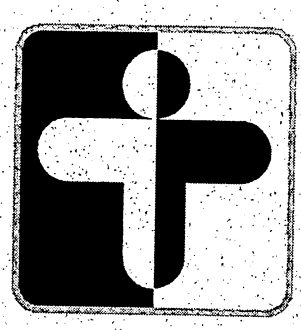
Cambridge Public Health Assessment 2000

A Report of the Cambridge Health Alliance



Cambridge Health Alliance

1493 Cambridge Street • Cambridge, MA 02139 • 617.503.2300

January 15, 2000

Robert W. Healy
City Manager
City Hall
Cambridge, MA 02138

Dear Mr. Healy,

The Cambridge Health Alliance proudly submits the Cambridge Public Health Assessment 2000: A Report from the Cambridge Health Alliance. This document represents the fourth annual report to the City Council and provides information on health programs and services as well as public health trends in our city.

To complement the extensive qualitative and quantitative analysis provided in the 1999 report, this year's assessment provides an update of the Alliance activities over the past year as well as a summary of clinical services offered. This year, a particular focus is provided in Chapter 5 on Geriatrics and elder care services.

I'd like to thank Harold Cox, our Chief Public Health Officer, Lynn Schoeff, Director of Community Health and Ellen Kramer, Director of the Health Information Unit for leading this year's assessment project and for doing a superb job in compiling and synthesizing the work of many contributing writers.

I hope you find the Cambridge Public Health Assessment 2000 to be a useful tool in better understanding the needs of Cambridge residents. We look forward to engaging the City Council in a dialogue about this information so that we can continue to fulfill our mission, which is to improve the health of our city.

Sincerely,

John G. O'Brien
Chief Executive Officer

Affiliated with Harvard Medical School

Cambridge Hospital Campus
1493 Cambridge Street • Cambridge, MA 02139 • 617.498.1000

Somerville Hospital Campus
230 Highland Avenue • Somerville, MA 02143 • 617.666.4400

Cambridge Health Alliance

This document was created by the Cambridge Public Health Alliance.

The information contained in this document was current as of our production date of January 15, 2000. Data presented in charts, graphs, and tables throughout this document are source-and-date-referenced and represent the most recently available data.

We encourage the reproduction of the *Cambridge Public Health Assessment 2000* and its usage in any form and by any organization or individual seeking to improve public health.

Please visit our website at **www.challiance.org** for access to this document online, and to print out specific pages, sections, or the document in its entirety. To receive a printed copy by mail, please call us at 617-665-3800.

Table of Contents

List of Charts, Graphs, and Tables

Chapter 3: Priority Areas

Chapter 5: Focus on Geriatrics

Cambridge City Council and City Manager

The Cambridge Health Alliance would like to acknowledge the leadership of the City of Cambridge for its advocacy of and commitment to Public Health.

Kathleen L. Born
James S. Braude
Henrietta Davis
Marjorie C. Decker
Anthony D. Galluccio
David P. Maher
Kenneth E. Reeves
Michael A. Sullivan
Timothy J. Toomey Jr.

Robert W. Healy, City Manager

Cambridge Health Alliance Board of Trustees

Richard deFilippi, PhD, Chair
Robert H. Arnold, Vice Chair

Eugene Brune
Terry Cline, PhD
William Craig
Elaine DeRosa
Gerard P. Donahoe
Paul Erickson, MD
John Francis
Mary Ann Hart, RN
Ralph Hergert
Camara Jones, MD
James Maloney
John O'Brien, CEO
David Osler, MD
Estelle Paris, RNC
Neil Rosenburg
Karen Routt
Ellen Semonoff

Cambridge Health Alliance Joint Hospital Board

Elaine DeRosa, Acting Chair

Barbara Ackermann
Thomas Bent
Daniel Berkowitz, MD
Carol Cerf
Melvin Chalfen, MD
Terry Cline, PhD
Audrey Cunningham
Richard deFilippi, PhD
Ralph Hergert
Margaret S. Joyce
Pearl Morrison
John O'Brien, CEO
David Osler, MD
Estelle Paris, RNC
Ellen Semonoff
Jonathan Stearns

Cambridge Public Health Subcommittee

Carol Cerf, Chair

Barbara Ackermann
Melvin Chalfen, MD
William Craig
Elaine DeRosa
Laurie Tennant-Gadd
Robin Harris
Jill Herold
Camara Jones, MD, MPH, PhD
Jean McGuire, PhD
Nina Mishkin
John O'Brien, CEO
Estelle Paris, RNC
Dianne Perlmutter
Irene Uraña-Maxwell

Joint Public Health Board

Jack Hamilton, Chair

Regina Bertoldo
Carol Cerf
Linda Cornell
Elaine DeRosa
Victor DoCouto
Karen Edlund, RN
Brian Greene
Robin Harris
Jill Herold
Genita Johnson
Camara Jones, MD, MPH, PhD
Jean McGuire, PhD
John G. O'Brien, CEO
Sylvia Saavedra-Keber
Yves Rose St. Dic

Neville Manor Board

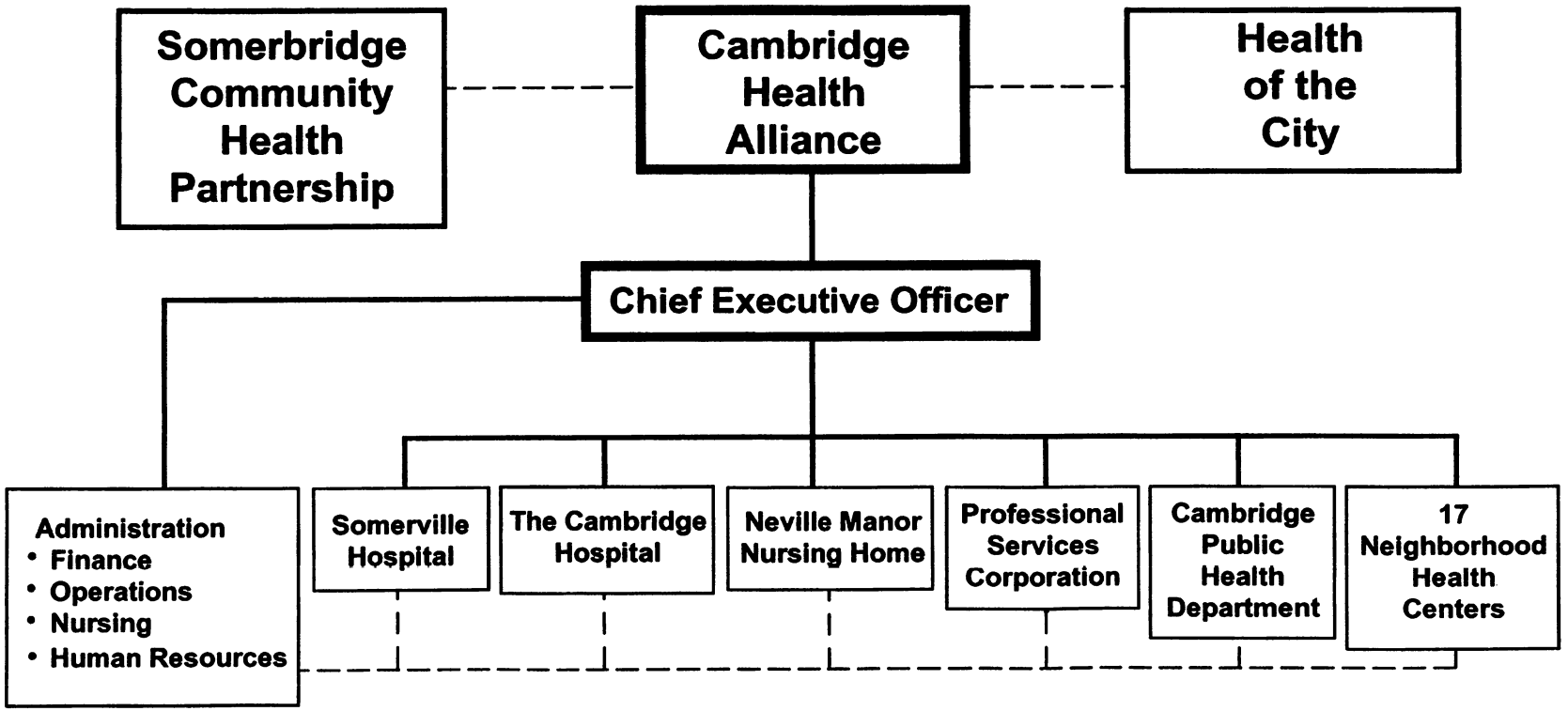
Neil Rosenburg, Chair

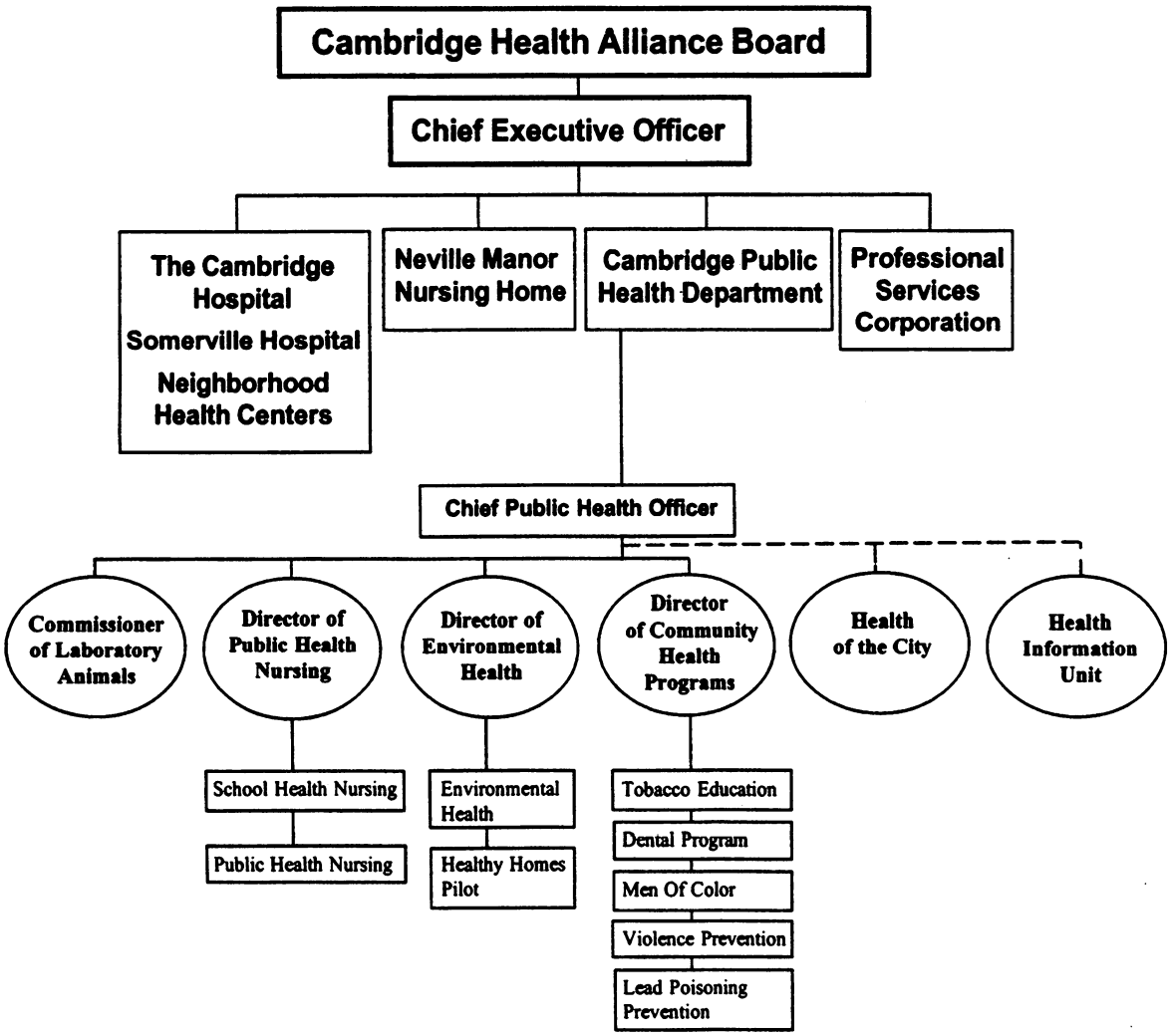
William Craig
John Francis
John O'Brien, CEO
Estelle Paris, RNC

Acknowledgements

Alan Abrams, MD, MPH, CMD
Patrick Barton
David Bor, MD
Shari Brenner, MPH
Virginia Rall Chomitz, PhD
Mary Clark, JD, MPH
Harold Cox, MSSW
Linda Cundiff, RN, MSN
Ellen Davis, MDiv
Allyson Doyle, MSW
Barbara Fisher, MBA
Jean Granick, LICSW
Juhee Kim, MS
Donna King, RN, MPH
Ellen Kramer, ScD
Ricki Lacy, RN, MS
Joyce Lefevre, RDH
Sam Lipson, MS
Jeff Nussbaum, MAMA
Bernard Plovnick, MEd, MS
R. Lynn Schoeff, MEd
Lee Swislow, RN, MS
Jack Vondras, MPH
Jeff Walker
Joseph F. West, MSc
Richard Wright, MS

Cambridge Health Alliance Organizational Structure




Cambridge Health Alliance Board
Chief Executive Officer
The Cambridge Hospital
Somerville Hospital
Neighborhood Health Centers
Neville Manor Nursing Home
Cambridge Public Health Department
Professional Services Corporation
Chief Public Health Officer
Commissioner of Laboratory Animals
Director of Public Health Nursing
Director of Environmental Health
Director of Community Health Programs
Health of the City
Health Information Unit
School Health Nursing
Public Health Nursing
Environmental Health
Healthy Homes Pilot
Tobacco Education
Dental Program
Men Of Color
Violence Prevention
Lead Poisoning Prevention

EXECUTIVE SUMMARY

This edition of the Cambridge Public Health Assessment is the fourth annual report to the Cambridge City Council prepared and submitted by the Cambridge Health Alliance. The *Cambridge Public Health Assessment 2000* (2000 Report), is presented in one volume with information on public health programs, services, and trends in Cambridge.

Programs and Services

The *Cambridge Public Health Assessment 2000* will update policymakers and the public on those priority areas and populations identified in previous reports. The emphasis of the 2000 Report is on reporting Alliance activities of the past year by examining the larger health care environment, community engagement efforts, and program initiatives within selected priority public health areas. A summary of clinical services offered by the Alliance and by other agencies and health care providers helps to complete this overview of the public health status of the Cambridge community. Finally, information on health concerns for Cambridge residents sixty-five years of age and older is included at the end of this report. *Focus on Geriatrics* launches a process of more intense annual focus on each of several demographic groups identified in the 1999 Public Health Assessment. In the 2000 Report, we examine more closely the health and welfare of seniors living in Cambridge. Other populations that will be assessed in future reports include men of color and children, among others.

The first two chapters of this report offer a broad picture of challenges, accomplishments, and coalition-building efforts that took place during 1999. Chapter 1: *Current Health Care Environment* highlights some of the economic pressures affecting the availability of and access to health care resources. Chapter 2: *Community Involvement in Public Health Planning* describes efforts to encourage participation by all community members in the process of identifying and responding to local health needs. These chapters offer a larger view of the dynamics of public health engagement with less emphasis on the specific features of the priority areas identified in previous years. Both provide an opportunity to reflect on the larger forces that shape the nature and scope of services that health care providers and institutions will need to offer in the future.

Chapter 3: *Priority Areas,* summarizes activities undertaken within the past year in each of the six identified priority areas: Access to Healthcare, Violence Prevention, Environmental Health, HIV/AIDS, Substance Abuse Prevention, and Health Promotion and Disease Prevention. Each priority area includes accomplishments, community engagement activities, and emerging concerns. Written by public health professionals, these sections offer a ground-level view of both the daily efforts and the broader hopes and goals for these programs.

Chapter 4: *Clinical Services of the Cambridge Health Alliance,* describes the clinical services offered by the Alliance, and the numbers of patients served in fiscal year 1999. With The Cambridge Hospital and the neighborhood health centers, the Alliance's impact

on health care within Cambridge is extensive. Medical challenges are presented daily, while the broader goal of properly tailoring health services to the community evolves over time. The annual Public Health Assessment is part of the regular review of challenges facing delivery of services and of opportunities for continuous improvement within the organization.

Chapter 5: *Focus on Geriatrics,* devotes greater attention to seniors in Cambridge, the first of the populations at risk identified in the 1999 Public Health Assessment. This roving lens will allow us to develop a more thoughtful assessment of one population in particular need of health services and strategies. As with each group identified for closer consideration, the elderly are challenged by economic, bureaucratic, and social obstacles that have a direct bearing on health care. By focusing greater attention on the challenges facing seniors in Cambridge, we can highlight the services available for this vulnerable population, as well as the gaps in service that still exist.

Highlights of Accomplishments

Examination of our core priorities is a continuing enterprise in such a competitive environment for health care. The 2000 Report summarizes our current activities and will facilitate internal and external review of our work. The further objective of informing the community about what the Alliance does is also served by this quick tour of accomplishments within the established priority areas. These activities are highlighted below. (See also page 9, Cambridge Public Health Department Highlights 1999.)

Priority Public Health Issues

Access to Health Care

Recent measures to improve access to health care in Cambridge are summarized:

- Health centers located throughout the city provide a broad menu of services in a culturally sensitive and welcoming environment during both daytime and evening hours.

- The Interpreter Services Department assists patients in over thirty languages on a regular basis.

- Language classes in English, Spanish, Portuguese, and Haitian Creole are available to employees to enhance patient care.

- The Alliance accepts reimbursements from the full range of third parties and insurers and reviews all options with the patient. Patients eligible for free or subsidized care are given information and guidance about applying for these benefits.
- Programs for certain high-risk populations are offered to improve availability of routine services. These include Health Care for the Homeless, the Teen Health

Center, the Men of Color Health Program, House Calls for Frail Elders, and the Healthy Homes Program.

- The Alliance offers many choices to meet the preferences of patients, including traditional obstetrics and gynecological care, or midwifery and a birthing center. Parents have a choice of pediatric health care providers including pediatricians, nurse practitioners, and family physicians.

- The Department of Psychiatry offers outpatient, inpatient, individual, group, and family therapy through its Adult and Child programs. Specialized linguistic services include the Latino, Haitian, Portuguese, and South Asian Mental Health Teams.

- The Renewal and Expansion as a Center for Community Health (REACH) will upgrade and expand facilities at The Cambridge Hospital through the spring of 2001. The REACH expansion will accommodate 100,000 additional ambulatory patient visits each year with 100 new examination and treatment rooms and physician offices.

- New neighborhood health centers at Windsor Street and in East Cambridge have been opened to replace facilities that could no longer meet the demand for services. These facilities offer a full array of primary and specialty health care services.

- Two programs aimed at identifying and meeting the dental needs of Cambridge residents include the new Windsor Street Dental Clinic and the Children's Dental Project, a comprehensive dental education, screening, and referral program.

- The Health Outreach for Community Health Improvement project was a door-to-door survey of Area 4 households to document barriers to health care access. During a five-day period, 188 interviews were conducted in English, Spanish, Haitian Creole, French, Portuguese, and Bengali. Responses from this survey will be used to evaluate the current scope of services and to develop indicators to monitor delivery of health care to a multicultural population.

Violence Prevention

Efforts in 1999 to combat domestic violence included:

- The first Domestic Violence Free Zone Status Report was published in early 1999.

- Domestic violence screening, counseling, and referral were added to the current intake and evaluation services offered by the Employee Assistance Programs for the Cambridge Health Alliance and the City of Cambridge.
- An initiative to serve Children Who Witness Violence began with the formation of a working group that includes professionals from the courts, police, health care system, schools, and human services programs.

- A comprehensive, school-based domestic violence training was initiated to assist primary responders in the School Department in issues of child abuse, domestic violence, reporting, documentation, counseling, and safety planning.

Environmental Health

Some of the work of the Environmental Health Unit in 1999 is listed below:

- The Healthy Homes program, aimed at eliminating or reducing indoor triggers of childhood asthma, was launched in September 1999. An asthma prevention and management workshop for nurses and other health and housing professionals is scheduled for January 2000.

- Review of several large hazardous waste sites continues. This oversight work has been carried out in coordination with local neighborhood groups that have articulated concerns about hazardous exposures. Sites include Russell Field, the W. R. Grace property, and the Cambridge Research Park development in Kendall Square. Frequent meetings are held with major developers to clarify measures needed to protect public health when large volumes of contaminated material are being excavated or disturbed.

- The Environmental Health Unit drafted an asbestos protection ordinance in collaboration with members of the City Council and City staff. This local statute will govern property that has been found to contain asbestos in the soil exceeding the minimum standard set by the United States Environmental Protection Agency. The Environmental Health Unit will be the enforcing agency under this law, which expands on the limited protection offered by current state environmental law.

- This unit continues to enforce the Recombinant DNA ordinance, facilitates the Cambridge Biosafety Committee, and approves all new and expanded DNA laboratories in Cambridge. There has been a steep increase in the volume of recombinant DNA research in recent years as this industry has matured and gained the attention of larger pharmaceutical companies.

- The Environmental Health Unit responds to health concerns from the public resulting from exposures in the home or at work. This work often involves negotiating between parties to achieve mutually acceptable solutions and occasionally requires investigation of the exposure source. State laws and environmental codes are invoked as needed to compel individuals or businesses to remediate unhealthful sources of chemical or biological exposure.

HIV/AIDS

Maintaining high quality HIV/AIDS services at a time when this disease has less media visibility remains a primary goal of the Alliance. Activities in 1999 that served the HIV-infected and affected communities included:

- The Zinberg Clinic provided ongoing prevention and service programs for individuals with HIV and their families.

