope and scale of this project, it likely will need to be developed in multiple phases possibly unfolding over a period of several years.

Staff to support the work of the Task Force and this initiative will be provided by the Office of the President, the Office of the Executive Vice President for Medical Affairs, the Office of the Provost and Executive Vice President for Academic Affairs, the Office of the Executive Vice President and Chief Financial Officer, M-Care, the UM Health System, and Human Resources and Affirmative Action.