- Clinical outcomes of treatment were assessed in order to measure the impact of services on health status. The first set of evaluations indicates that more than 25% of fifty uninsured patients tracked experienced a significant decrease in viral load (the amount of HIV detectable in the blood) over a six to twelve month period. Mental health indicators were measured for stress level, depression, social support, and self-advocacy skills.

- Effective prevention strategies have begun to take into account broader social risk factors such as poverty, racism, sexism, and homophobia. Examining the factors of economics and social isolation in assessing risk of infection has expanded the traditional medical model of prevention.

Substance Abuse Prevention

Efforts in 1999 to combat substance abuse featured education, program development, and evaluation.

- The Middle School Health Survey was administered in March 1999 in an effort to understand how pre-teens experience drug use, violence, sexual activity, and other critical social challenges. The results of the previous 1997 survey were presented to faculty and staff at each of the thirteen Cambridge elementary schools during the 1998-1999 school year. Preliminary results of the 1999 survey suggest that substance use rates have declined among middle school students.

- Several "science-based" prevention strategies and curricula were reviewed by the Cambridge Prevention Coalition. The "Life Skills Training" program will be implemented in sixth grade classrooms in four elementary schools during the 1999-2000 school year.

- CASPAR instituted a Student Assistance Program that will eventually include comprehensive substance abuse education for sixth grade students, identification of students at high risk for substance abuse, and an evaluation of intervention and prevention programs.

- The Multidisciplinary Homelessness Working Group began examining issues related to homelessness, public intoxication, and nuisance behaviors. Substance abuse was recognized as a common barrier to transition from homelessness and a major element of nuisance behaviors among housed and homeless individuals. Recommendations from this group include expansion of emergency and residential services, support for chronic users of these services, public education about homelessness, and implementation of targeted enforcement activities. A comprehensive report was submitted to the City Council in November.

Health Promotion and Disease Prevention

A great variety of disease prevention and health promotion activities took place during 1999. These efforts are summarized below:

- Health promotion and education efforts included participation in public events around Cambridge including Women's Health Day, Family Fun Day, National Night Out, Central Square World's Fair, Central Square Caribbean Festival, Sharing the Journey, Cambridge Walks, and the Windsor Street Health Center Open House.

- The Health of the City initiated several health promotion projects on topics such as obesity prevention, physical activity and nutrition promotion, pediatric mental health, geriatric health, and asthma. These activities involved other City agencies and students from area universities. Health of the City also provided support and technical assistance to the Children's Dental Program, the Agenda for Children, and the Domestic Violence Task Force.

- The Health Information Unit, as part of the larger Health of the City effort, had two major data gathering and publishing projects. First, the *1999 Public Health Assessment: A Report from the Cambridge Health Alliance, Volume 2*, was published in January 1999 as a compilation of health data for Cambridge culled from local and state sources. The Health Information Unit also produced *The Health of Cambridge at a Glance*, a one-page overview of current health facts and statistics that was sent to each household in Cambridge to raise public awareness of our most pressing public health priorities.

- Health of the City continued to convene the Healthy Children Task Force, a panel of pediatric providers, children's advocates, and community members. In 1999, the Task Force focused attention on the levels of obesity in grade school, provided advocacy for improving facilities and open space for physical activity, and collaborated with the Health Information Unit on Walk Our Children to School Day in October. Health of the City co-developed several initiatives with the Cambridge Public Schools Food Service, including hiring a full-time manager, forming an advisory committee, and writing a successful breakfast promotion proposal. Pediatric mental health became the focus of a task force subcommittee that was further supported by an inventory and needs assessment performed by graduate students from the Harvard School of Public Health.
- The Cambridge Public Health Department has worked to strengthen local tobacco control regulations. After much negotiation with restaurant and club owners, a Tobacco Control Ordinance was drafted and enacted by the City Council in June. This ordinance prohibits smoking in restaurants, with certain exceptions for some establishments. New limits on cigarette machines and self-service displays in businesses that serve people under eighteen years of age were also included in the revised ordinance. A trilingual educator was hired to lead a smoking cessation and outreach program for English-, Spanish-, and Portuguese-speaking residents.

- The Public Health Nursing group at the Cambridge Public Health Department worked on several initiatives, including health education and screenings at local shelters, senior centers, and religious organizations. Public health nurses consulted with several childcare and after-school programs and established a partnership with the Harrington School Extended Day Program. Over 240 cases of reportable communicable diseases were reviewed and public health nurses contacted patients and medical providers to ensure that residents received proper treatment and education. Vaccination programs were provided both on a walk-in basis and at local businesses that had employees at greater risk for disease. Newborn Home Visiting, initially piloted in North Cambridge, was expanded to the entire city in 1999.

- The TB Clinic had 2,268 visits in fiscal year 1999, though the number of active TB cases among Cambridge residents has remained essentially steady over the past five years at between nine and eleven cases. Concern about teenagers who have not properly completed their TB therapy has led to development of a coordinated process involving students, parents, and school nurses. Cambridge will also be a pilot site for a state program to increase TB screening rates.

- The Public Health Nursing staff held flu clinics across the city in 1999, and more than 9,700 flu vaccinations were given.

- The School Health Nursing staff worked to ensure that all children entering the public school system in the 1999-2000 school year had received all required immunizations. All new kindergarten students had met this requirement by the end of the second week of class in September 1999. School nurses facilitated student groups on eating disorders, self-esteem, hygiene, and smoking cessation. Nurses provided expert guidance to schools in identifying the health and education requirements of special needs students. The nursing staff also trained other school staff to recognize and prevent respiratory emergencies and to properly identify allergic reactions in children. The Teen Health Center offered health orientations to each freshman advisory group and each ninth grade student had the opportunity to meet with a nurse to discuss his or her health care needs.

- The Agenda for Children worked intensively during the 1998-1999 school year to engage more than 600 residents in selecting two primary goals: (1) "All children and their families will be able to read," and (2) "All children will have access to supervised activities in safe and nurturing environments at all times." In April 1999, two corresponding action teams were established to develop strategies and to measure progress toward these goals. Each action team included education and childcare development professionals, parents, clergy, health, and human service professionals.

- The Men of Color Health Program engaged in several projects in 1999, including a Prostate Cancer Screening Program in collaboration with local churches to educate African American men about prostate cancer. A youth outreach program was started to inform young men between fourteen and eighteen years of age about issues of substance abuse, sexually transmitted diseases, violence prevention, physical activity,

and personal development. A forum to discuss high blood pressure and heart disease took place at a local youth center and in several barbershops around Cambridge in March. Finally, the sixth annual Hoops-n-Health basketball event was held at Hoyt Field, drawing several hundred participants and spectators. Health risk assessments and one-hour health information sessions on homicide, sexually transmitted diseases, seat belt use, smoking, and substance abuse were required before participants could join the game.

- In 1999, the Breast and Cervical Cancer Initiative conducted outreach efforts at local health fairs and housing developments. This program offers free annual physical examinations (with Pap smear and mammogram) to women forty years of age or older who are uninsured or underinsured.

While the specific activities listed in this summary are not categorically inclusive, they do exemplify the broad array of services and projects undertaken by the Alliance in 1999. More detail is provided within the body of the 2000 Report, along with discussions on emerging issues and community engagement efforts that were such an important part of this work.

1999 Cambridge Public Health Department Highlights

- Newborn Home Visiting Program, originally a pilot in North Cambridge, was expanded to the whole city:
  - 84 home visits were made
  - Home visits now include discussion of early literacy development practices
- TB and communicable disease monitoring:
  - 2,268 visits to the TB clinic
- Healthy Homes program was launched in September to help parents understand asthma triggers affecting children at risk.
- Vaccine Distribution:
  - 7,400 doses distributed to area providers
  - 2,300 doses given by Public Health Nurses in flu clinics
- Permits for recombinant DNA research and manufacturing:
  - 41 permits were issued
- Massage Therapist Licenses:
  - 160 individual licenses were issued
- Permits to conduct experiments on live animals:
  - 33 permits were issued
- Funeral Director Licenses:
  - 15 licenses were issued
- Oral hygiene education and screening:
  - Education was provided to grades one through four
    1,300 students attended
  - Screening was provided to grades one through four
    1,193 students were screened
- Domestic Violence Training was provided to more than 60 Cambridge Public School and City employees as part of a comprehensive, school-based Domestic Violence training project continuing through 2000.
- The *Walk Your Child To School Day* campaign informed more than five-thousand Cambridge Public School children and their families of both the health benefits and safety concerns of walking.
- The *Socks Campaign* collected more than two-thousand pairs of new socks to provide the homeless in Cambridge, at the same time raising awareness of health concerns of homeless individuals.
- *The Health of Cambridge at a Glance*, a one-page overview of current health facts and statistics, was sent to each household in Cambridge to raise public awareness of our most pressing public health priorities.

CHAPTER 1: CURRENT HEALTH CARE ENVIRONMENT

Massachusetts health care providers have entered an era of intense economic change and uncertainty. At a time when the national and local economies are booming, and when the demand for quality medical services and access are at an all time high, the health care system is operating under unprecedented financial constraints. There are two major factors contributing to the financial squeeze on health care providers and patients. First, spending cuts passed by Congress in the Balanced Budget Act of 1997 have significantly reduced provider payments under Medicare. Second, private insurers in Massachusetts—particularly health maintenance organizations (HMOs)—are responding to financial pressure by reducing payments for services, delaying payments to providers, and limiting some covered services for their members.

The Balanced Budget Act of 1997

While the Balanced Budget Act included several provisions to increase access to health care, it financed this access through drastic cuts in Medicare payments to hospitals, ancillary providers, and physicians. Medicare payments to Massachusetts hospitals are expected to be reduced by between $1.7 and $2.2 billion between 1998 and 2002, making Medicare payments to Bay State hospitals actually lower in 2002 than they were in 1997. The Cambridge Health Alliance is expected to experience a $7.5 million reduction in Medicare payments.

These cuts have come in a variety of areas. Hospitals are being severely affected by reductions in indirect medical education payments and cuts in outpatient rates. There are also cutbacks in Medicare reimbursement for patients who are transferred from acute hospitals to post-acute care, such as rehabilitation hospitals or skilled nursing facilities. Further reductions are being felt in home health services and transitional care units, which will now be reimbursed on a prospective rather than a cost reimbursement basis.

In response, Massachusetts providers have been lobbying extensively in Washington through their local legislators and trade associations such as the Massachusetts Hospital Association to address problems created by the Balanced Budget Act. The Cambridge Health Alliance has also been working with the National Association of Public Hospitals in an effort to preserve disproportionate share payments to "safety net" hospitals, such as The Cambridge Hospital, that serve a higher proportion of the area's uninsured. The outcome of these efforts is uncertain, although there is increasing support to use part of the federal surplus to repair some of the damage caused by the Balanced Budget Act. Unfortunately, proposals are still being debated in Washington and there is no clear solution to the Medicare payment reductions currently affecting Massachusetts providers.

Health Maintenance Organization Woes

The impact of Medicare cutbacks is compounded by payment reductions imposed by some of the region's HMOs, which are also experiencing severe financial problems. Premiums charged to many businesses and individuals were held relatively flat by some HMOs at a time when medical costs, particularly prescription drug costs, were rising rapidly. As a result, there has been significant financial turmoil in the area's HMO industry affecting both members and providers.

Harvard Pilgrim Health Care, New England's largest HMO, posted an operating loss of over $94 million in 1998, and may post losses of over $100 million in 1999. Tufts Health Plan, the region's second largest HMO, posted a loss of over $12 million. Among the major HMOs in Massachusetts, only Blue Cross reported a positive bottom line. All of the major plans are announcing premium increases ranging from 8% to 15% to take effect in 2000.

In response, HMOs are consolidating operations, eliminating unprofitable lines of business, and limiting benefits. Harvard Pilgrim Health Care, for example, has eliminated 245 positions (approximately 7% of its workforce), and put its Rhode Island operation, currently in receivership, up for sale. Tufts Health Plan is leaving the Maine market.

Unfortunately for seniors seeking Medicare HMO coverage, the senior plan product lines are proving unprofitable for many insurers. More than six million seniors, including 228,000 in Massachusetts, have switched from traditional Medicare coverage to senior managed care plans offered by commercial HMOs. Medicare HMOs in Massachusetts have drastically limited their prescription drug coverage for members, and some plans are leaving the market altogether. Several HMOs, including Blue Cross (Blue Care 65), Harvard Pilgrim Health Care (First Seniority), Tufts Health Plan (Secure Horizons), Kaiser Permanente, and United Healthcare of New England are eliminating their Medicare HMO coverage in certain Massachusetts markets deemed unprofitable. In addition, these plans are reducing reimbursement rates to area physicians and acute care providers. In response, some providers, including physicians at Brigham and Women's Hospital, the Massachusetts General Hospital, and St. Lukes Hospital in New Bedford, have stopped participating in these senior plans. The net result for Massachusetts seniors is reduced benefits and access to care.

Hospital Closures and Consolidations

The financial pressures described above have also taken a toll on hospitals in the greater Boston area. Since 1998, several regional providers have either eliminated key services or gone into bankruptcy. Malden Hospital closed its 106-bed inpatient facility and emergency department in the summer of 1999, and is now providing only outpatient care. Boston Regional Medical Center filed for bankruptcy in the fall of 1999, and is no longer operating as an acute care provider. Quincy Hospital, one of the few remaining city-owned acute care providers, recently needed an emergency $12.1 million loan from the state to continue operations, and has been acquired by Boston Medical Center. Many other acute care facilities are experiencing similar financial difficulties.

Overall, hospital operating margins continue to decline. A recent survey by the Massachusetts Hospital Association showed that the average operating margin for Massachusetts hospitals declined from -0.3% in the second quarter of fiscal year 1998, to -2.8 % in the same quarter of fiscal year 1999. Nearly two-thirds of the hospitals reported negative operating margins for the second quarter of 1999. Operating margins are a key indicator of financial performance because they reflect only the revenue and expenses associated with providing health care services and do not include revenue such as investment income. Providers, including the Alliance, must continue to identify excess operating expenses in their cost base and search for opportunities to operate with greater efficiencies. The challenges, however, are greater than ever before.

The Uninsured

The bright light in this environment is the continued decline in the uninsured population in Massachusetts. Despite a strong national economy, the number of uninsured individuals in the United States rose 2% in 1998 to 44.3 million, an increase of 833,000 individuals. In Massachusetts, however, new enrollees in the state's Medicaid program (MassHealth) helped reduce the number of uninsured to 627,000, a decrease of 128,000 individuals. These figures, released by the U.S. Census Bureau, showed a 17% drop in the number of uninsured individuals in the Commonwealth.

During this period, MassHealth enrollment increased to 634,189. Mirroring the difficulties in the private managed care market, several HMOs have pulled out of the Medicaid market, leaving only four managed care organizations for MassHealth recipients: Network Health (Cambridge Health Alliance), Boston Healthnet (Boston Medical Center), the Neighborhood Health Plan, and Fallon Community Health Plan. Network Health currently has approximately 11,000 members.

The Cambridge Health Alliance, along with the Massachusetts Hospital Association, has also been involved in crafting policies and legislation to revamp the funding mechanisms of the Uncompensated Care Pool. The Alliance is the second largest recipient of the Disproportionate Share Hospital and Uncompensated Care Pool money in the state.

The Cambridge Market

While there is significant change in the health care market, the City of Cambridge is experiencing demographic shifts that will almost certainly affect the demand for health care services over the next several years. Among the most significant changes in the City are rising property values and the elimination of rent control. In a recent study conducted for the Community Development Department, the median rent for decontrolled rental units increased by 54% between January 1995 and July 1997. As a result, many individuals have moved to less expensive outlying areas, leaving behind a larger proportion of individuals, often single, who have higher incomes and can better afford the more expensive units. Public school enrollment may be reflecting this trend to some

degree: the City has seen a total enrollment decline of 577 public school students (from a high of 8,023 students in 1994, to 7,446 in 1999).

These changing demographics have implications for the services and populations who have historically accessed care through the Cambridge Health Alliance. The 2000 census will help us to better understand the changing face of our community. We expect to see the continued in-migration of certain minority groups, particularly South Asians and Portuguese-speakers. We believe we will also see an increase in the average income level within the community, related to the elimination of rent control and the rising cost of living.

Competition for "covered lives" in our community is intense. Patients who have traditionally used the Alliance for their care have unprecedented choice in selecting where they receive their medical care. The Alliance continues to strive to improve the health of its communities and to serve all in need. We will continue to work to become more attractive to our existing and potential customers, regardless of whether they have insurance. In addition, we look to expand our primary care base—expanding Network Health, developing closer ties with the community, and renovating or building new health centers. We are developing service efficiencies that facilitate the change to a higher performing organization and we are accelerating the pace of improvement so consumers will choose to receive their care through our system.

Finally, reacting to ongoing financial pressures from our payors, the Cambridge Health Alliance continues to look for ways to offer our services in the most cost-effective and efficient manner without compromising the level or quality of care provided. Staff members at all levels of the organization have been working to identify and implement systems improvements to reduce operating expenses and to identify revenue enhancements. This will be an ongoing effort at the Alliance as we operate in this rapidly changing environment.

CHAPTER 2: COMMUNITY INVOLVEMENT IN PUBLIC HEALTH PLANNING

The Cambridge Health Alliance is actively involved with many communities within Cambridge. This involvement supports our belief that the individuals who live and work in Cambridge should be able to participate in processes that identify and define local needs and decide action steps to address those needs.

Ongoing Community Conversations

A number of task forces have been created to address health issues in particular subject areas or for specific population groups and to provide a vital mechanism for continuous feedback, planning, and accountability. The Cambridge Health Alliance provides staffing and leadership to several task forces that include a full range of representatives from across the community. These groups include the Women's Health Task Force, the Geriatric Task Force, the Cambridge Biosafety Committee, the Immigrant Health Task Force, the Domestic Violence Free Zone Core Group, the Agenda for Children, the Children Who Witness Violence Working Group, the School Health Task Force, and the Healthy Children Task Force. Cambridge Health Alliance staff members also work closely with advisory committees for several of the neighborhood health centers. The Joint Public Health Board and the Cambridge Public Health Subcommittee provide guidance to the Cambridge Public Health Department.

The Public Health Nurses participate in a community task force on TB prevention and control in Cambridge. This group has engaged community leaders and health professionals in order to evaluate the need for TB testing and prevention-based education among the high-risk populations in the City. The Massachusetts Department of Public Health supports the work of this task force.

Developing New Venues

The Alliance also seeks to develop creative ways to connect with community members who might not otherwise become involved in existing activities. Public Health Department staff members have engaged with community members at hearings and public meetings on issues of public concern, including tobacco control, environmental health, violence prevention, massage therapy, and hunger.

The Chief Public Health Officer has provided leadership to a number of ad hoc committees that have encouraged collaboration between community members and City Departments on very specific issues. These diverse groups have tackled such complex topics as coordinated services for HIV/AIDS, homelessness and public intoxication, student searches and security at Cambridge Rindge and Latin School, and service needs for adolescents who congregate in "the Pit" at Harvard Square.

The Cambridge Health Alliance has played a key role in the Agenda for Children, an innovative community planning project that directly involves Cambridge residents, community-based service providers, and staff from a number of City Departments.

In recent years, the Cambridge Health Alliance has embraced the philosophy of Continuous Quality Improvement, and has successfully applied the methodology to program development and improvement within the organization. The Alliance, in partnership with community-based organizations, has extended this approach beyond its own programs to focus on substance abuse, hepatitis prevention, and elder falls prevention.

Keeping the Community Informed

The Alliance has developed a number of ways to disseminate public health information to Cambridge residents.

The Health of Cambridge at a Glance, a one page "snapshot" of key health indicators in Cambridge, has been mailed to every household in the City. This publication was launched at the Windsor Street Open House in October 1999 with an engaging roundtable discussion of the data.

The Cambridge Public Health Assessment 2000 and the *1999 Public Health Assessment* are available on-line at www.challiance.org/cphd/assessment.htm.

Beyond Bandaids, a newsletter published by School Health Nurses and translated into four languages, provides health information directly to parents of all public school students in Cambridge.

Cambridge Health Department Update, is distributed monthly by electronic and traditional mail to community partners.

Health of the City News periodically provides updated information on the activities of Health of the City and the Health Information Unit, and is distributed to a diverse, city-wide mailing list.

Inspiring Health Awareness

The Cambridge Health Alliance has spearheaded special health awareness projects that inspire community involvement. Some examples include: Walk Your Child to School Day that encouraged children to walk more and taught pedestrian safety; a Sock Drive to increase awareness of the health problems of homeless individuals while engaging the community in the collection of socks; First-Year Urban Neighborhood Campaign (FUNC), an annual project which engages Harvard Medical School students in community-based health awareness projects; and Hoops 'n' Health, an annual health fair and basketball tournament that raises awareness of health issues for young men of color.

CHAPTER 3: PRIORITY AREAS

Introduction to Priority Areas

The focus on public health priorities has provided continuity in the Cambridge Public Health Assessments over the course of the past four years. The 1997 document included twenty-three chapters covering an extensive range of public health topics. The scope was narrowed in 1998 to six priority areas: Access to Health Care, Violence Prevention, Environmental Health, HIV/AIDS, Substance Abuse Prevention, and Health Promotion and Disease Prevention. While limiting the focus to these six priorities allows for greater attention to areas of particular concern, it is important to acknowledge that the priorities of the Cambridge Public Health Department will continue to evolve to respond to critical, timely public health concerns as well as to reflect the changing needs of this community.

These identified public health priorities are defined in terms of issues or disciplines, such as HIV/AIDS or Environmental Health. But although Cambridge residents may all be affected by the public health issues addressed in this chapter, it is clear that the health risks faced by all citizens are not uniform. For this reason, the 1999 Public Health Assessment included additional chapters with a different focus: to more closely examine and report on specific populations at increased risk for poor health. *Focus on Geriatrics*, the final chapter of the *Cambridge Public Health Assessment 2000*, is the first in the series of reports that will provide a more detailed analysis of issues affecting the health of a selected population at risk. This year's examination of issues affecting Cambridge seniors will set the stage for future studies of other groups in our communities that face disproportionate health risks.

TREND DATA IN PRIORITY AREAS

This section looks at the changing health status of our community, organized according to the six public health priority areas of the Cambridge Health Alliance.

Trends in health indicators are identified by analyzing data that is routinely and reliably collected over time. Since we do not collect the data ourselves, the source of the information is reported at the bottom of each figure. Currently, only limited information on health parameters over numerous years is available. It requires both persistence and considerable resources to collect data year after year. Furthermore, the data must be collected in the same way each year to be comparable. The information presented was selected to reflect community concerns; some readers, however, may not find their particular concerns addressed while others will find their questions only partially answered. Fortunately, while trend information may not be available for every health indicator, much additional information is available. The 1999 Cambridge Public Health Assessment, Volume 2, Cambridge Health Information is available on the internet at http://www.challiance.org/cphd/assessment.htm. To learn more about what we have collected, or to alert us to additional information that you may know about, please contact

Eller. Kramer, Director of the Health Information Unit, at (617) 665-3809. Our goal is to understand and improve the health of our City.

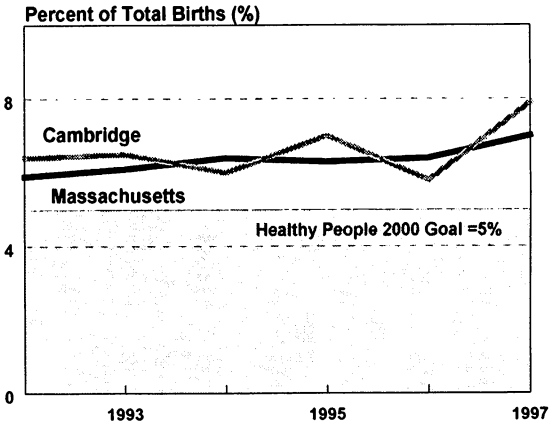
ACCESS TO HEALTH CARE

These graphs display health outcomes that provide some measure of accessibility to routine health services.

- *Some hospitalizations are preventable through primary care and behavioral change.*
- *Management of chronic and acute conditions through primary care can prevent progression to more serious diseases, hospitalization, and premature deaths.*
- *Some low- weight births in newborns may be prevented by early entry into prenatal care.*

(See Chapter 3: Priority Areas, 1. Access to Health Care)

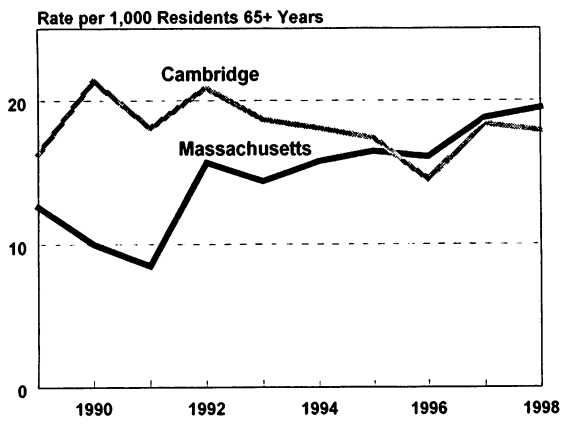
Low-Weight Births Cambridge: 1992-1997



Source: Bureau of Family and Community Health, in collaboration with the Bureau of Health Statistics, Research and Evaluation, Mass. DPH

The percentage of low-weight births in Cambridge increased to 7.9% in 1997. This increase may reflect a rise in multiple births related to fertility treatment and an increase in births to older women.

Bacterial Pneumonia Hospitalization Rates in the Elderly: 1989-1998

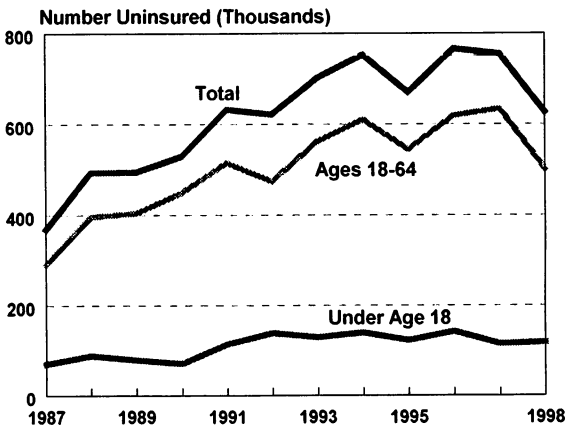


Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

The rate of hospitalization for bacterial pneumonia in Cambridge has decreased over the past decade. Some bacterial pneumonia hospitalization can be prevented with flu and pneumonia vaccination, early treatment of bronchitis, and reduced cigarette smoking.

(See Chapter 5: Focus on Geriatrics)

Uninsured Adults and Children Massachusetts: 1987-1998



Source: Access and Affordability Monitoring Project, BUSPH

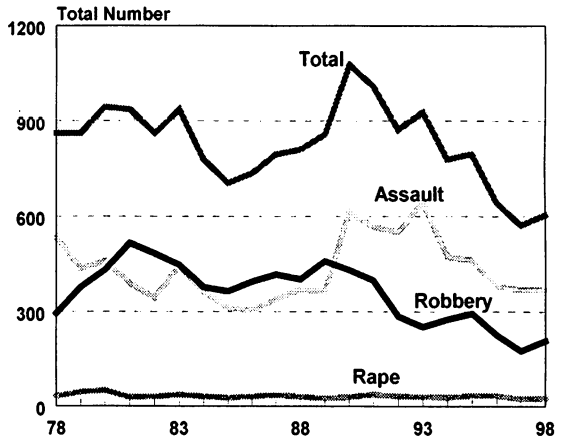
The number of uninsured Massachusetts residents rose from 368,000 in 1987 to 766,000 in 1996 and then fell to 627,000 in 1998. The decline in the last two years occurred mainly among those 18 to 64 years of age. The number of insured residents under age 18 remained relatively steady.

VIOLENCE PREVENTION

The decrease in violent crime in Cambridge reflects a national trend. During the 1990s, U.S. cities of 100,000 averaged six murders per year while the homicide rate in Cambridge was 2.3. Assaults also declined during this period. Domestic crime (offenses against family members, spouses, former spouses, roommates, and romantic partners) accounted for 43% of simple assault complaints and 24% of aggravated assault arrests.

(See Chapter 3: Priority Areas, 2. Violence Prevention)

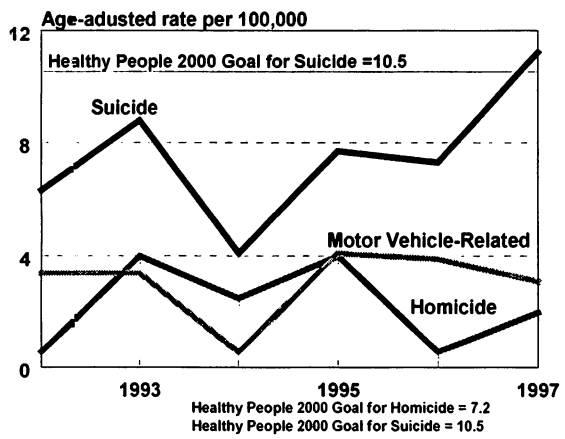
Trends in Violent Crime Cambridge: 1978-1998



Source: Uniform Crime Report Statistics, 1998 Annual Crime Report, Cambridge Police Department

Violent crime peaked at 1,077 crimes in 1990, then fell to 572 in 1997, a 47% decrease. The small increase in violent crime (6%) from 1997 to 1998 was due mainly to an 18% increase in robbery.

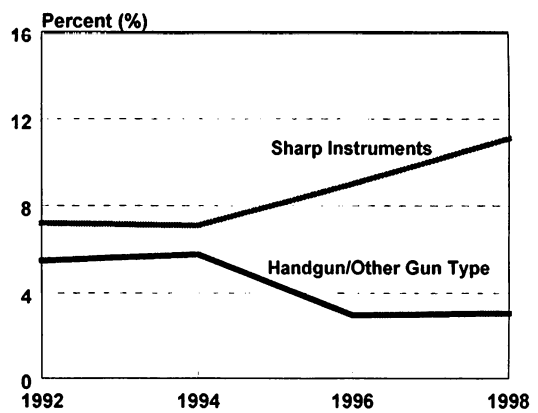
Injury Deaths Cambridge: 1992-1997



Source Mortality (Vital Records), MassCHIP, Mass. DPH, v2.2 r201.0, May 18, 1999

Suicice deaths greatly outnumbered both motor vehicle-related and homicide deaths in Cambridge between 1992 and 1997.

Weapons Carried by High School Students: 1992-1998



Source: Teen Health Survey, Cambridge Public Schools, 1992-1998

Between 1992 and 1998, the percentage of Cambridge students who reported carrying a sharp instrument during the past 12 months rose from 7.2% to 11.1%, while the percentage of those who reported carrying a gun fell from 5.5% to 3.1%.

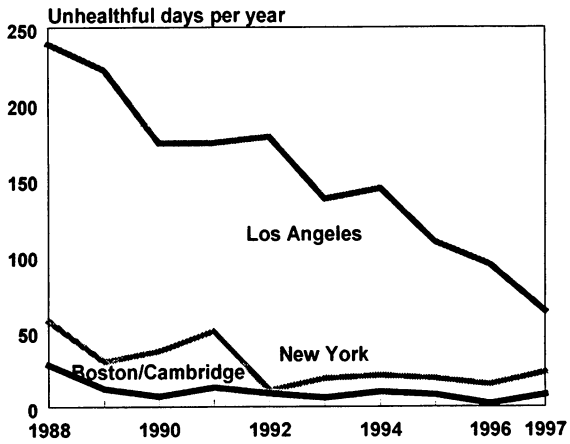
ENVIRONMENTAL HEALTH

Data provided here describe some environmental factors that affect the health of the community.

- *Air quality indicators have broad implications for human health; we have little ability to avoid this source of risk.*
- *Drinking water (not shown) and surface water represent sources of risk for intestinal and viral illnesses.*
- *Other hazardous exposures (e.g., lead paint, chemical poisonings, and foodborne illnesses) are difficult to track with available data and must be examined using the best available indicators.*

(See Chapter 3: Priority Areas, 3. Environmental Health)

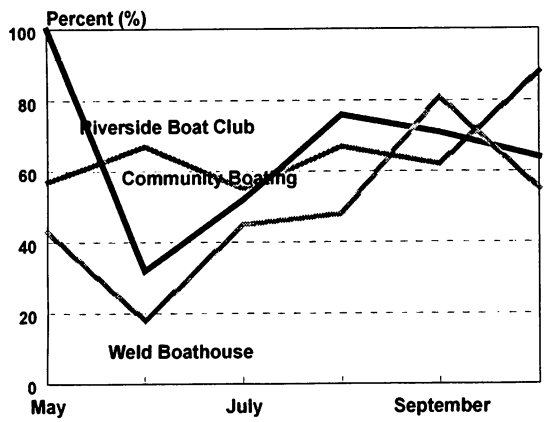
Unhealthful Air Quality Days by City: 1988-1997



Source: Nat'l Air Quality Trends Report, 1997, U.S. EPA

Tighter emission regulations have reduced the number of unhealthful air quality days in the Boston/Cambridge area since 1988.

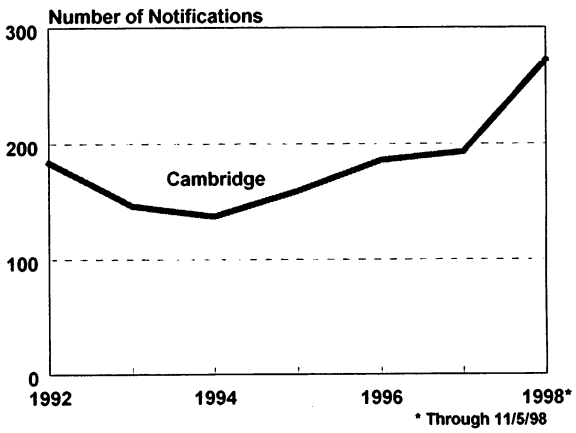
Percentage of Days the Charles River Met Federal Swimming Standards: 1998



Source: Charles River Watershed Association, 1998

Seasonal variations in bacterial contamination were the result of storm-sewer overflows after heavy rains.

De-Leading Notifications: 1992-1998



Source: Childhood Lead Poisoning Prevention Program, Mass. DPH

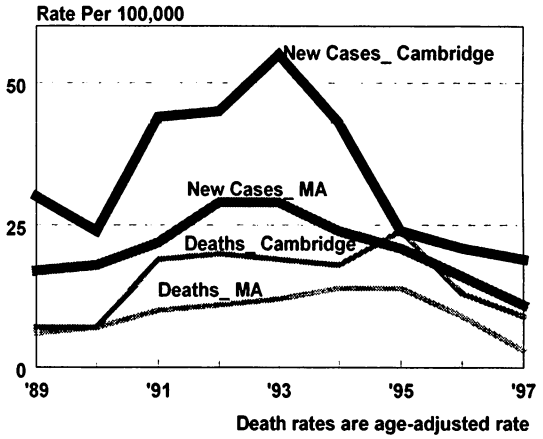
The number of Cambridge residences de-leaded has increased each year since 1994.

HIV/AIDS AND STDs

Rates of new HIV infections are remaining stable overall nationally, although the number of HIV-related deaths have dramatically declined. In 1997, the largest number of new infections were reported among African Americans, with the second largest number reported among Latinos. Changing standards of HIV care require additional effort to monitor and support patient adherence to more complicated medication regimen.

(See Chapter 3: Priority Areas, 4. HIV/AIDS)

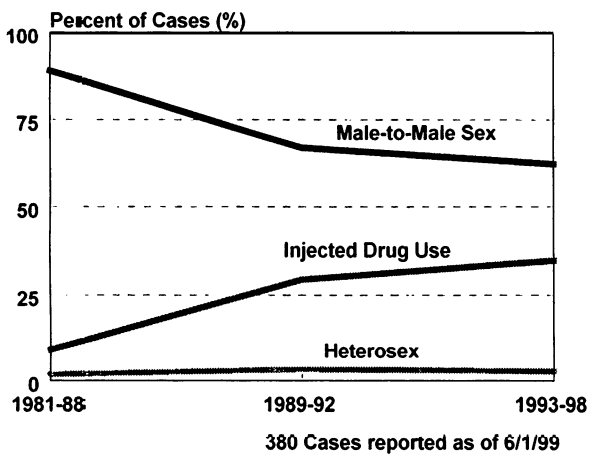
New AIDS Diagnosis and AIDS-Related Deaths: 1989-1997



Source: AIDS Surveillance Program, Mass. DPH, June 1999

The rate of new AIDS cases in Cambridge and Massachusetts has fallen each year between 1993 and 1997. The AIDS death rate declined between 1995 and 1997.

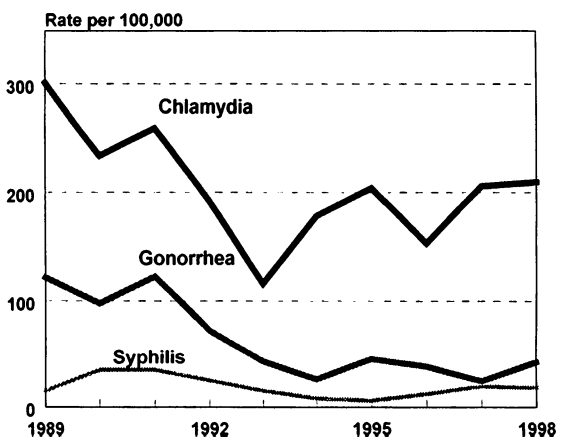
AIDS by Selected Risk and Year of Diagnosis: 1981-1998



Source: AIDS Surveillance Program, Mass. DPH, June 1999

Transmission of AIDS by injected drug use rose from 9% to 30% of cases diagnosed between 1981 and 1998. Transmission by male-to-male sex declined from 84% to 54% of cases during that same period.

Sexually Transmitted Disease Rates Cambridge: 1989-1998



Source: Division of STD Control, Bureau of Communicable Disease Control, Mass. DPH

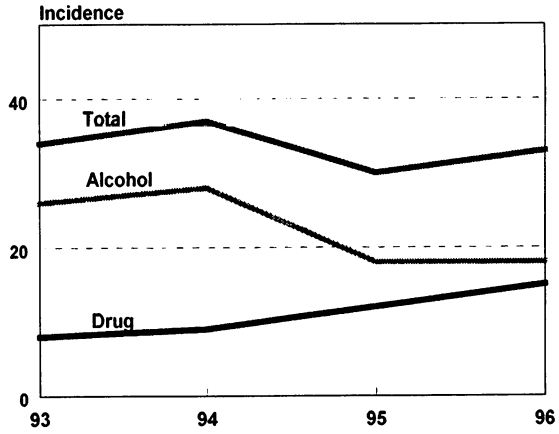
Rates of chlamydia were consistently higher than rates of gonorrhea or syphilis in Cambridge between 1989 and 1998.

SUBSTANCE ABUSE

"Lifetime Use" in these charts can include a single experimental use of tobacco, alcohol, or marijuana.
"Current use" is defined as use within the last 30 days and is a more effective measure of the level of drug and alcohol use, especially for adolescents.
The increases in tobacco, alcohol, and marijuana use in Cambridge are reflective of trends across the country.
Although these charts indicate a significant upward trend in the current use of all three of these substances between 1992 and 1998, Cambridge rates remain lower than those for Massachusetts.

(See Chapter 3: Priority Areas, 5. Substance Abuse Prevention)

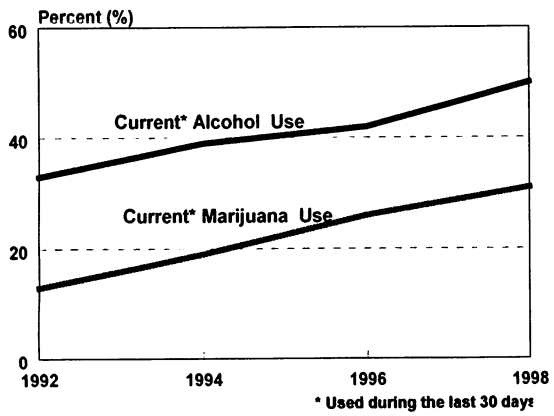
Alcohol and Drug-Related Deaths Cambridge: 1993-1996



Source: Health and Addictions Research, Inc. and Bureau of Substance Abuse Services, Mass. DPH

Alcohol-related deaths declined while drug-related deaths almost doubled between 1993 and 1996.

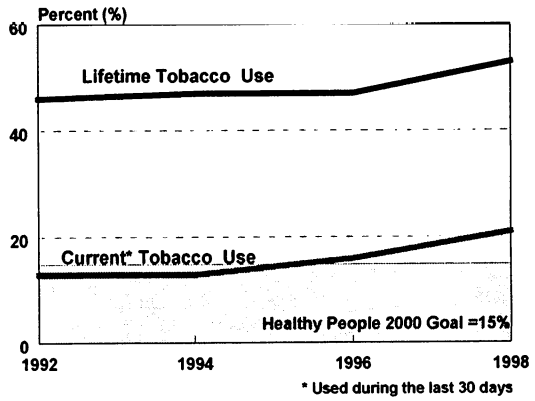
Alcohol and Marijuana Use Among High School Students: 1992-1998



Source: Teen Health Survey, Cambridge Public Schools, 1992-98

The percentage of Cambridge public high school students reporting current use of marijuana rose from 12.5% in 1992 to 30.6% in 1998. The percentage reporting current use of alcohol rose from 32.8% to 50.4%.

Tobacco Use Among High School Students: 1992-1998



Source: Teen Health Survey, Cambridge Public Schools, 1992-98

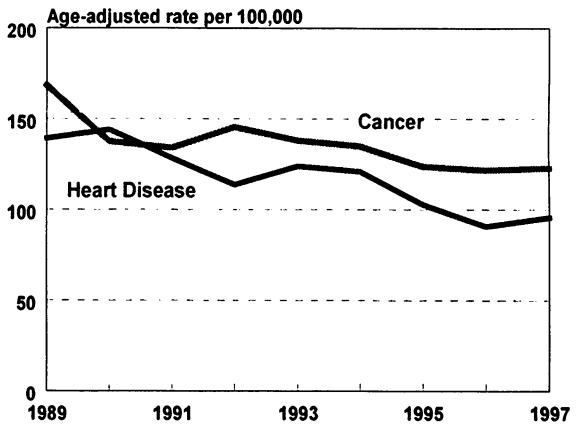
The percentage of students who reported current use of tobacco increased from 13% to 21%. However, 53% of Cambridge public high school students reported using tobacco at least once in their life.

ENCOURAGING HEALTHIER BEHAVIORS

Healthy choices in tobacco avoidance, nutrition, increased physical activity, and safer sexual practices can prevent chronic disease and increase life expectancy. The graphs on this page display three examples of health outcomes that can be positively affected by behavior.

(See Chapter 3: Priority Areas, 6. Health Promotion and Disease Prevention)

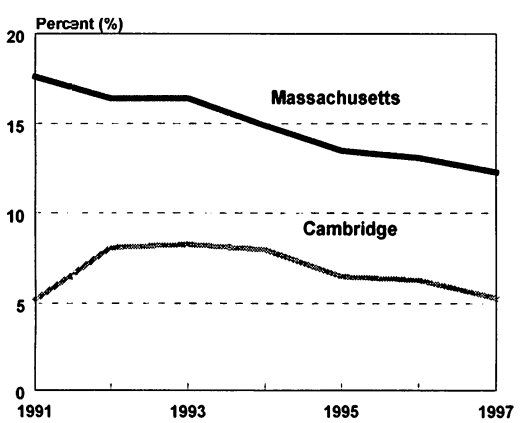
Heart Disease and Cancer Deaths Cambridge: 1989-1997



Source: Mortality (Vital Records), MassCHIP, Mass. DPH, v2.2 r201.0, May 18, 1999

Death rates for both cancer and heart disease in Cambridge decreased between 1989 and 1997. These rates have achieved the Healthy People 2000 Goal of 130 for cancer and 100 for heart disease, per 100,000 population.

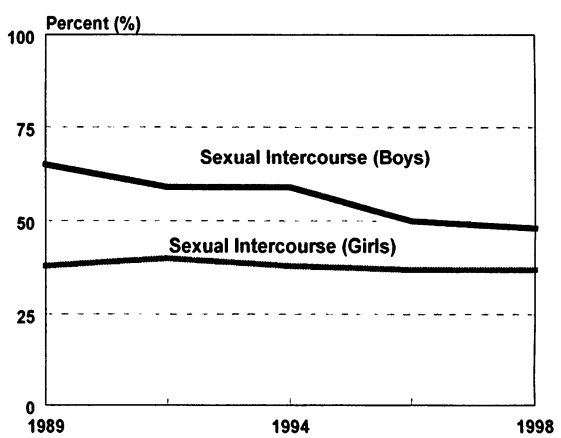
Tobacco Use During Pregnancy Cambridge: 1991-1997



Source: Natality (Vital Records), MassCHIP, Mass DPH, V2.2 r201.0, May 5, 1999

The percentage of Cambridge mothers reporting tobacco use during pregnancy was consistently lower than the statewide rate from 1993 to 1997.

Sexual Experience Among High School Students: 1989-1998



Source: Teen Health Survey, Cambridge Public Schools, 1992-98

The percentage of high school boys reporting sexual intercourse declined between 1989 and 1998 but remained higher than among girls. Note: Condom use by sexually active students (not featured on graph) rose from 54% in 1989 to 77% in 1992, and has remained relatively stable through 1998.

OVERVIEW OF PRIORITY AREAS

1. **Access to Health Care**
    A. REACH Project Overview
    B. Primary Care Expansion
    C. Access to Dental Care
    D. Health Outreach for Community Health Improvement
    E. Linguistic Mental Health Services
2. **Violence Prevention**
3. **Environmental Health**
4. **HIV/AIDS**
5. **Substance Abuse Prevention**
6. **Health Promotion and Disease Prevention**
    A. Health of the City
    B. Tobacco Education and Control
    C. Public Health Nursing
    D. School Health Nursing
    E. Agenda for Children
    F. Men of Color Health Program
    G. Breast and Cervical Cancer Initiative

1. ACCESS TO HEALTH CARE

Introduction

Access to health care is a top priority. For the Alliance, that means that our sites and programs must be readily accessible and our services easily obtained. In order to accomplish that goal, the programs must respond to a variety of concerns. Where are services or programs located? Can people get to the service locations? What are the options for individuals without their own transportation? Are facilities open when people can go? What services are needed? Does the staff speak the language spoken by the patient? What insurance is accepted? What if the patient isn't insured? Does the patient feel welcomed and comfortable in the setting?

The administration and staff at the Cambridge Health Alliance are committed to encouraging all Cambridge residents to participate in our programs, and to providing a comprehensive range of services that responds to the needs of the people who live and work in Cambridge.

- Health centers located throughout the city provide an array of services during morning, afternoon, and evening hours to accommodate the varied schedules of Cambridge residents and workers. The health centers offer a welcoming atmosphere and expert clinical and administrative staff who are culturally sensitive and speak many languages.

- The Interpreter Services Department provides invaluable assistance to patients and providers who must communicate about delicate and complex issues related to health and mental health care.

- The Alliance commitment to building cultural sensitivity is evident in the Organizational Development Department. English, Spanish, Portuguese, and Haitian Creole language classes are available to employees for personal and professional enrichment as well as to enhance services for patients.

- The Alliance accepts the full range of public and private insurance and third party reimbursements. Staff members at the health centers review insurance and payment options with patients in a private and respectful atmosphere, helping many individuals obtain free and reduced-fee health care.

- The Alliance offers many programs designed to overcome barriers to care for individuals in some high-risk population groups who might not otherwise use routine services. These programs, such as Health Care for the Homeless, the Teen Health Center, the Men of Color Health Program, and House Calls for Frail Elders, bring health care into the communities where the target populations live.

- The Alliance emplys a richly diverse staff, enabling patients to find a provider with whom they feel comfortable. For instance, parents can choose from a variety of

health care providers for their children, including pediatricians, nurse practitioners, and family doctors. Pregnant women seeking health care can opt for traditional obstetrical and gynecological care, or midwifery and a birthing center.

- The Department of Psychiatry offers individual, group, and family treatment in both outpatient or inpatient formats through its Adult and Child programs. Linguistic Mental Health Teams offer culturally and linguistically competent care. Innovative programs such as the Community Crisis Response Team and the Emergency Outreach Team provide interventions outside the traditional boundaries of psychiatry.

The following sections describe several ongoing Alliance efforts to enhance access to health care in Cambridge.

A. THE REACH PROJECT

The REACH Project (Renewal and Expansion as a Center for Community Health) is a major initiative undertaken by the Cambridge Health Alliance to upgrade and modernize clinical facilities at The Cambridge Hospital campus. Planning for REACH began in the early 1990's, and has involved many hospital staff members, community leaders, neighborhood groups, and government officials from both Cambridge and Somerville. Construction activities began in late 1996 and will continue through the spring of 2001. As we begin the year 2000, a number of project components have already been completed and others are near completion.

The most prominent and integral component of the REACH Project is the construction of a new three-story wing to The Cambridge Hospital's Main Building, designed to accommodate more than 100,000 ambulatory patient visits per year. The new ambulatory wing will feature over 100 new examination and treatment rooms and physician offices, along with support facilities to accommodate Cambridge Pediatrics, the Primary Care Center, Obstetrics and Gynecology, Orthopedics, Cardiology, Medical Specialties, Surgical Specialties, Same Day Surgery, and Rehabilitative Services. Completion of the ambulatory wing is anticipated in the spring of 2000.

A second key component of the REACH Project is construction of an underground parking garage beneath the new wing. A four-level parking structure will have the capacity for 219 cars and fifty bicycles. An elevator will take patients and visitors from the parking garage to the Main Lobby. The placement of the new Main Entrance on Camellia Avenue will improve public access to all outpatient and inpatient areas as well as the Emergency Department.

In May 1999, the first stage of a three-phase total renovation of the busy Emergency Department was completed and that department moved into the rebuilt and newly equipped facilities on the Hospital's main floor. The Emergency Department has increased its physical capacity and enhanced its ability to treat patients with greater efficiency than previously possible. An Express Care section devoted to more rapid treatment of minor medical problems is included in the new configuration. The ambulance drive is now located on Cambridge Street, providing direct and private access to the hospital for patients arriving by ambulance. A new Imaging Center adjacent to the Emergency Department, an expansion of the existing Radiology Department, will offer the latest in imaging technology to provide mammography and ultrasound testing.

As of the spring of 2000, the surgical suite on the third level of the hospital will be completely renovated. New Same Day Surgery and Post-Anesthesia Care Units will provide pleasant surroundings and easily accessible facilities for surgical patients and their families during pre- and postoperative care. The operating rooms will be rebuilt to accommodate advancing biomedical technologies. Elsewhere on the third floor, new space is being constructed for Pathology laboratories. A new Learning Center will be located on this level, encompassing a Health Sciences Library and a suite of rooms for

lectures, conferences, and meetings. The Learning Center will support The Cambridge Hospital's clinical teaching programs and its community health education initiatives.

The Intensive Care Unit will be completely renovated at its existing location in the Main Building. The renovated unit will feature six fully equipped, single-bed patient rooms with added privacy and comfort for seriously ill patients and their families. Newly built-out space on Levels 4-6, along with moderate renovations to the inpatient care units on these floors, will improve privacy and handicapped access for patients and visitors as well as much needed support space for clinical staff.

In an earlier phase of the REACH Project, the following construction was completed: a redesigned Maternity Suite, the Cambridge Birth Center, a new Psychiatric Emergency Service, a mechanical and structural upgrade to the Macht and Cahill Buildings, and renovations for temporary accommodations for hospital functions displaced during the construction period.

B. PRIMARY CARE EXPANSION

In 1999, the Cambridge Health Alliance built new facilities for two of its largest Neighborhood Health Centers: Windsor Street Health Center and East Cambridge Health Center. Both facilities had outgrown the spaces they had occupied for two to three decades.

In February 1999, the Windsor Street Health Center moved to 119 Windsor Street, along with the Cambridge Housing Authority Community Programs. The joint project gives neighborhood residents access to both community and health programs in a center with over 7,600 feet of space. The modern health center now offers expanded comprehensive health care services including pediatrics, adult medicine, prenatal care, midwifery, family planning, social services, nutrition, HIV counseling and testing, mental health, and dental services. The health center has waiting areas for children and adults, a separate playroom for children, new registration stations, a large medical record room, more treatment and examination rooms, a state-of-the-art laboratory, offices, and meeting rooms. Windsor Street Health Center is open four evenings a week, in addition to daytime hours.

The community programs offered through the Cambridge Housing Authority include the Cambridge Head Start Day Care, Community Arts Center, Community Learning Gateways Program, Computer Center, Recreational Activities Program, and Work Force Unemployment Prevention Program. The building is accessible throughout the week for use by residents. Access to a full-size gym is available through the Recreational Activities Program. Two large conference rooms are used regularly by community organizations as well as by Cambridge Health Alliance programs.

In May 1999, the Cambridge Public Health Department and the main office of the Women, Infants and Children Program (WIC) moved into the Windsor Street building. Having the WIC office located in the same location as the health center and Head Start increased access and convenience for clients who use these programs. The building provides a much more comfortable setting for patients and families and a greater capacity for expanding services.

The East Cambridge Health Center opened at 163 Gore Street in June 1999. The new location is just one block from the old site. This new state-of-the-art facility has almost three times as much space as the previous center, and was designed to provide patients with high quality, comprehensive health care. Services include adult and pediatric primary care, obstetrics and gynecology, midwifery, family planning, HIV counseling and testing, laboratory services, nutrition, social services, podiatry, mental health, and addiction services. The center has a separate waiting and play area for children, a large conference room, and a patient education room. East Cambridge Health Center is open two evenings a week.

C. ACCESS TO DENTAL CARE

Accomplishments

Windsor Street Dental Clinic

After years of planning, the Windsor Street Dental Clinic opened in the early spring of 1999 as part of the Windsor Street Health Center. This clinic addressed the well-documented need for accessible and affordable dental services. The dental facility has seven operatories staffed by multilingual, multicultural professionals fluent in English, Mandarin Chinese, Spanish, and Portuguese. Interpreter services are available for individuals who speak other languages.

Although there is currently a four-to-six week wait for routine dental appointments, this is a significant improvement from previous years when the wait was considerably longer. Patients who call with emergency needs are screened to determine the degree of urgency. No individual with a true dental emergency is refused treatment.

The Children's Dental Project

The Children's Dental Project is a three-faceted program developed to provide dental health education, screenings, and referrals to Cambridge children in their schools. The program, managed by the Children's Dental Coordinator, has reached students in grades one through four in all fifteen elementary schools, the Benjamin Banneker Charter School, and a number of preschools in the City. All children received dental screenings unless they were absent from school or their parents declined participation.

The dental education in the schools has been provided with the help of Harvard Vanguard dental staff. This partnership with Harvard Vanguard has allowed us to extend classroom education to include all kindergarten, first, and fourth grade students. Approximately 2,190 children received dental health education in the 1998-1999 school year.

Screenings were provided to 281 children in seventeen preschools during the summer of 1999. Screenings of preschool children are always preceded by a brief introduction, an explanation of the screening procedure, and an oral hygiene awareness unit. Consultation is also offered to preschool staff members about implementing an oral hygiene program.

The Children's Dental Coordinator helps parents schedule urgent appointments for children who have been identified in the school dental screenings. These children are given priority for treatment at the Windsor Street Dental Clinic.

Dental Screening

In 1997-1998, the first school year of the program, 936 children were screened. (This includes approximately 62% of all children enrolled in the targeted elementary grades and 104 preschool children.) As a result of the screening, 443 children (47% of those screened) were advised to seek dental treatment in the near future, and seventy-four children (8% of those screened) were referred for immediate, urgent care.

During 1998-1999, 1,324 children were screened. After screening, 518 children (39% of those screened) were advised to seek treatment, and seventy-one children (5% of those screened) required immediate, urgent care. (Note: A small number of children have been screened in successive years and therefore there may be some duplication in the number of children screened.)

Table 1: Distribution of screened children according to level of dental care need

Referral	Sept 1997-Aug 1998	Sept 1998-Aug1999
No need for treatment (Triage 1)	419 (45%)	735 (55%)
May need treatment (Triage 2)	443 (47%)	518 (39%)
Needs immediate attention (Triage 3)	74 (8%)	71 (5%)
Total	**936**	**1,324**

Emerging Issues

The Children's Dental Project is midway through its final year of funding from the Bullock Foundation. The Cambridge Public Health Department is exploring other possible funding sources to keep this important program alive.

It is necessary to look at this program through the lens of "prevention" to understand its significance. Its primary prevention value lies in the direct education of children and educators and the introduction of children to non-threatening dental professionals. Its secondary prevention value is in the dental screenings, referrals to dental care, and direct connection to the Cambridge Health Alliance Dental Clinic.

D. OUTREACH FOR COMMUNITY HEALTH IMPROVEMENT

In the fall of 1999, the Department of Community Affairs completed a random door-to-door survey in Area 4 designed to document and address barriers to health care access. The expansion of the Windsor Street Health Center presented an opportunity to reach out to the community and understand more closely the perceptions and attitudes of those seeking health care. The collaboration and support from community-based organizations was instrumental in helping to develop a survey project that was meaningful to all of the residents of Area 4 and to the health center.

The objectives of this project were to: (1) identify barriers to health care access at the Windsor Street Health Center; (2) increase outreach to Area 4 neighbors; (3) shape the Alliance's improvement strategy for quality care to a diverse, multicultural community; and (4) respond to concerns about access to health care voiced by community members.

A cadre of multicultural outreach workers from the Cambridge Health Alliance and community-based agencies visited the ethnically diverse households in Area 4. A total of 188 interviews were completed over the course of five consecutive days. Surveys were conducted in English, Spanish, Haitian Creole, French, Portuguese, and Bengali.

Overview of Preliminary Survey Results

Demographics

There were 188 individuals interviewed, with 57% female and 43% male and a mean age group between twenty-nine to forty-eight years of age. Among those interviewed, 77% had lived in the neighborhood more than three years while 14% had lived there for less than one year. In terms of languages, 50% spoke English as a primary language at home, 37% spoke another primary language in the home, and 13% spoke both English and another language at home.

Health Insurance

Of the 188 participants, 35% had private health insurance, 30% had MassHealth, 16% had Network Health, 14% were uninsured, and 5% had Medicare.

Participants' Perceptions of the Cambridge Health Alliance

A significant number of the interviews indicated a lack of awareness of key Alliance programs: 41% were not aware that the Alliance provides services regardless of health insurance status or ability to pay; 43% were not aware of Network Health and its availability through the neighborhood clinics; and 35% did not know of the linguistic capacity of the Cambridge Health Alliance.

Implications

Residents who participated were open and forthright in expressing their opinions about health care. Information and data acquired from this survey will be used to evaluate the current scope of services and to develop indicators that monitor the delivery of care to a multicultural population. The success and positive community response to this project make it a model for assessments in other neighborhoods in Cambridge.

For more information regarding this project, please contact the Community Affairs Department at (617) 591-6930.

E. LINGUISTIC MENTAL HEALTH SERVICES

South Asian Mental Health Team

The Division of Psychiatry has developed a system of specialized linguistic mental health services that initially included Latino, Haitian, and Portuguese Mental Health Teams. Services are provided at The Cambridge Hospital and in the neighborhood health centers, and are staffed by bilingual, bicultural mental health professionals.

The linguistic mental health service has recently been expanded with the development of the South Asian Mental Health Team. This program offers a full range of culturally competent mental health services to the Asian and Asian American communities. The program serves adults, children, couples, and families. Language capacity includes Hindi, Punjabi, Gujarati, Telegu, Korean, and Mandarin Chinese. Interpreters are available to assist patients who speak other languages. Over the past year, there has been a steady growth in the number of referrals and consultations, and a larger patient base within the Alliance. A new training component for psychology and psychiatry students has been added.

Development of the team has included leadership and community-building with state-wide agencies. Cambridge Health Alliance participation on the Asian Task Force Against Domestic Violence, the South Asian Advisory Committee, and the Massachusetts Asian AIDS Prevention Project has been instrumental in advocacy work for the Asian communities. Symposiums were held in 1999 to address awareness of health and psychotherapeutic issues for Asian immigrants. Additional outreach to community-based language and cultural groups will help raise awareness of these services within the Asian communities.

2. VIOLENCE PREVENTION

During 1999 there were a number of significant accomplishments in domestic violence prevention in Cambridge. As in the previous four years, the Domestic Violence Free Zone (DVFZ) Initiative has been the mechanism guiding this work.

The first Domestic Violence Free Zone Status Report was published in January of 1999 and submitted to the City Manager. The Report details the first sixteen months of work by the DVFZ Core Group, and outlines the work on the eleven city-wide DVFZ initiatives.

The following are highlights from the Report:

- The Employee Assistance Programs for the City and the Alliance incorporated domestic violence screening, counseling, and referral in their intake and evaluation services.

- A grant-funded domestic violence training for the Cambridge Housing Authority and the Department of Human Service Programs was conducted in 1998. Approximately 500 employees participated in the four-hour program on identification, intervention, and referral. As part of this effort, a domestic violence protocol was developed for the Cambridge Housing Authority, and a comprehensive domestic violence manual was developed and distributed to all trainees.

- The Violence Prevention Coordinator convened the Children Who Witness Violence Working Group. Meeting quarterly, this group included forty representatives from the courts, police, health care system, schools, and human service programs.

- The Public Health Department received a modest grant to augment services for children who witness violence. The funds were allocated to local domestic violence shelters and community mental health agencies to provide training and to expand existing support groups.

In the spring of 1999, a DVFZ Oversight Committee, including major City Department heads and the City Manager, was convened to review the Status Report and proposed initiatives for 1999-2000. Actions identified as priorities for the DVFZ Core Group for 1999-2000 included:

1. Continuing to seek and expand services for children who witness violence and to increase provider expertise in this area.
2. Continuing domestic violence training programs, with the primary recipients of such training to be staff in the Cambridge Public Schools and the Cambridge Health Alliance.

3. Beginning the development of a public education campaign utilizing a comprehensive domestic violence video and the City Web page.
4. Continuing the development of domestic violence policies for the School Department, City Personnel Department, and the Alliance. Policies will consider issues such as flextime for domestic violence victims, safety planning, and manager training.

Progress on 1999-2000 initiatives

Children Who Witness Violence

The working group on Children Who Witness Violence met through 1999, giving providers an important opportunity for networking and coordination of services.

The Cambridge Public School Department worked with the DVFZ Core Group to finalize a training plan that will help to prepare school staff members to identify and help children who have witnessed domestic violence. One objective is to identify and train Domestic Violence Resource Persons for each public school in Cambridge.

Domestic Violence Training

A Domestic Violence Training Specialist, jointly funded by the Cambridge Police and Public School Departments, was hired by the Health Department to provide training and guidance to the School Department—a wonderful example of inter-departmental collaboration. This trainer will work with the School Department's Administrative Response Teams to ensure integration of services. Other organizations included in this effort are the Department of Social Services, the Middlesex District Attorney, the Attorney General, Transition House, Respond, the Cambridge Youth Guidance Center, the Family Center, and Boston Medical Center's Child Witness to Violence Project.

In December of 1999, the Child Witness to Violence Project offered two days of interdisciplinary training in conjunction with the Cambridge Public Health Department and the Cambridge Public Schools. Approximately forty individuals attended, representing twenty agencies in the City.

The Cambridge Health Alliance has received funding from the U.S. Department of Health and Human Services for a domestic violence training and advocacy program ("Improving the Health Care Response to Domestic Violence"). A training specialist will be hired to develop a program geared toward all levels of the Alliance staff.

Public Education Campaign

The Cambridge Police Department has provided significant program support for a public education campaign. Thanks to their funding, a domestic violence video for training and public information has been developed and will be released in early 2000.

The Domestic Violence Liaison of the Police Department has been working to collect and analyze data regarding domestic violence incidents and applications for restraining orders. This analysis is essential to evaluate the DVFZ, and will be valuable in a public education campaign.

A public meeting of the City Council Health and Hospitals Subcommittee in October 1999 provided an opportunity to update policy makers on DVFZ initiatives. The Police Department presentation to the Subcommittee began the process of releasing data to the public.

Policy Development

In 1999, the Cambridge Housing Authority hired a Domestic Violence Investigator as part of its commitment to enforcing the policies developed in 1998. This individual has joined the DVFZ Core Group.

The Cambridge Health Alliance Domestic Violence Training Specialist will also be supporting policy development. First, she will work with battered women's shelters to increase access to health care services for domestic violence victims and their children. This will involve working closely with primary health, mental health, and dental facilities within the Alliance. Secondly, she will work with the Alliance leadership and the Domestic Violence Task Force to review and develop policies and procedures that ensure domestic violence screening, documentation, referral, and safety planning for patients and staff members.

Emerging Issues

The Cambridge Domestic Violence Free Zone has received national and international recognition. The Violence Prevention Coordinator has been invited to present at Harvard University, in numerous sites across the country, and at an international conference in Montreal.

Despite these impressive accomplishments, the need for a formal, comprehensive evaluation of the DVFZ is quite clear. Specific projects such as training programs can be evaluated through the use of pre- and post-test knowledge questionnaires, assessment of the number of identified cases, and implementation of quality assurance measures. The DVFZ Core Group will continue to review the number of restraining orders, domestic incidents, and arrests. Additional evaluation resources will be necessary to determine whether the DVFZ initiative has an impact on reducing domestic violence in the City.

The DVFZ Core Group, under the leadership of the Violence Prevention Coordinator, will issue a second status report in 2000. This report will further explore emerging issues and identify the focus for the next round of DVFZ work.

3. ENVIRONMENTAL HEALTH

In 1999, the Environmental Health Unit responded to a broad range of public concerns related to chemical or biological threats and other contaminant exposures. A grant awarded by the Childhood Lead Poisoning Prevention Program at the Massachusetts Department of Public Health has allowed this unit to begin a major initiative addressing asthma in young children who live with housing conditions known to cause or aggravate respiratory illness. The Environmental Health Unit continues to scrutinize several major hazardous material releases in locations around Cambridge, including the W.R. Grace property, Russell Field, and Cambridge Research Park. Other continuing activities include coordination of the Cambridge Biosafety Committee and administration of the Recombinant DNA Ordinance, participation in the Local Emergency Planning Committee led by the Fire Department, adjudication of non-emergency exposure disputes between residents and businesses, and public education on a variety of toxicological and environmental health issues. Finally, the Environmental Health Unit worked on several policymaking efforts including crafting a local ordinance to assure safe handling of asbestos-contaminated soil, redrafting the procedures and protocols for the enforcement of the Recombinant DNA Ordinance, and consulting with the Massachusetts Departments of Environmental Protection and Public Health on a number of evolving regulatory concerns.

Healthy Homes Pilot Program

The Cambridge Public Health Department received funding in the fall of 1999 to establish the Cambridge Healthy Homes Pilot Program. The initiative, funded by the Massachusetts Department of Public Health, builds on two successful lead poisoning prevention programs, one in the Health Department and one in the Community Development Department. A program coordinator was hired and began developing workshop material and fostering inter-agency referral agreements. Partners include Network Health, pediatric providers, Lead Safe Cambridge, the Inspectional Services Department, school and public health nurses, and community-based affordable housing agencies. (See page 21 for trend data on de-leading notifications). An asthma prevention and management workshop for nurses and other health and housing professionals is scheduled for January 2000. Continuing education credits will be available for nurses attending. Healthy Homes counselors have begun visiting referred families to provide education on asthma management and environmental triggers commonly found in the home. Counselors will conduct home assessments to identify potential asthma triggers and other child safety hazards. Data will be compiled on households receiving educational and safety material, referrals, and other services or equipment. The program will also track the long-term respiratory health of participating families to help evaluate the effectiveness of this approach. This emerging issue will remain a primary focus of the Health Department into the foreseeable future.

Hazardous Waste Release Sites

As in the previous year, the Environmental Health Unit has worked intensively in 1999 with City staff and concerned residents to address concerns and assess possible health threats arising from hazardous waste release sites in Cambridge. The Environmental Health Unit endeavors to enforce health and safety standards on all major hazardous waste release sites. These include sites that have been the focus of public concern for many years as well as sites that have not received such attention.

W.R. Grace, a global supplier of chemicals and industrial materials, has conducted research and development in Cambridge on a large property at the intersection of Route 2 and the Alewife Brook Parkway for several decades. A variety of chemical releases have occurred prior to and during its occupancy of that site. Though large-scale operations for Grace are conducted elsewhere in the state, sufficient releases have been documented at their Cambridge site to compel the Massachusetts Department of Environmental Protection to require that Grace conform to environmental clean-up laws. The Public Health, Community Development, and Law Departments have worked closely with residents who have expressed concern for the health and safety of the neighborhood over the past decade or more. As a result of this intense scrutiny by residents, asbestos was also recently identified at the site, although Grace had not originally acknowledged its presence. Efforts to fully characterize chemical releases are largely completed and Grace's compliance with state environmental laws is proceeding at this point.

Russell Field, a City-owned athletic field adjacent to the W.R. Grace property, has come under investigation in recent years. During construction of the MBTA tunnel to the Alewife station in the 1980's, large quantities of soil from the Grace site were deposited at the field. Although clean topsoil was brought in during the later development of the athletic field, some soil from the Grace site remains below this clean layer. Extensive testing has been completed for a very broad list of possible chemical contaminants; soil and air testing for asbestos has also been conducted. Minor violations of allowable state environmental standards for chemicals were found, but asbestos investigations have not revealed any public health risk in excess of that found normally in urban environments throughout the country. The City and the Public Health Department have worked closely with Alewife Neighbors, Inc., during every phase of this investigation, offering these concerned residents a voice in the decision-making process. Interactive discussions have focused on testing plans, chemical data, and clean-up strategies for this site.

Cambridge Research Park, previously known as the Com Energy site, is located in Kendall Square and is bounded by Third Street, the Broad Canal, Linsky Way, and Second Street. This property was the site of a manufactured gas plant from 1870 to 1966, where coal and coke was processed to generate combustible gas for fuel. These activities resulted in the release of volatile organic compounds, polycyclic aromatic hydrocarbons, tar, and other petroleum waste products. The proposed commercial development of this site for hotel, office, and laboratory use has raised concerns in the East Cambridge community. Primary concern has focused on traffic congestion anticipated from the additional parking slated for the site, but questions about chemical exposures during

excavation for underground garages have also been articulated. The efforts of the East Cambridge Planning Team and the Environmental Health Unit have significantly raised the level of assurance and oversight on this site. Provisions of the clean-up plan established with the developer will now include constant realtime monitoring, public display of this data at an information kiosk adjacent to the site, stringent airborne standards that may trigger immediate work stoppage, and public availability of extensive data generated during subsequent investigations of the site.

Cambridge Biosafety Committee

The work of the Biosafety Committee proceeded in 1999, a time of rapid expansion in the biotech industry in Cambridge. While there has been some consolidation of smaller research laboratories with larger companies, the overall volume of recombinant DNA research has steadily increased. Both the number of scientists and the volume of genetically altered material have expanded as the industry has matured with proven technology and a greater understanding of the path to effective treatment of human and plant diseases. Many large American and European firms now desire a presence in Cambridge which is internationally recognized as a hub of innovation in biotechnology. The Biosafety Committee has been challenged over the past year with frequent requests to approve changes in laboratory facilities, relocations within the city, merged facilities, and new protocols for research and manufacturing. Additionally, the Cambridge Biosafety Committee has expanded its collaboration with the Cambridge Water Department's backflow prevention program and with the Harvard and MIT biosafety offices.

Environmental Health Complaints

As an ongoing service to Cambridge residents, the Environmental Health Unit addresses concerns and complaints stemming from chemical and biological exposures throughout the city. These calls cover reports of possible inhalation threats from neighbors or nearby businesses; general indoor air quality and sick building concerns; bacterial threats from basement flooding; allergic responses to plants, pests, and chemical sources; and many other topics. Questions about possible disease clusters related to suspected hazardous material threats are also addressed, and the epidemiology tools available to the public health community are introduced and explained. When individual questions cannot or should not be addressed by the Environmental Health Unit, referrals to state and federal agencies and to other health professional services are offered. Among the informational resources that this unit makes available to the public at-large is the small but growing environmental health collection in the Public Health Department library. The Environmental Health Unit is also expanding a hazardous waste database covering every site in Cambridge where the release of a controlled material or chemical has been recorded by the state.

The overall work of the Environmental Health Unit, though often highly technical in nature, has been strengthened by public participation. Other emerging areas, such as child respiratory health and universal hazardous waste site tracking, have been identified within the Cambridge Public Health Department. Ongoing work will include information

exchange with the community on the very broad range of concerns regarding chemical and microbiological quality of air, soil, and water in our immediate environment.

4. HIV/AIDS

Introduction

The issues surrounding HIV/AIDS have become less visible over the last few years as the general media are focusing less attention on the pandemic over time. Despite this decreasing publicity, we have not lost sight of the continuing changes, advances, and challenges for individuals living with HIV, their families, and caregivers. New medications have improved the health and quality of life for many individuals, keeping them healthier for longer periods of time. The remarkable improvements in health that some individuals have experienced may contribute to the decreased public awareness of HIV/AIDS, as healthier individuals focus their energies on other aspects of their lives. However, this diminished visibility may threaten continued funding and services, affecting individuals and communities still hard-hit by the disease, and hindering vital prevention efforts.

Despite the wealth of information generally available about how to avoid transmission of HIV/AIDS, new infections continue to occur. It is crucial that the public not interpret the media silence as evidence that the HIV epidemic is over. The epidemic is still devastating disenfranchised communities: the number of newly-identified infections among women of color continues to grow at a rate exceeding any other segment of the population, as it has for the last several years. (See p. 22 for trend data on diagnosis.)

Accomplishments

HIV prevention programs and services for people with HIV are well-established in Cambridge. For nearly a decade, the Zinberg Clinic has been offering high-quality comprehensive care for individuals and families living with HIV. In 1999, in response to both external pressure and a commitment to clients, clinical outcome evaluations were done to measure the impact of services on health status.

The results of the first set of outcome evaluations were truly heartening: in a sample of approximately fifty uninsured patients studied over a six to twelve month period, 27% experienced a significant decrease in viral load (the amount of HIV detectable in the blood), and 57% experienced no change. As an individual's viral load decreases to an undetectable level, there are improvements in the function of his or her immune system.

Additionally, four different indicators of mental health status were measured in this sample: stress level, depression, social support, and self-advocacy skills. With only one exception on one indicator, all results showed consistency or improvement in each area.

Community engagement

While the Alliance is the largest provider of primary care for individuals with HIV in Cambridge, many other agencies provide services essential to maintaining access to care and enhancing quality of life. In 1999, the possibility of funding from the federal Substance Abuse and Mental Health Services Administration provided an opportunity for HIV service providers, substance abuse treatment programs, and community-based organizations serving communities of color to discuss coordination of HIV-related services across Cambridge. Partners in the discussions included Concilio Hispano, Cambridge Cares About AIDS, North Charles Institute for the Addictions, CASPAR, Massachusetts Alliance of Portuguese Speakers, the Somerville Haitian Coalition, and the Cambridge Health Alliance. Together, these organizations will continue to pursue innovative programs that provide creative and specific services to meet the diverse needs of consumers.

Emerging Areas

A very clear shift has occurred over the last few years with the advent of powerful medications that are lengthening and enhancing the lives of many individuals with HIV. The nature of the medical interventions has changed. Patients often require much more individual attention to help them adhere to complicated medication regimens, monitor debilitating side effects, and deal with chronic, life-threatening illness.

Federal, state, and local funding has supported the establishment and maintenance of high quality services for individuals with HIV. These funders are increasingly imposing requirements that programs document clinical outcomes that show enhanced health. In Cambridge, we are fortunate to be well-prepared to begin this work and to document positive outcomes as a result of services provided.

As with HIV *care*, the field of HIV *prevention* is experiencing changes as well. During the early stages of the epidemic, extensive factual information about HIV was produced and disseminated to teach people about the virus and its modes of transmission. Over the years, it has become clear that this information provides a necessary starting place for decreasing individual risk of infection, and that additional, more complicated work is needed. An examination of the root causes of HIV infection, including racism, sexism, homophobia, and poverty is emerging as a crucial component for any effective HIV prevention program. While it is important to understand that unprotected sex and needle sharing put individuals at risk, it is of greater prevention value to understand why women, people of color, needle users, poor people, and gay men and lesbians may make choices that jeopardize their health. As these issues are discussed with individuals, in families, and throughout communities, subtle changes are being made that may influence individuals to use the factual information available to make healthy choices. Although HIV prevention outcomes are extremely difficult to document, there is a clear national consensus that factual information alone is of limited value in preventing HIV infections, particularly among the disenfranchised populations that are so severely affected by the disease.

5. SUBSTANCE ABUSE PREVENTION

Introduction

In Cambridge, a number of community-based organizations and City departments are involved in substance abuse prevention efforts. CASPAR, Concilio Hispano, the Massachusetts Alliance of Portuguese Speakers, the Massachusetts Prevention Center, North Charles Institute for the Addictions, the Cambridge Prevention Coalition, Cambridge Cares About AIDS, Mt. Auburn Hospital, and the Cambridge Health Alliance are all service providers committed to prevention activities. Through the unifying efforts of the Cambridge Prevention Coalition, part of the City's Department of Human Service Programs, these agencies, competitors under other circumstances, continue to work together to tackle the difficult problems of substance abuse in our community.

Background: Substance Use by Youth

The Student Health Surveys monitor substance abuse as well as other health risk behaviors by Cambridge youth. This ten-year-old project is the result of a very successful long-term partnership between the Department of Human Service Programs, the Cambridge Public Schools, and the Cambridge Health Alliance. The Teen Health and Middle School Health Surveys are administered on an alternate year schedule, providing valuable information about the health risk behaviors of Cambridge youth.

The Student Health Survey data, collected since 1989, reveal both good and bad news regarding drug and alcohol use. (See p. 23 for trend data). On one hand, results of the 1998 Teen Health Survey show that rates of current use (defined as use within the past thirty days) of alcohol, cigarettes, and marijuana are at or below state levels. On the other hand, current use of these three drugs most commonly used by Cambridge high school students has increased since 1992. The percentage of high school students reporting current alcohol use rose from 34% to 50% during this period; for cigarettes, the percentage increased from 13% to 21%; and reports of marijuana use rose from 14% to 31% of the students responding. Binge drinking (defined as consuming five or more drinks in a row in the last thirty days) is also a serious concern. Of the 1998 Cambridge Rindge and Latin School students who reported drinking in the last thirty days, 60% reported binge drinking at least once during that same period. The 1998 Teen Health Survey also reports information about where students are getting alcohol, thus providing an opportunity to design interventions that address this issue.

Students in the sixth through eighth grades showed high levels of substance use as well, although the most recent survey data show a small decrease in use. In 1997, the percentages of middle school students who had *ever used* alcohol or other drugs were as follows: 43% used alcohol, 20% cigarettes, 13% marijuana, 8% inhalants, and 3% other drugs. That same year, the percentages of students reporting *current use* (used within the past thirty days) of alcohol or other drugs were 25% for alcohol, 8% for cigarettes, 8% for

marijuana, 5% for inhalants, and 2% for other drugs. Drug use was present even among the youngest students participating in the survey.

While these substance use trends among Cambridge youth are alarming, they mirror state and national trends in alcohol, tobacco, and other drug use. A full report on the 1998 Teen Health Survey data is available through the Cambridge Public Schools' Office of Program Evaluation and Assessment.

Accomplishments

Accomplishments in 1999 included research efforts to monitor substance use and provide information for program development and evaluation, the introduction of state-of-the-art prevention strategies, and coordinated efforts to address complicated social issues related to substance abuse.

Middle School Health Survey

The second Cambridge Middle School Survey was administered in March 1999 and built on the baseline data from 1997. Frequency distributions have been prepared for all variables and additional analyses are in process. Preliminary data analysis indicates that substance use rates have declined among this age group. A more detailed analysis of all of the survey data is needed to confirm these findings.

During the 1998-1999 school year, selected results of the 1997 Middle School Health Survey, including substance use rates, were presented to the faculty and staff at each of the thirteen Cambridge elementary schools.

Science-Based Prevention: School Focus

The increases in substance use by Cambridge Rindge and Latin School students, the use rates reported by Cambridge Middle School students, and the information on youth access to alcohol, together created the impetus for a review of Cambridge underage substance use prevention efforts. (Last year's Public Health Assessment describes the beginning of that process in the chapter on Substance Abuse.) To date, most Cambridge substance use prevention efforts have been designed locally. This has allowed prevention program providers to customize their programs to address the specific needs of the youth in the community. However, rigorous evaluation of the effectiveness of these efforts was beyond the scope of local prevention programs. Several state and federal agencies interested in funding prevention efforts have identified a number of "science-based" prevention curricula and strategies whose use they encourage. These science-based curricula and strategies have been shown to be effective in positively affecting youth behaviors, particularly regarding substance use.

In 1999, the Cambridge Prevention Coalition spearheaded an effort to review these strategies and curricula to determine which might have the greatest chance of success in Cambridge. The Prevention Coalition identified a curriculum that is repeatedly cited as

an effective tool for reducing substance use among youth: the "Life Skills Training" program. This three-year program is intended for use in middle schools and addresses drug-resistance skills and information, self-management skills, and general social skills. It will be piloted in sixth-grade classrooms in four Cambridge elementary schools in the 1999-2000 school year. The Prevention Coalition, the Cambridge School Department, and the Cambridge Police Department are exploring ways to expand the program in subsequent years.

Also in the realm of science-based prevention, CASPAR was awarded a grant to conduct a study of the CASPAR Student Assistance Program in four other Cambridge elementary schools. One component of the Student Assistance Program provides substance abuse prevention education to sixth grade students. Another component includes identification of students at high risk for substance abuse and targets additional intervention services for these students. A third component is a rigorous evaluation to determine the effectiveness of this comprehensive prevention and intervention program.

As a result of its own internal review process, the Cambridge Police Department decided to phase out the DARE program and to transfer its support to school-based community liaison officers and the science-based curriculum described above. The DARE program will, however, continue in 1999-2000 in the six schools not participating in the Life Skills Training pilot or the Student Assistance Program.

Science-Based Prevention: Server Intervention Project

There are 252 establishments that serve alcoholic beverages in the City of Cambridge. Significant clusters of licensed premises exist near student centers including Kendall Square, Central Square, Harvard Square, and Inman Square. In 1998, thirty-six police reports were categorized as "bar/alcohol" related, and thirty-nine involved liquor violations, most involving a minor in possession of alcohol. It is important to note that crime incidents involving licensed premises are often under-reported for a variety of reasons including fear of official sanctions and embarrassment on the part of now-sober victims. The Cambridge License Commission conducts semi-annual "sting" operations to monitor service of alcohol to minors at licensed establishments. For the last five years, the License Commission has issued violations after every undercover investigation.

To supplement the work being done by the police and the License Commission, the Cambridge Prevention Coalition will implement a science-based strategy, the Server Intervention Project, designed to address both community norms and underage access to alcohol. The Server Intervention Project will consist of four components: (1) a server training program for employees of establishments that serve or sell alcohol; (2) policy development and technical assistance to the Cambridge License Commission and licensed establishments to encourage and support consistent enforcement of laws and policies; (3) a social marketing media campaign to alter adult social norms about underage drinking; and (4) an evaluation of this project to measure its effectiveness.

Emerging Issues

There are costs and benefits associated with mobilizing science-based prevention strategies in Cambridge. Clearly, with rising local and national rates of substance use among youth, there are benefits to using effective prevention and intervention initiatives. Federal and state funding sources are requiring that programs implement proven strategies and incorporate rigorous outcome-based project evaluation. Implementing well-tested programs increases the likelihood of success, and incorporating more detailed evaluation into the project design provides a means for identifying and measuring performance. In addition, federal and state emphasis on science-based prevention is expanding to areas other than substance abuse. Cambridge will be able to draw from the experience gained through implementing science-based substance abuse prevention initiatives as it begins to explore the use of science-based prevention programs in other areas such as violence prevention.

At the same time, there are costs associated with these improvements. Special training may be needed for staff of new projects, and project materials may need to be purchased. As the comprehensiveness of evaluation increases, so does the cost of that evaluation. Finally, there is rising concern about the number of academic and non-academic tests and surveys that Cambridge youth are asked to complete. Since pre- and post-testing of participants is a necessary component of evaluation, implementation will require careful consideration and planning in order to minimize the perception that Cambridge youth are receiving more evaluation than actual services.

Homelessness, Public Intoxication, and Nuisance Behaviors

In the spring of 1999, the Multidisciplinary Working Group Addressing Issues of Homelessness, Public Intoxication, and Nuisance Behaviors, chaired by the Chief Public Health Officer, began meeting to discuss a series of City Council Orders related to problem behavior by some individuals in Cambridge, particularly those who are inebriated in public. This Working Group included representatives of a number of City departments, the District Courts, and non-profit service providers. The Working Group's task was to formulate recommendations for responding to the public nuisance behaviors of these individuals.

Building on the foundation of previous efforts, the Working Group carried out this task in ten meetings throughout the spring and summer of 1999. The work included reviewing relevant documents, resources, and regulations, as well as data reports issued by the Emergency Communications Department and the Cambridge Police Department.

The Report of the Working Group included recommendations to: (1) expand emergency and residential services for homeless individuals; (2) provide support for the chronic users of services; (3) educate the public; and (4) implement specific police actions. A comprehensive report with discussion and recommendations was submitted to the City Council in November of 1999. For more information, or to obtain a copy of the Working Group's Report, contact Jeff Walker at (617) 665-3834.

6. HEALTH PROMOTION AND DISEASE PREVENTION

Health promotion and disease prevention initiatives are traditional public health activities. The Cambridge Health Alliance provides a range of these efforts and works closely with local medical providers in primary care sites throughout the city. The significance of these programs is increasingly appreciated as the Alliance works toward improved community outcomes during these times of health care cost containment.

Health promotion activities can take place in any number of ways. They may be single events held in school classrooms, youth centers, hospital clinics, or a private doctor's office, or media campaigns utilizing newspaper articles, TV, or radio stations to promote a particular program or activity. They may also be the focus of entire programs such as the Tobacco Education and Control Program and the Cambridge Prevention Coalition. And health promotion may be part of a comprehensive initiative like the Multidisciplinary AIDS Program or the School Health Program. Whether the work takes place as a single large event or as part of a dedicated program, health promotion and disease prevention activities are vital components of the work of the Cambridge Health Alliance.

Health Promotion Events and Activities

In 1999, the Alliance initiated or participated in a number of city-wide cultural and health-related events. These events offered excellent opportunities to provide the public with essential information about health education, disease prevention screenings, and service resources. Examples include Women's Health Day, Family Fun Day, National Night Out, Central Square World's Fair, Central Square Caribbean Festival, Sharing the Journey, and Cambridge Walks. Collaborative efforts with community-based agencies included open houses at new Windsor Street and East Cambridge Health Centers, Brazilian Independence Day Festival, Haitian Health Fair, health fairs at local churches, resource fairs at area libraries, and health programs benefiting the elderly. The events and outreach efforts are well-suited to bring together residents from all of the communities in Cambridge and support the work of maintaining a healthy City.

The following sections describe the major health promotion activities of the Alliance and some of our community partners.

A. HEALTH OF THE CITY

Introduction

Health of the City is dedicated to improving the health of Cambridge residents through community-based health promotion and disease prevention activities, and to engaging Harvard Medical School and other academic health centers in this work. Formed in 1990, Health of the City brings together people from across the community to identify and prioritize health needs and develop strategies to address them. In 1992, the Healthy Children Task Force was created to develop programs and advocate for children, and the Men of Color Task Force was created to address issues of particular concern to that community. The Health Information Unit collects and provides data about the health status of Cambridge residents, and develops and supports health promotion projects.

Accomplishments

In 1999, Health of the City initiated health promotion and disease prevention activities and provided technical assistance for several ongoing projects. The focus of its work centered on obesity prevention, physical activity and nutrition promotion, pediatric mental health, and improvements in health care delivery and patient satisfaction. The Health of the City also initiated activities in the emerging areas of asthma and geriatric health. Graduate students from local universities provided much of the research support for these initiatives.

An important goal of Health of the City is to develop and support community-based prevention initiatives. Among the programs that continue to receive Health of the City technical assistance and support are the Children's Dental Program, the Agenda for Children, and the Domestic Violence Task Force.

Health Information Unit
Activities of the Health Information Unit in 1999 included:

1999 Public Health Assessment: A Report from the Cambridge Health Alliance, Volume 2. This publication compiles data on Cambridge health indicators from a number of sources, relying heavily on information disseminated by programs of the Massachusetts Department of Public Health, to provide quantitative information on priority health areas as well as traditional public health concerns. An equivalent Somerville Data Report is forthcoming.

The Health of Cambridge at A Glance, a one-page overview, reports current health facts and statistics that measure progress toward achieving the national health goals. This document has been mailed to all Cambridge households to raise awareness of the work of the Alliance and to inform residents about health status indicators.

Healthy Children Task Force

The Healthy Children Task Force is a coalition of Cambridge-based pediatric providers, children's advocates, and community members. The Task Force includes representatives from the Cambridge Health Alliance, School Department, Department of Human Service Programs, City Council, School Committee, Harvard School of Public Health, and community groups such as Cambridge Youth Soccer. In 1999, the monthly Healthy Children Task Force meetings focused on three priority areas: (1) promoting physical activity and nutrition; (2) mental health; and (3) asthma.

1) Promoting physical activity and nutrition:

- Obesity is an increasing problem both nationally and locally. Cambridge Public School data indicate that 11% of students in the fourth through the eighth grades are obese, and another 17% are overweight. Health of the City is seeking funding for a school-based obesity prevention effort that builds on work done by the Physical Education Department and applies lessons learned from other school-based projects.

- A Healthy Children Task Force subcommittee provided technical assistance to on-going efforts of the School and other City Departments to improve opportunities for physical activity through open-space and facility development initiatives. A directory of youth-oriented physical activities available to families in the city is being developed.

- With input from Health of the City, the Cambridge School Department hired a new full-time food service director who has made several important changes in food service. The School Department, again in collaboration with Health of the City, received grant funding to promote participation in the school breakfast program. A newly formed Food Service Advisory Committee will work to improve the school-year menu and the summer food program, improve communications and promotion, and provide linkages to classroom learning.

- The Cambridge Public Health, Police, School, and Community Development Departments collaborated on a project initiated by the Health Information Unit to promote the health benefits of walking regularly. Cambridge designated October 6, 1999 as Walk Our Children to School Day. Patterned on a national campaign to encourage walking, the local effort raised awareness through letters to parents, promotional items to students, and class lessons on walking safely.

2) Pediatric mental health:

- The Healthy Children Task Force created a subcommittee of mental health providers and stakeholders to investigate ways of improving services and understanding the prevalence of mental health problems among children and youth. The group

compiled an inventory of mental health services available to public school students and precepted several Harvard School of Public Health students conducting needs assessment research.

3) Asthma

- Health of the City recently identified asthma as an issue of increasing concern. To best understand how the issue affects Cambridge children and youth, Health of the City is engaged in identifying pediatric asthma-related programs and projects in the Cambridge area, supporting Cambridge Public Health Department initiatives, and partnering with an inter-hospital community-based initiative involving the Cambridge Health Alliance and the Massachusetts General Hospital.

Linkages with Universities

This past year, Health of the City has worked with Harvard Medical, Dental and Public Health Schools, and Tufts University on several research projects:

- Health Promoting Behaviors among Cambridge Teens: A Tufts University graduate student analyzed the 1998 Teen Health Survey data to assess which factors in teens' lives are associated with positive health choices.

- Community Assessment of Pediatric Mental Health: Three Harvard School of Public Health graduate students surveyed pediatric medical providers and school personnel to assess their perceptions of mental health problems among Cambridge children and to describe gaps in the current provision of mental health services.

- Cultural Sensitivity and Patient Satisfaction at Cambridge Hospital: Three Harvard School of Public Health graduate students conducted a randomized control study to investigate ways to address hospitalized patients' worries and concerns.

- First-Year Urban Neighborhood Campaign: Nine Harvard Medical School students participated in a project to solicit input from twenty-six Cambridge seniors on their use of public services, especially health-related services. This inquiry focused on the potential for improving services and the participants' general perceptions on quality of life. The results of these qualitative interviews are included in Chapter 5: *Focus on Geriatrics*.

Emerging areas

- Rising rates of obesity among children and youth continue to challenge our community. Health of the City is dedicated to developing innovative and appropriate approaches to obesity prevention and positive intervention strategies.

- Children's mental and emotional health is an area that both community members and providers have identified as requiring collaborative focus and resources. Health of the City will continue to facilitate interdisciplinary explorations on prevalence, prevention, and service response.

- Health of the City will work closely with initiatives in asthma research and service programs. Health of the City will give particular focus to exploring the interrelationships of asthma, obesity, physical activity, and mental health.

B. TOBACCO EDUCATION AND CONTROL

Introduction

The Tobacco Control Program of the Massachusetts Department of Public Health funds three health promotion initiatives of the Cambridge Health Alliance. These programs are funded to address smoking cessation, educate the general public about the dangers of tobacco, and develop and enforce local tobacco control policies relating to both youth access and exposure to secondhand smoke. The ultimate goal of all of these programs is to change social norms regarding the use of tobacco.

Accomplishments

Tobacco Control

The Cambridge Public Health Department continued to work closely with the Five City Tobacco Control Collaborative and other local tobacco control programs to strengthen tobacco control regulations in Cambridge. Retailer and Restaurant Forums and individual educational meetings were held throughout the first half of 1999 to both inform the public about what was being proposed and to receive feedback from those who would be most affected by the changes. A working group composed of restaurant owners, interested organizations, and Cambridge Public Health Department staff members met regularly to provide input to the Public Health Department while the proposed amendments to the Tobacco Control Ordinance were being crafted. In June, the Cambridge City Council passed the recommended amendments to the Tobacco Control Ordinance.

The strengthened tobacco control regulations will be successful only when people understand their rights and responsibilities and when the regulations are consistently enforced. The Cambridge Tobacco Control Program addresses this issue on multiple levels.

<u>Tobacco Retailers</u>

The revised ordinance for tobacco retailers clarified the system for fining offenders and prohibited the use of tobacco vending machines and self-service displays in establishments that serve minors. Retailers continue to receive education through visits to their stores, community retailer forums, onsite training for store employees, targeted mailings, and compliance checks. There were 342 educational visits in 1999, and retailers were invited to three community-wide training sessions during the year to ensure that they would understand their responsibilities under federal, state, and local regulations governing sale of tobacco products. Informational mailings are also sent to remind retailers of the legal requirements and to offer assistance as needed.

Tobacco vendors are subject to biannual compliance checks for enforcement purposes and to evaluate the educational and outreach services offered to retailers. Of 263

compliance checks in 1999, twenty-four resulted in sales to minors, a 9% rate of sale. This is a significant improvement over 1998 compliance checks, which resulted in a sales rate of 16%.

Restaurants

The revised ordinance prohibits smoking in restaurants unless the establishment has a separated bar area or only serves patrons over eighteen years of age. Following passage of the ordinance, all restaurants received an informational packet regarding the changes and the new procedures to be followed to allow smoking in restaurants. Those restaurants eligible to apply for permits to allow smoking received applications as well. Eligible restaurants that did not apply for permits to allow smoking were contacted again by mail. The Tobacco Control Coordinator visited all restaurants that submitted applications (approximately seventy-five). The Tobacco Control Coordinator also worked with local business organizations, including the Chamber of Commerce and the Harvard Square Business Association, to promote awareness of the impending changes. The changes related to smoking in Cambridge restaurants will take effect on January 2, 2000.

Innovative Outreach and Smoking Cessation

In the spring of 1999, a trilingual Tobacco Education Coordinator was hired to provide targeted education and outreach to Spanish- and Portuguese-speaking residents. She has provided innovative outreach in health center waiting rooms and has conducted awareness presentations at agencies and churches serving Spanish and Portuguese speakers. Smoking cessation counseling is now offered in Spanish, English, Portuguese, and Cape Verdean Creole.

Cambridge Health Alliance educators work with local community agencies and state-wide organizations to provide tobacco education at major community cultural events such as the World's Fair. Collaboration among tobacco control and education programs in Cambridge and Somerville allows for innovative events such as the Great American Smokeout "Butt Out" Concert, which brought together local bands and youth to celebrate a smoke-free lifestyle. Tobacco education presentations are also offered to local public and private schools and educational programs. Programs ranging from "Protecting Your Children from Secondhand Smoke" (for YWCA residents) to "Media Literacy and Tobacco" (for the Cambridge Friends School) have been successful in spreading a tobacco-free message.

Emerging Areas

A growing number of adolescents and young adults in Cambridge and throughout the country have used tobacco in recent years. This age group is often difficult to reach, and requires new, creative approaches. The "Butt Out Concert" is a recent attempt to target and engage this age group.

As tobacco marketing becomes increasingly subtle, it is essential to build media awareness among consumers, with special attention given to the young people who are targeted by the tobacco industry.

Children and adolescents can obtain tobacco products in many ways. It is important to develop strategies that address "social sources"—parents, friends, and other adults—as well as retailers, to prevent youth from becoming addicted to tobacco.

C. PUBLIC HEALTH NURSING

Introduction

Public Health Nursing provides population-based health and nursing services as well as education and health promotion to people who live and work in the City of Cambridge. Some of the major areas of nursing services are tuberculosis (TB) and other communicable disease control, maternal and child health home visiting, and annual flu vaccine programs. Additionally, the nurses provide health care support, education, and guidance to a variety of community-based agencies.

Accomplishments

Health education and promotion efforts continue to be provided in many settings throughout the city. Public health nurses regularly visit several area shelters to provide guidance and consultation to staff and guests. The nurses have ongoing relationships with senior centers and several religious congregations in the city, and provide group and individual education, health promotion, and screenings in those settings.

Public health nurses also work as health care consultants to some childcare and after-school programs in Cambridge. In the fall of 1999, the nurses began a partnership with the Harrington School Extended Day Program and have provided training in CPR and First Aid to the staff of this new program. They will continue to offer educational sessions for both staff and parents throughout the year. As health care consultants to this and other childcare and after-school programs, the nurses are responsible for reviewing health care and medication administration guidelines as well as being available for general health-related questions and concerns.

The public health nurses reviewed more than 240 cases of reportable communicable diseases in 1999. This work entails contacting patients and medical providers to ensure that individuals have received appropriate treatment and education to prevent transmission of disease. The nurses work closely with area businesses and other agencies when there is a work-related exposure to a communicable disease. In 1999, public health nurses conducted a rubella vaccine clinic for a local business where staff members had been exposed to a co-worker with this disease.

Newborn Home Visiting, a pilot program in the North Cambridge area, has been expanded to the entire city; eighty-four families were visited in 1999. During these visits, parents of newborns are given information about area health, education, social, and recreation resources for families and children. In 1999, the nurses entered into a collaborative relationship with the Cambridge Public Library and began distributing books for young children. The objective is to support parents in encouraging early literacy skills for their children.

The Cambridge TB prevention and control program is a state model for treatment of tuberculosis. In fiscal year 1999, there were 2,268 visits to the TB clinic. The number of Cambridge residents with active (communicable) TB has remained stable over the last five years with between nine and eleven Cambridge residents treated each year. The rest of the visits to the TB clinic are for routine skin testing, evaluation, or follow-up care for individuals who have been exposed to TB but do not have active disease. The TB staff (nurses, physicians, and an administrative coordinator) are multilingual and provide a welcoming and supportive environment for patients being treated for active disease or for exposure to TB. Nurses provide "directly observed therapy" through home visiting to ensure that individuals with active TB are taking medication as necessary to prevent worsening or transmission of the disease.

Evaluation of data on rates of teenagers who do not complete therapy has led to an initiative that provides coordination among the students, parents, and school nurses. Medication administration by school nurses and public health nursing case management is now provided in the school health offices, eliminating the need for students or parents to make additional visits to the TB clinic for these services.

Community Engagement

The work of the public health nurse is grounded in strong community involvement. Offering flu clinics is one way in which service is brought to the community in a variety of public settings. Over 9,700 doses of flu vaccine were distributed to area medical providers in the fall of 1999 by the Cambridge Public Health Department, and 2,300 doses were administered to city residents in community-based clinics run by Public Health Nursing. Clinics took place in senior centers, elderly or low-income housing, schools, businesses with staff members at increased risk, the YMCA, The Cambridge Hospital, City Hall, and other sites in the community.

A new state initiative focusing on populations at increased risk for TB has begun in Cambridge. The public health nurses participate in this program along with community members to identify areas where education and increased screening for TB should be directed. Cambridge is one of the pilot sites for this effort, chosen by the Massachusetts Department of Public Health as a result of the strong commitment of the TB team and the wonderful resources available through the hospital-based clinic.

Emerging Areas

Efforts to curb the spread of Hepatitis A, B, and C have been the focus of discussions between the Cambridge Department of Public Health, the Somerville Board of Health, the Department of Community Affairs of the Cambridge Health Alliance, and the North Charles Institute for the Addictions. The individuals who receive services at North Charles are at increased risk of illness and death due to exposure to Hepatitis B and C. Education and vaccination for Hepatitis B are planned as part of this effort that will take place onsite at the North Charles Institute for the Addictions.

Public Health Nursing is working with the Massachusetts Department of Public Health as the state Hepatitis C Advisory Group examines new approaches to surveillance and prevention of this dangerous disease.

In 2000, the public health nurses will expand their role in the efforts to reduce environmentally-related illness. Through cooperative work with the staff of the Healthy Homes Pilot Program (see Chapter 3: Priority Areas, 3. Environmental Health), Public Health Nursing will be able to enhance services to patients for whom we already provide home visiting.

D. SCHOOL HEALTH NURSING

Introduction

School-based health care is provided by experienced registered nurses, each responsible for the health care program in one or two schools. The nurses are assisted in their work by specially trained school health aides and receive clinical support from the Medical Director. In school year 1998-1999, there were over 69,000 visits to the school health offices. The Cambridge School Health Program stands out from those in other cities by providing health staff in each public school every day.

School nurses provide direct care including medication administration, medical treatment, and first aid, as well as a variety of educational and health promotional activities. They function as case managers for children with complicated medical and psychological concerns, and often assist parents and medical providers by monitoring students' progress during the school day.

Accomplishments

In the fall of 1999, efforts continued to ensure that all children who entered the public school system had received immunizations required by state law. By the end of the second week of school, all new kindergarten students had met this requirement.

This year, in compliance with new regulations by the Massachusetts Department of Education, all school nurses have applied for and been granted status as certified school nurses/health educators. Some of the nurses bring additional skills to the program, further enhancing school health services. Our year-old publication, *Beyond Bandaids*, is written and produced in four languages by a small group of school health nurses and is distributed to all parents of students in kindergarten through the eighth grade. Several school nurses facilitate student groups focused on eating disorders, self-esteem, hygiene, and smoking cessation

The school nurses are highly qualified health care professionals who can provide key interventions that greatly improve the lives of Cambridge students. Some examples follow:

- In one school, the nurse was the first person to identify a child with a worsening medical condition. She was instrumental in bringing the parent, primary care doctor, and specialist together to change the care plan for this child with a most positive outcome for the child.

- Several young diabetic children get support and education in the school nurse's office as they learn skills such as blood sugar testing and injecting insulin, crucial skills they will need for the rest of their lives.

- Another nurse carefully and privately reminds a student with toileting problems to use the bathroom in order to prevent accidents and embarrassment.

- A school nurse was instrumental in planning and conducting a program that encouraged parents and students to understand the need for healthy breakfasts. City Council and School Committee members as well as hundreds of students and parents attended this early-morning event.

School nurses provide significant expertise in planning for health and education resources when students with special needs enter the public school system. In the 1998-1999 school year, one of the school nurses worked diligently to provide a plan of care that the Bureau of Pupil Services implemented to enable a severely handicapped student to attend a special Head Start classroom. This effort involved home visiting and working with medical and social service staff from several other agencies concerned with the child's care.

In response to increasing rates of asthma and other allergic conditions among school-age children, school nurses train school staff about how to prevent and recognize respiratory distress and how to use Epi Pens® for severe allergic reactions. School nurses have also been called upon to train staff and individuals in community groups and childcare sites, further enhancing the relationship between the public schools and neighboring community agencies.

Nurses at the high school work closely with leaders of the freshman advisory groups and visit each group to orient new students to School Health and the Teen Health Center. Each ninth grade student also meets individually with a school nurse to discuss his or her health care needs and to review important health education tips for adolescents. The school nurses are a major resource for students in need of counseling and support services.

Community Engagement

School Health program staff members work with a variety of community agencies and participate in city-wide initiatives on a regular basis. School nurses have been active in city-wide health promotional events focused on girls' athletics and fitness, and on pedestrian safety. Nurses work closely with family liaisons and Family Resource Center staff to assist new families as they register their children for school. They are on hand to help with referrals for health insurance and health care providers.

Most of the school nurses have been asked by the principals in their schools to become members of the Administrative Response Teams, a system-wide approach to responding to crisis situations in the schools and the community. One school nurse with an interest and expertise in children with special health care needs has been appointed to the School Department advisory committee on special education.

Emerging Areas

In 1999, the program benefited from the addition of computer terminals in each of the School Health offices. Efforts in 2000 will focus on collaborating with the School Department to implement a secure system for electronic documentation of school health care. This capacity will be useful in analyzing health care information and will serve to inform Health Department decisions for program development.

Two new initiatives of the Cambridge Public Health Department will provide an opportunity for School Health staff to enhance services to students and families. The Healthy Homes pilot program will support the care and education provided to students with asthma and other environmentally-related health concerns. School nurses are also participating in training being provided in the schools by the Public Health Department's Domestic Violence Training Specialist. As a result of these efforts, school health staff can be better resources to school staff, students, and families in need of social support and health care.

E. AGENDA FOR CHILDREN

Introduction

The Agenda for Children is a city-wide initiative to improve the lives of children in our community. This effort developed through an intensive collaboration among the Cambridge Public Health Department, the Department of Human Service Programs, Cambridge Public Schools, the Police Department, and Cambridge Public Library, in partnership with the Cambridge Community Foundation and many private non-profit community-based organizations.

The mission of the Agenda for Children is to ensure *Healthy Children, Success in School, and a Strong Community,* with a commitment to cultural sensitivity, respectful involvement of diverse families, and an understanding of the economic stresses that affect families in Cambridge.

The City's Departments of Public Health, Schools, Human Service Programs, Police, and Library have devoted significant leadership and staff time to this project. Funding for the Agenda for Children has come thus far from the City of Cambridge, the Cambridge Community Foundation, and the Cambridge Health Alliance.

Accomplishments

The first phase of this project was concluded in the winter of 1998-1999 following a comprehensive, year-long process involving more than 600 residents that included many public discussions with elected officials and community activists. The Kids' Council serves as the oversight body for the Agenda for Children. Its members selected two primary goals from a list of nine on which to focus Agenda for Children resources: (1) All children and their families will be able to read; and (2) All children will have access to supervised activities in safe and nurturing environments at all times.

In April of 1999, action teams were formed on Reading and on Supervised Activities to develop objectives, strategies, and measures of success for each of the primary goals. A Community Engagement Working Group was established to ensure that the Agenda for Children continues to work closely with residents, community-based organizations, and providers as the action plans evolve.

The focus and energy of this ambitious planning effort have also led to the enhancement of several projects implemented or expanded during the planning process: the Extended Day Pilot program at the Harrington School is one such effort. The Agenda for Children also supported literacy promotion activities such as a summer reading list developed by the Library and School Department; Family Fun Day (a family literacy event); a collaboration between the Library and Public Health Nursing to deliver books to families

of newborns; and planning for a literacy conference sponsored by the Harvard Children's Initiative.

As meetings with community groups, providers, and City leaders have progressed, the need for a comprehensive source of information about human service and educational programs available to Cambridge families has become apparent. A centralized database, accessible to all families, may be developed through the work of the Agenda for Children. Over the years, individual agencies or departments have collected referral information, but none have had the financial or organizational support to maintain a current and accurate database. Efforts are currently under way to explore options for development and maintenance of such a system.

Action Teams

The membership of the Reading Action Team includes experts in literacy and early childhood from the School Department, the Library, higher education, and community-based agencies. Parents, clergy, and health professionals are represented as well. Beginning in late spring 1999, the group reviewed best practices in literacy development, national and local program models, and the current state of reading achievement of Cambridge Public School students. Subcommittees identified literacy objectives and preliminary strategies for each of the following age groups: early childhood, school age, and adult. In addition to utilizing the collective expertise of the Action Team members, ideas were gathered from parent focus groups held in the summer and fall of 1999, and from the many community group meetings held during 1998.

Similarly, the Supervised Activity Action Team includes experts in childcare and youth development, school personnel, police, parents, and community activists. This group began with the complex task of defining a very complicated goal statement. The goal, ensuring access for all children to supervised activities in safe and nurturing environments at all times, has required much study and clarification.

Throughout the spring and summer of 1999, the Supervised Activities Action Team reviewed national and local program designs, examples of best practices, and documentation of existing programs and gaps in Cambridge. Among the needs identified first by this Action Team is development of a central, user-friendly source of information for parents and providers about existing childcare and supervised activities.

Action plans will be drafted by January 2000 and will include measurable objectives and initial strategies. Further development of strategies to accomplish the goals and objectives will require ongoing community engagement. It is essential to maintain continuing collaboration among planning groups, residents, community-based organizations, and City leadership.

Community Engagement

The purpose of the Community Engagement Working Group is to ensure ongoing community participation in the planning and implementation of the Agenda for Children. This group has conducted focus groups with community members and provided valuable information to the Action Teams. Among the conclusions of the focus groups is the importance of integrating literacy development into supervised activities for children in Cambridge.

In October of 1999, the Agenda for Children and the Kids' Council announced the availability of funds for an innovative approach toward maintaining community engagement. This funding allows community-based agencies serving distinct ethnic, neighborhood, or socioeconomic groups in Cambridge to participate directly in the Agenda for Children. Contracted agencies will organize their respective communities and facilitate participation of community members in the development and implementation of the Agenda for Children goals.

Emerging Issues

The next phase of the Agenda for Children, implementing the objectives developed by the Action Teams, will require the ongoing commitment and active involvement of community members from all sectors of Cambridge.

The action plans will be the starting point for new initiatives in literacy development, childcare, and supervised activities that have not been finalized at the time of this assessment. The development of a user-friendly database project will facilitate access to Cambridge programs and identify gaps in service to be addressed through future policy decisions and program development.

The Agenda for Children is an extremely ambitious and complex endeavor. The Agenda is building a growing network of involved residents, community-based organizations, and City departments that exemplifies the best of interdisciplinary collaboration. The considerable financial and human resources committed over the past two and one-half years by the School, Human Service Programs, Public Health, Library, and Police Departments is evidence of the City's significant investment in this project. Continuing departmental support will be required to sustain the effort through the implementation phase, itself a long-term project. The Agenda for Children leadership will be examining the feasibility of hiring designated staff for this project.

F. MEN OF COLOR HEALTH PROGRAM

Introduction

Health disparities between racial and ethnic groups in the United States remain a significant public health concern. In August 1998, the Department of Health and Human Services began an initiative to specifically address racial disparities in health, focusing primarily on the health needs of women and children. There is overwhelming evidence that men of color also experience disproportionately higher rates of morbidity and mortality on several health indices.

The Men of Color Health Program was established to improve the health of minority men by providing outreach and access services. Our aim is to address behaviors that affect health status as well as various societal factors that can affect health. During 1999, the Men of Color Health Program was successful in connecting with the community on these issues and providing effective services in chronic disease prevention.

Accomplishments

Prostate Health Initiative

In an effort to address one of the immediate health concerns of men of color, the Public Health Department initiated a Prostate Cancer Screening Program. This program is a collaborative effort between the Health Department and local churches (St. Paul African Methodist Episcopal, Western Avenue Baptist, and Abundant Life) to educate African American men about the risks of prostate cancer. The Prostate Health Team also informs men about testing and treatment options for prostate cancer. Public health nurses, working with the Men of Color Health Program staff, held informational meetings and provided prostate screenings in several churches. Approximately 150 men and women participated in the information seminars.

Youth Outreach

One of the new activities of the Men of Color Health Program in 1999 was an outreach effort directed specifically toward young men between fourteen and eighteen years of age. In collaboration with the Willis Moore Youth Center and CASPAR, the Men of Color Health Program sought to engage young men around issues of substance abuse, sexually transmitted diseases, violence prevention, physical activity, and personal development. A new topic was highlighted in each three-month group with activities designed specifically to encourage the young men to bond together to solve problems and share experiences. Each group was attended by twenty to thirty young men. These activities helped prepare participants for the risk-assessment and health information sessions at the Annual Hoops-n-Health Event.

Men's Outreach

In 1999, as in previous years, the Men of Color Health Program made concerted efforts to meet with men of color in various community settings and discuss risks and health

behaviors. In March, there was a health forum set around the NCAA Basketball Tournament that discussed heart disease and high blood pressure. Although the event was initially to take place in the Willis Moore Youth Center, the activity expanded to include a social club and several barbershops. Prior to this event there were several men's focus groups that evolved into sessions on access to health and mental health care. These sessions were extremely helpful in enhancing the program's objectives.

Hoops-n-Health

The Sixth Annual Hoops-n-Health Event was held at Hoyt Field with considerable success. Hoops-n-Health is a basketball tournament and health fair that draws several hundred participants and spectators each year. Approximately 100 men sixteen years of age and older take part in a one-game elimination basketball tournament after completing a health risk assessment and attending a one-hour health information session. In 1999, the sessions covered homicide, sexually transmitted diseases, seat belt use, smoking, and substance abuse.

Public health nurses staffed a first aid station adjacent to the basketball court. Another station nearby, "Ask the Doc," was staffed by Cambridge Health Alliance physicians. Other health fair participants included Cambridge Voter Registration, the WIC Program, Tobacco Education, and the Breast Health Project. Jamnastics organized children's games and entertainment, while free food and a DJ added to the festival atmosphere.

G. BREAST AND CERVICAL CANCER INITIATIVE

Introduction

The federal Breast and Cervical Cancer Mortality Prevention Act was passed in 1990. It authorized the Centers for Disease Control (CDC) to establish a national program to ensure that women are screened for breast cancer as recommended. The CDC carries out these activities through partnerships with public health agencies such as the Massachusetts Department of Public Health.

The Breast and Cervical Cancer Initiative of the Cambridge Health Alliance receives funding from the Massachusetts Department of Public Health. The program provides free annual physical exams with Pap smears and mammograms to women forty years of age and older who are uninsured or who have insurance that does not cover these services. While the program also pays for some diagnostic procedures, it does not cover the cost of treatment. Multilingual outreach workers recruit, educate, support, and link women from diverse communities to health care coverage if further treatment is needed.

Accomplishments

Breast and Cervical Cancer Initiative outreach efforts continue to be very aggressive as we strive to maintain and increase access to screening services for under-served populations. The majority of patients are between forty and sixty-four years of age; 37% of the women are White, 31.5% are Black, 16% are Hispanic, 2.5% are Asian, and 13% fall into other categories.

During 1999, the program increased its visibility in the community through participation in local health fairs and educational presentations in libraries, housing developments, and other community locations. The program continues to focus on the needs of its current patient groups while reaching out to others who are not using its services. The challenge in the coming year will be to further expand outreach so that the patients served more accurately reflect the demographic target groups while adapting to the ever-changing fiscal environment in health care.

Increasing access to health care is a fundamental goal of the Breast and Cervical Cancer Initiative. To this end, staff members learn about affordable health resources and public benefits, and have referred more than one hundred women who did not qualify for the program to alternate sources of affordable care.

An electronic billing system, instituted in 1998, was recently upgraded and has increased the program's ability to track its progress. It has enhanced communication with the Massachusetts Department of Public Health by facilitating data retrieval and reporting.

Emerging Areas

As of July 1999, the Massachusetts Department of Public Health changed the reimbursement formula for FY 2000 from a cost reimbursement system to a unit rate system that bases payments on the units of service delivered. Payments are based on the number of services such as mammograms, Pap smears, and physical exams provided, not on the actual cost of providing the service. This payment method places a greater financial responsibility on the Cambridge Health Alliance and has required innovative strategies to meet program volume projections. Strengthening outreach and education efforts in the community and within the Alliance continues to be a top priority. Breast and Cervical Cancer Initiative outreach workers meet regularly with other Cambridge Health Alliance community health workers to promote collaboration and to share strategies.

Guided by the Massachusetts Department of Public Health, the Breast and Cervical Cancer Initiative plans to expand its current initiatives in 2000 to include coverage for certain chronic illnesses. Women in the target population are at increased risk for diabetes and hypercholesterolemia as the incidence of these conditions increases after age fifty. Expanding the program's focus will be a great benefit for women who participate in the program. Additional education and training for our staff members will be required to successfully implement the expansion.

CHAPTER 4: CLINICAL SERVICES OF THE CAMBRIDGE HEALTH ALLIANCE

Introduction

As part of the Health Services Agreement between the Cambridge Health Alliance and the City of Cambridge, the Alliance agrees to provide a number of core services to members of the Cambridge community. These services include the inpatient and outpatient activities that comprise much of the business of the health care delivery component of the Alliance. The following sections provide a review of the services provided in fiscal year 1999, including volumes delivered and any relevant programmatic changes. Also included are service projections for fiscal year 2000.

Accomplishments

Inpatient and Outpatient Surgery

	FY 99 Actual	FY 00 Projected
Inpatient	962 procedures	1,065 procedures
Outpatient	1,655 procedures	1,762 procedures
TOTAL	2,617 procedures	2,827 procedures

During FY 1999, Surgical Associates of Cambridge, a private practice group closely affiliated with the Cambridge Health Alliance, joined the Alliance as part of the Professional Services Corporation. This new relationship allows for closer integration and strategic planning.

Inpatient and Outpatient Orthopedics

	FY 99Actual	FY 00 Projected
Outpatient	8,019 visits	9,290 visits
Inpatient	42 discharges	48 discharges

During FY 1999, we saw a continued increase in the need for orthopedic services. A physician's assistant joined the department to better meet the demand for services.

Inpatient and Outpatient Medicine

	FY 99 Actual	FY 00 Projected
Outpatient (primary care)	59,973 visits	64,792 visits
Inpatient	1,971 discharges	2,305 discharges

Outpatient adult primary care medicine is delivered at The Cambridge Hospital in the Primary Care Center; at the East Cambridge, Windsor Street, North Cambridge and Riverside Health Centers; and at Cambridge Family Health in Inman Square. (Senior Center activity is reported under Geriatric Services.) During FY 1999, we opened two outstanding new facilities—the Windsor Street Health and Community Center and the East Cambridge Health Center.

Inpatient and Outpatient Mental Health and Addictions

	FY 99 Actual	FY 00 Projected
Outpatient	100,886 visits	114,900 visits
Inpatient	2,504 discharges	2,823 discharges

The need for mental health and addiction services continued to grow during FY 1999, particularly on the outpatient side. One major new initiative was the expansion of services in the area of child psychiatry and mental health, responding to an important identified community need.

Inpatient and Outpatient Obstetrics and Gynecology

	FY 99 Actual	FY 00 Projected
Outpatient	11,930 visits	15,500 visits
Inpatient	716 discharges	791 discharges
Deliveries	625 deliveries	677 deliveries

The Alliance was able to successfully recruit an excellent new chief of OB/GYN who brings not only her expertise in the area of gynecological surgery and oncology, but also a strong interest in women's health. Under her leadership, we have begun planning for integrated and expanded women's health services.

Midwifery Program

	FY 99 Actual	FY 00 Projected
Birth Center		
Deliveries	43	75
Visits	1,567	2,100

We saw a slow but steady growth of the Cambridge Birth Center. A number of Birth Center families came to the Center's one-year birthday party in January. The Doula Program, which trains community women in perinatal support services, continues to provide a unique method of support to clients of the midwifery service.

Comprehensive Women's Health Services

Comprehensive women's health services include services related to reproductive health, such as obstetrics and gynecology, abortion services, and family planning, as well other services required for good health, such as primary care, mental health services, and a number of specialty services. With the recruitment of our new chief of obstetrics and gynecology, the Cambridge Health Alliance committed to an intensive planning process to identify the approach to women's health best suited to meet the needs of our community. This planning process will begin in FY 2000.

Comprehensive Pediatric Services

	FY 99 Actual	FY 00 Projected
Outpatient	28,326 visits	31,150 visits
Inpatient	786 discharges	862 discharges

Pediatric primary care is offered at The Cambridge Hospital through Cambridge Pediatrics office practice, the Teen Health Center, and all the neighborhood health centers except the Senior Center. The numbers above reflect primary care visits. Specialized pediatric nutrition services are also available at all pediatric sites. Mental health care is offered onsite at the Teen Health Center and by referral to our Child Psychiatry Department.

Comprehensive Geriatric Services

	FY 99 Actual	FY 00 Projected
Senior Center	3,692 visits	3,600 visits
Geriatric Consult Service	7,820 visits	8,400 visits
House Calls	1,279 visits	1,300 visits
Elder Service Plan	994 member months	1,356 member months

Geriatric service providers associated with the Cambridge Health Alliance continue to meet regularly to improve coordination of services and to identify gaps in services. A guide to geriatric services was compiled and made available to providers and community members to assist in identifying needed services. Programs available include outpatient care through the Senior Center, specialized outpatient and home-based mental health services designed for the elderly and chronically mentally ill through the Geriatric Consultation Service, primary care home visits through the House Calls program, and comprehensive services for the frail elderly through the Elder Service Program. The decline in the projected number of Senior Center visits for FY 2000 is due to the departure of a long-time provider and the start-up time required for new staff.

Neighborhood Health Centers

	FY 99 Actual	FY 00 Projected
Outpatient	78,918 visits	88,014 visits

Replacement facilities at East Cambridge and Windsor Street were opened in 1999. Other Neighborhood Health Centers in Cambridge include Riverside, North Cambridge, and Cambridge Family Health (visits for the Teen Health and Senior Centers are reported separately under Pediatric and Geriatric services). In addition to adult and pediatric primary care, all sites also offer obstetrics and gynecology care and nutrition services. Linguistic mental health teams provide care at East Cambridge, Riverside, and Windsor Street Health Centers.

Emergency Department, including Emergency Psychiatric Services

	FY 99 Actual	FY 00 Projected
Medical	22,520 visits	24,570 visits
Psychiatric	4,825 visits	4,845 visits

The long-awaited opening of a new facility for the Medical Emergency Department occurred in 1999. This new space allows us to provide emergency patients with first-rate clinical care in a setting that includes both private and semi-private rooms, a separate area for pediatric patients, and appropriate patient and family waiting areas.

Nutrition Services

	FY 99 Actual	FY 00 Projected
Outpatient	3,270 visits	3,955 visits

Comprehensive nutrition services are offered at all ambulatory sites. This includes adult and pediatric nutrition, prenatal nutrition, and special services for the elderly (through House Calls, Elder Service Plan, and the Senior Center) and individuals with HIV/AIDS (through the Zinberg Clinic). Nutritional services are also a central component of an initiative to identify and implement a comprehensive approach to the treatment of people with chronic diseases such as congestive heart failure and diabetes.

Medical and Surgical Subspecialty Programs

	FY 99 Actual	FY 00 Projected
Medical	4,935 visits	6,225 visits
Surgical	8,719 visits	10,182 visits

Medical subspecialties include dermatology, endocrinology, gastroenterology, oncology, neurology, and rheumatology. Surgical subspecialties include podiatry, ear/nose/throat, plastic surgery, urology, vascular surgery, and the breast clinic. The oncology program and dermatology services expanded with the addition of two new providers.

Dental Services

	FY 99 Actual	FY 00 Projected
Outpatient	6,645 visits	20,416 visits

Dental services were greatly enhanced with the opening of the new Windsor Street Dental Clinic during the late spring of FY99. This has dramatically increased the capacity of the Cambridge Health Alliance to respond to the significant demand and community need for affordable, accessible dental services. We also recruited an acting chief of dentistry who has a strong background in public health and prevention.

Specialty Outpatient Programs for High-Risk Populations

Victims of Violence:

	FY 99 Actual	FY 00 Projected
Outpatient	6,593 visits	6,900 visits

The Victims of Violence program continues to meet a critical community need. The program provides individual services as well as community interventions through the Community Crisis Response Team. (These numbers were also reported as part of the Mental Health and Addictions section.)

Linguistic Mental Health Services:

	FY 99 Actual	FY 00 Projected
Outpatient	14,591 visits	15,900 visits

The Linguistic Mental Health Program includes Portuguese, Latino, Haitian, and South Asian Teams. We continue to see increasing numbers of immigrants in our community and related demand for linguistically and culturally competent services.

Health Care for the Homeless:

	FY 99 Actual	FY 00 Projected
Outpatient	812 visits	1,200 visits

The work of Health Care for the Homeless continues to be critical to a group of often forgotten Cambridge residents. The incredibly committed and talented clinicians provide medical services at local homeless shelters, serving clients in a familiar and accessible location. We project a significant increase in the number of visits for FY 2000 because the addition of a registration person to the team will enable us to better enroll individuals in Network Health and to bill for services provided.

CHAPTER 5: FOCUS ON GERIATRICS

Introduction

Previous editions of the Cambridge Public Health Assessment have included city-wide assessments of the health of the City. This chapter of the 2000 Report, *Focus on Geriatrics,* is the first in a series that will highlight specific populations at risk in our community.

Why focus on the elderly? As stated in previous public health assessments, health risk is not uniform. The elderly represent one of several segments of the population that are at increased risk for poor health. Many Cambridge Health Alliance services are geared toward groups and individuals that are at high risk for illness and injury and have the fewest personal or economic resources to address their needs. Future assessments will focus on children, men of color, and other groups at disproportionate health risk.

The City of Cambridge is proud of the support it offers its senior residents, and caring for the elderly is an important aspect of the work of the Cambridge Health Alliance. We face a number of economic challenges, however. Recent cuts in Medicare payments to hospitals and providers as well as state changes in service reimbursement formulas are requiring the Alliance to search for innovative ways to find the resources necessary to continue ensuring access to a full range of high quality health care services. Seniors with lower fixed incomes are feeling the impact of the elimination of rent control and the rise in market rents. Seniors in Medicare HMOs have lost their comprehensive prescription coverage, and state assistance has provided only limited relief for rising prescription costs for individuals not eligible for MassHealth. As a result, seniors with incomes only marginally above the federal poverty level are having to choose which basic necessity—food, housing, or medical care—they can afford from month to month. The anticipated increase in the number of individuals sixty-five years of age or older beginning in 2010 will only exacerbate these problems. The Alliance and its community partners have responded and will continue to respond to this challenging environment with innovative approaches such as the Elder Service Plan, assisted-living for low- and moderate-income residents, wellness programs for older adults, and development of a senior care organization.

In this chapter, we provide a thumbnail description of Cambridge seniors (sixty-five years of age or older), focusing on barriers to their access to health care and patterns of mortality. This is followed by a discussion of the recent economic changes that are affecting access to services for many seniors. Next, we chart the landscape of services for seniors provided by the City and the Alliance. And finally, we present demographic and statistical information available on Cambridge seniors in a collection of charts and graphs.

1. THE POPULATION OF SENIORS IN CAMBRIDGE

A. Demographics

The 1990 U.S. Census counted 10,071 individuals in Cambridge who were sixty-five years of age or older. These seniors accounted for 10.5% of the total Cambridge population (Figure 1); statewide, 14.1% of the population was over sixty-four years of age. Women sixty-five years of age or older greatly outnumbered men in that age group. These census figures are now ten years old, and the next census may show a somewhat different picture.

A look at national data and demographic projections may give some indication of what to expect in Cambridge. There were approximately 34 million individuals sixty-five years of age or older living in the United States in 1997[1]. They accounted for approximately 13% of the total population, or one out of every eight Americans. As of 1997, the number of older Americans had increased 9% since 1990, compared to an increase of 7% for the population younger than sixty-five. Demographic projections predict a substantial increase in the number of individuals between the ages of sixty-five and seventy-four between 2000 and 2020. The Census Bureau projects that the elderly population will double between now and the year 2050, when as many as one in five Americans could be over the age of sixty-five. Most of this increase will occur between 2010 and 2030, when the baby boom generation enters its senior years. Population trends in Cambridge are likely to mirror the national trends, and a surge in the number of residents sixty-five to seventy-five years of age is expected to occur around 2020.

B. Access to Health Care

In 1998, 16% of the total U.S. population reported that they were uninsured for the entire calendar year. Although 99% of individuals sixty-five years of age or older had some form of health insurance, many of these individuals still had inadequate access to health care. Medicare, which covers the majority of seniors after age sixty-five, provides hospitalization and primary care, but does not cover prescription medications, eyeglasses, hearing aids, dental care, and many other important aspects of health care including long-term care in an institution or at home. Medicare supplemental policies are available to cover prescription drugs and other costs, but a senior in Massachusetts would have to pay over $1,600 per year to purchase a supplemental policy. Nationally, individuals sixty-five years of age or older paid almost a quarter of their total income for medical expenses, including supplemental health insurance coverage and long-term care. While Medicaid covers the cost of medical care for the poorest Americans, individuals with annual incomes from $8,244 to $10,305 (100% to 125% of the federal poverty level for 1999) paid the highest percentages of their income toward out-of-pocket medical expenses.

[1] Profile of Older Americans: 1998. Administration on Aging, Department of Health and Human Services.

Approximately 60% of all preventable hospitalizations occur among older people (Figure 12), reflecting their age and increasing frailty as well as health care access issues. Some of these hospitalizations may have been preventable through lifestyle behavioral change, or through consistent access to primary care (Figure 13). Primary care can often prevent unnecessary hospitalization through early interventions: providing antibiotics for bronchitis to prevent progression to bacterial pneumonia, treating hypertension to prevent hospitalization for congestive heart failure, and prescribing drugs to control chronic diseases that would otherwise progress to hospitalization. (See trend data on preventable hospitalization on page 19.) The number of hospitalizations due to falls increases with age (Figures 16, 17, and 18), with the highest rate in Cambridge for residents eighty-five years of age and older.

C. Mortality

Heart disease and cancer are the leading causes of death among Cambridge residents age sixty-five years of age and older (Tables 4 and 5). The death rates due to heart disease and cancer are higher in men than in women.

2. ECONOMIC CHALLENGES TO SERVICE DELIVERY

Low- to moderate-income seniors in Cambridge have been affected by economic and housing policy changes occurring at the city, state, and federal levels. The elimination of Cambridge rent control protections has significantly affected some senior citizens on fixed incomes, who must now pay a greater percentage of their income toward rent if they wish to remain in the City and do not choose to live in subsidized housing. As their out-of-pocket payments for medical and pharmacy bills increase, some lower-income seniors may be forced to choose between housing and healthcare. Others may delay seeing their physicians or forgo medications that would reduce their risk of functional decline or prevent the onset of a serious illness. To save money, some seniors choose medical options that may not be optimal but are more affordable. For example, newer medications show efficacy in preventing osteoporosis, a major concern for seniors, are particularly expensive. One senior treated at the Alliance stopped taking the new medication because "it was too expensive," and switched to a less expensive, but less effective alternative. If seniors are compelled through economic circumstance to choose less effective treatment alternatives, they are more susceptible to disabilities and functional declines that might otherwise be prevented.

National funding changes have created a challenge for the Cambridge Health Alliance and the City to maintain the resources that have been available to seniors in the past. As noted at the beginning of this 2000 Report, the Balanced Budget Act of 1997 has taken billions of dollars out of the Medicare system, significantly reducing funding for senior health care services. Its impact extends beyond hospital care out into the community, as the law represents the first-ever reduction in recipient benefits since Medicare's inception. For example, under certain circumstances this law would cap reimbursement for physical therapy at $1,500 a year. A Medicare recipient who requires $1,500 in rehabilitation services to treat back problems at home without a hospital stay would have to assume the cost if, later in the year, she requires physical therapy services for a shoulder injury. Seniors with limited incomes are more likely to forgo therapy to save money, and the result may be an increase in preventable disabilities that are attributable to under-treatment.

In 1998, Medicare implemented a prospective payment system for long-term care which could affect the continued financial viability of the Alliance's Transitional Care Unit, short-term stays at Neville Manor, and the House Calls program. The rules that govern prospective payment reimbursements to skilled nursing facilities and home health agencies seemingly penalize facilities that treat "costly" individuals, and discourage efforts to expand relationships to managed Medicare programs which operate outside the prospective payment system. Caring for individuals with multiple medical problems may result in financial loss for providers. For example, under prospective payment a skilled nursing facility must bear the costs of ambulance rides for its patients. Neville Manor or the Transitional Care Unit would have to pay the ambulance transportation costs for a patient who needs both rehabilitation following surgery to repair a fractured hip and dialysis three times a week at a dialysis center. The remainder of the prospective payment

reimbursement would not cover the costs of rehabilitation, and the skilled nursing facility would bear the financial burden. And because the amount of reimbursement provided for rehabilitation services has itself decreased, the financial impact to the skilled nursing facility is exacerbated. This scenario and other similar ones will create competition for the "easiest" patients, leaving fewer options for patients with more expensive, complex treatment needs.

Reimbursements for home health care services have also been reduced and are expected to drop further in 2000. This makes it difficult to provide ongoing chronic and rehabilitative care for seniors who have managed to remain in their homes despite rent increases. During 1998, the capacity of visiting nurses and home health aides to support clients with chronic illness has declined, and hospitalizations of frail elderly clients cared for in the Alliance House Calls program have increased. Somerville-Cambridge Elder Services has responded by providing personal care attendants, when possible, to provide care formerly given by home health aides. As a result, many older Cambridge residents may lose long-standing relationships with trusted providers and have to build new trust at a time of frailty and ill health. The effect on the quality of life and health outcomes for these Cambridge seniors could be significant.

With decreased financial support for maintaining older adults in their homes, one looks next to the nursing home system for relief. However, the Balanced Budget Act of 1997 and the budget-neutral approach of Medicaid to institutionalized long-term care have made it more difficult to support nursing home beds. This year, 239 beds have been eliminated by the closings of Cantabrigia and Youville. Neville Manor is moving ahead with a renovation that will provide seventy-one low-income assisted living units, and maintain 112 nursing home beds.

Cutbacks have also affected mental health care for the elderly. Despite recent recognition that the prevalence of mental illness, especially depression, is high in the senior population and often remains untreated, it is more difficult to qualify for mental health services and inpatient mental health hospital stays. Coverage for mental health medication has also decreased while the costs of newer drugs have increased dramatically.

The gero-psychiatry efforts of the Cambridge Health Alliance have continued to reach out to community partners to provide mental health services. The geriatric medical psychiatric unit at the Somerville Hospital provides inpatient care for Cambridge residents with psychiatric conditions too severe for treatment at home or in a nursing home. The Cambridge Health Alliance Psychiatric Geriatric Service provides outpatient mental health services in a variety of settings, including private homes, nursing homes, and the Senior Health Center. These outpatient services are provided in close collaboration with community partners such as the Cambridge Visiting Nurse Association, the Visiting Nurse Association of Eastern Massachusetts, and Somerville-Cambridge Elder Services.

Finally, increasing costs and decreasing coverage of prescription drugs has become an acute concern for many seniors in 1999. Medicare does not cover the cost of prescription drugs, and supplemental or "Medigap" policies offering prescription coverage are prohibitively expensive for many. Medicare HMOs in Massachusetts have drastically limited their pharmacy benefits, leaving many seniors to bear the costs of prescriptions that their HMO will not cover. While there has been great progress in the pharmacological treatment of mental illness, arthritis, osteoporosis, and heart disease, many health care plans have significantly restricted their drug formularies to reduce access to these newer, more expensive medications. These restrictions affect both treatment of active disease and prevention of potentially debilitating conditions and jeopardize the health of seniors without the financial resources to cover the costs of new treatments. Recently enacted legislation will provide some relief: the State Senior Pharmacy program, which has provided limited assistance to low-income seniors by supplementing up to $750 per year, will expand to cover catastrophic drug costs. The Cambridge Health Alliance provides medications to Network Health participants, but seniors covered by Medicare are not eligible for this program.

3. SERVICES FOR THE ELDERLY IN CAMBRIDGE

A. Public Services

City, state, and federal funding as well as local non-profit and other programs support the continuum of services available to Cambridge seniors. Agencies and service providers in Cambridge operate at a high level of collaboration and coordination to provide model health care services. In this section, we highlight a number of agencies and programs that coordinate a range of services or provide health-related services for seniors, though there are many other agencies providing services for Cambridge seniors.

In August 1999, Health of the City convened an outreach team to assess the health concerns and needs of seniors in Cambridge. The team of nine students from the Harvard Medical School conducted personal interviews and focus groups with twenty-six seniors in Cambridge ranging in age from sixty-eight to ninety-six. Some of their comments appear in the shaded boxes that follow:

Voices of Cambridge Elders

Most elders interviewed believed that Cambridge generally supports its elderly residents, and they voiced appreciation for this support. They mentioned preventive screening, exercise classes, safety features in the housing units, social workers, and opportunities for socializing as important and positive.

Complaints about community services focused on unreliable transportation services, the expenses and difficulties in taking medications, and problems with hospitalization – including uncertainty about the cost of services and inadequate explanations about tests and medications.

"When you're indigent, it's no problem at all. You can get all the services you need. When you have a little money, it's difficult. You don't have enough to pay for full services, but you don't qualify as indigent."

The Cambridge Council on Aging

The Council on Aging (Council) is a City department that serves as the gatekeeper or conduit for information, referrals, and direct services for all Cambridge residents over sixty years of age. Working with seniors and their families, the Council refers individuals to appropriate social and medical services based on their specific needs. Between July 1, 1998 and June 30, 1999, the Council received approximately 25,000 requests for information and referral services, with approximately 500 elders receiving case management services. Requests for services have increased significantly, reflecting both the demand for services designed to help seniors age in place, and the impact of state and federal cuts to programs supportive of seniors.

The Council operates the Cambridge Senior Center in Central Square and the North Cambridge Senior Center. These Centers offer drop-in services, meals, and a wide variety of social services, recreational programs, and classes. During this past fiscal year, the Senior Centers served approximately 28,000 meals, and a shuttle provided transportation for more than 400 riders each month. There is a food pantry at the Central Square Center that serves approximately 200 Cambridge seniors each year. The Council subcontracts with agencies in the community to provide other direct services such as medical and shopping transportation services, housing assistance, and discount programs. The Council also sponsors programs designed to serve elder Haitian, African American, and Asian residents.

A program for substance abusing elders includes home visiting and sobriety groups. The home visiting addictions treatment counselor, funded by the Cambridge and Somerville Councils on Aging, is a unique and vital position that enables older adults in the community to address substance issues in their homes. The community lacks, however, a post-acute substance abuse rehabilitation program, and residents who need these services must be referred out of Cambridge. Substance abusing older adults also struggle to find housing that is affordable, private, and safe.

Elders Comment On the Senior Center:

"There's something here for everybody"

"We have everything we need. We can dance, cook..."

"There are many, many kinds of games there. I can exercise there. There are word games so I can learn English vocabulary. I learn sewing there and picture puzzles. I learn a lot of skills there."

Somerville-Cambridge Elder Services

Somerville-Cambridge Elder Services was established in 1972 as a non-profit agency dedicated to improving the quality of life and maintaining the dignity and independence of older people in Somerville and Cambridge. This needs-based program provides services for seniors who meet income and medical criteria, offering case management, education and support, meals, mental health services, transportation, adult family care, homemaking, maintenance, and personal care. Somerville-Cambridge Elder Services is a state-designated Home Care Corporation, and a federal Area Agency on Aging. In 1999, the Executive Office of Elder Affairs designated the agency as an Aging Service Access Point (ASAP). ASAPs are designated to plan, develop, and implement the coordination and delivery of community-based, long-term care services. ASAPs also provide other services including nutrition, information and referral, case management, clinical screening, and protective services.

Cambridge Housing Authority

Several arrangements for independent living in subsidized housing are available in Cambridge. Based on income and social eligibility, independent seniors live in publicly subsidized housing developments for families and for elderly disabled persons. The housing developments offer or coordinate a variety of services for their elder residents such as social work, transportation, and meals. As of July 1998, there were 234 heads of household over the age of sixty-two living in state or federally funded family housing, representing 18% of the total residents in family housing developments. As of November 1998, 1,578 heads of household over the age of sixty-two lived in state or federally funded elder housing developments (Figure 9). Currently, there is a three-to four-month wait for subsidized housing for the elderly, with a turnover of approximately 120 to 140 units per year.

Elders Comment On Social Support:

Elders expressed appreciation of the social workers and elder housing staff in developing safety features like Lifeline, door tags, and other types of notification, and for efforts to promote social activities among residents.

B. Cambridge Health Alliance Services

The Cambridge Health Alliance provides primary care for the majority of senior citizens in Cambridge. In 1999, the Alliance began efforts to create a geriatric primary care group that will develop models of care for older adults. This group provides primary care for

seniors at the 60+ Clinic (located in Somerville but also serving Cambridge residents), Youville Hospital, and the Senior Health Center at Central Square. Efforts to improve the outreach and efficiency of this multisite primary care system are under way.

The Cambridge Health Alliance continues its longstanding commitment to city residents who have difficulty accessing the health care system or who have special needs. The Alliance offers a continuum of geriatric services including:

- Case management
- Clinical nutrition
- Falls prevention consultation
- Medical psychiatry unit
- Rehabilitation
- Neville Manor nursing home
- Osteoporosis Center
- Arthritis clinic
- Ophthalmology
- Outpatient addiction
- Psychiatric emergency and emergency outreach
- Podiatry clinic
- Urology
- Vascular clinic

In 1999, the Alliance continued its efforts to reach frail, elderly city residents. Several innovative programs illustrate these efforts and highlight the continued commitment and success of the Alliance in addressing the needs of our aging population.

Neville Manor Nursing Home

To increase the availability of assisted living arrangements for individuals with limited means, the Cambridge Health Alliance has moved forward on an assisted living and nursing home project on the Neville Manor campus. With the successful completion of this project, Neville Manor will become one of the very few low- and middle-income assisted living projects in the Commonwealth. The new facility will have seventy-one assisted living units available, allowing residents of Cambridge to continue living in the community with coordinated medical care and social support available on site. The nursing home will have 112 beds.

Elder Service Plan

The Alliance's Elder Service Plan provides an in-home alternative for residents eligible for nursing homes. The program has proven successful in keeping many seniors at home within the Cambridge community. The Elder Service Plan continued to increase enrollment during 1999. More than 125 frail seniors participated in the program over the course of 1999, with approximately 100 participants currently enrolled. A redevelopment project at the Harvard Manor Nursing Home will provide residence for several Elder Service Plan participants.

House Calls

The House Calls program of the Cambridge Health Alliance continues to deliver vital medical services to homebound individuals who are unwilling or unable to qualify for the Elder Service Plan. The House Calls program has had great success in reaching out to homebound older residents and works closely with its community partners, Somerville-

Cambridge Elder Services and the Cambridge Visiting Nurse Association. We continue to monitor the impact of the Balanced Budget Act on the delivery of health care services to these frail members of the Cambridge community.

Senior Health Center

The Senior Health Center currently provides primary care services to the mature adult population of Cambridge and the surrounding communities. In addition to primary care, other services, including urology, gynecology, mental health, and podiatry, were added in 1999 to increase access for health center patients. Physical therapy services are planned for 2000. A group of physicians works in a collaborative practice model with nurse practitioners to enhance the delivery of primary care services at the center. As in previous years, providers participate in health promotion and wellness initiatives, which take place within the same building.

Falls Prevention Project

Previous epidemiological data highlighted the need for a falls prevention strategy for seniors served by the Cambridge Health Alliance. The program began as a component of the Somerbridge Project and was shifted to the Geriatric Division in 1999. The division has been working to reduce the prevalence of falls and fall-related injuries. A falls-injury identification system has been developed, and the division is piloting a falls- injury risk assessment in collaboration with orthopedics and rheumatology. One of the division's geriatric nurse practitioners has widened her falls consultation program and spearheaded efforts to identify residents with a high risk of falling and focus preventive strategies on those individuals. She does this both in the community and at the Senior Health Center. Another geriatric nurse practitioner has been leading the effort to coordinate a wellness program to reduce falls in the community and thereby reduce injury. These two nurse practitioners have collaborated with an ongoing study being conducted in the Cambridge area to reduce the "fear of falling" by providing direct education to seniors who have experienced a fall. Cambridge will be one of four or five sites participating in this targeted education project.

Medical and social studies of the elderly consistently point to isolation and depression as important problems. Maintaining social networks appears to have a positive effect on their health. Cambridge seniors have similar experiences. When asked about the problems they were facing, Cambridge elders mentioned health conditions, loss of a spouse or other loved ones, isolation, depression, not being able to do what they used to do, and difficulties in maintaining a social network.

Elders Comment on Isolation:

"When I go to bed at night, I think, 'Gee, I hope I don't die tonight because people may not find me for weeks and I don't want to leave a mess.' A lot of people think this way."

"On the one side, I live alone so I get lonely. But I cannot have my children [in the same house]; I do not want to be a burden to them."

"My mother taught me to save for a rainy day, but the rainy day is a nursing home and I'm ***not*** *going there."*

Response to the Challenges

This has been a year of challenges for many Cambridge seniors and for the Cambridge Health Alliance efforts in providing comprehensive geriatric services. Economic pressures have limited many services that have helped sustain residents in the community. The Cambridge Health Alliance, through its Geriatrics Division, continues to address these issues by working closely with our community partners to develop and maintain as seamless a system of care as possible for the most vulnerable of our older adult population. The Alliance's Elder Service Plan continues to work with the Cambridge Housing Authority and Cambridge and Somerville Community Apartment Program (CASCAP) to develop low-income assisted living units. Somerville-Cambridge Elder Services is participating in programs funded by the Executive Office of Elder Affairs, which will also help Cambridge seniors who wish to remain in their homes rather than move into institutional care settings covered by Medicare.

On the horizon for the Alliance is the development of a senior care organization, a managed care Medicare and Medicaid program. While Medicare HMOs have shifted prescription drug costs to their members by limiting covered drug benefits, the senior care organization has a pharmacy benefit built into its reimbursement structure. The Cambridge Health Alliance expects to apply for designation as a senior care organization through an upcoming request for proposals process.

Concerted efforts to develop a more organized wellness program for the Alliance as a whole are ongoing. The Geriatric Division has already launched innovative initiatives such as the falls injury prevention program, and will continue to be an active partner in the Alliance-wide effort to promote wellness by reaching out to older adults throughout all Cambridge communities.

Asked about the best things in their lives at this time, seniors mentioned family, friends, and faith; being busy and social; having good health; continuing to learn; the Norfolk Street Home; the freedom to do as they pleased; and happy memories of the past.

Elders Comment on Hope and Growth:

"God has always been here protecting me even when I didn't know he was there."

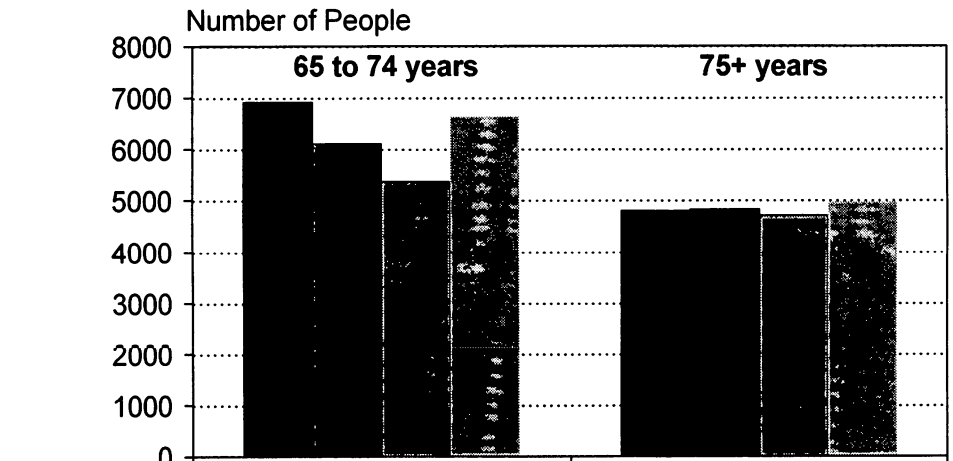
"Books take me places that I'll never go ... I'm very interested in different cultures."

The next section highlights information that is currently available on elders' demographics, access to health and preventative services, and mortality.

DEMOGRAPHICS

Figure 1

Cambridge Population Trends By Age Group

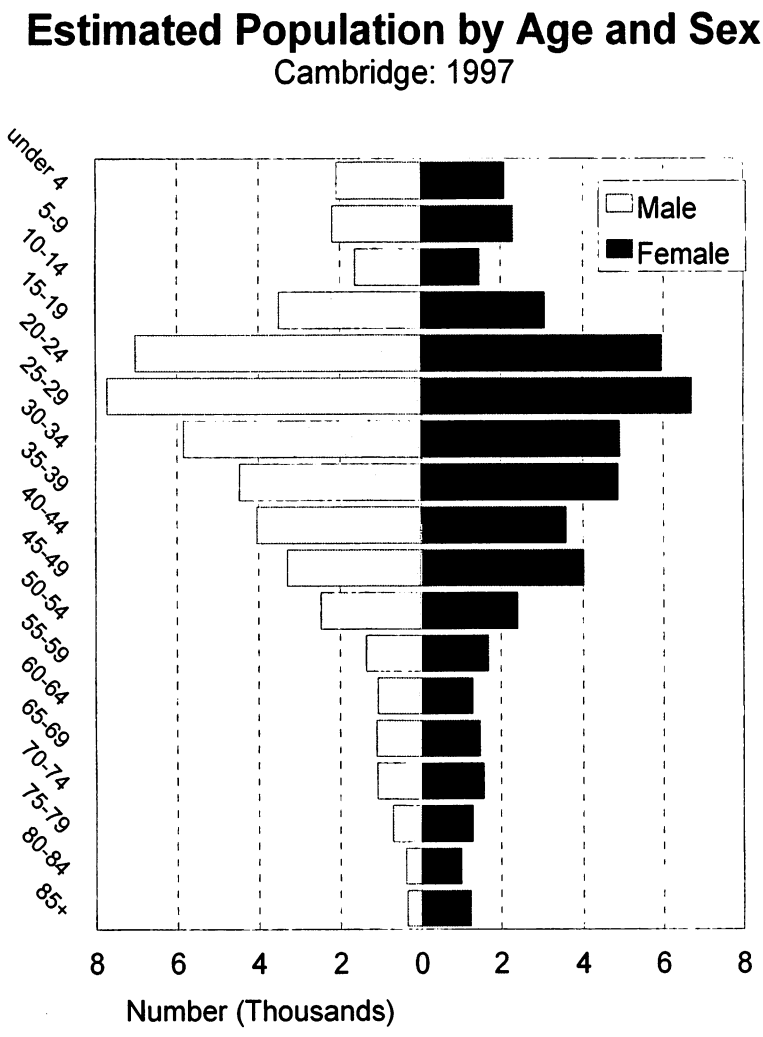


Total Population	65 to 74	75+
1970: 100,361	6898	4802
1980: 95,322	6099	4825
1990: 95,802	5369	4702
1996: 100,563	6623	4957

Source: 1970, 1980, and 1990 populations are from The U.S. Census; 1996 estimates from The Massachusetts Institute for Social and Economic Research (MISER)

The total population of Cambridge declined from 100,361 in the 1970 census to 95,802 (approximately 5%) in 1990. Over the same twenty-year period, the number of Cambridge residents sixty-five to seventy-four years of age declined 22%, and the number of residents age seventy-five or older declined only 2%. In 1990, individuals sixty-five years of age and older accounted for 10.5% of Cambridge residents.

Figure 2

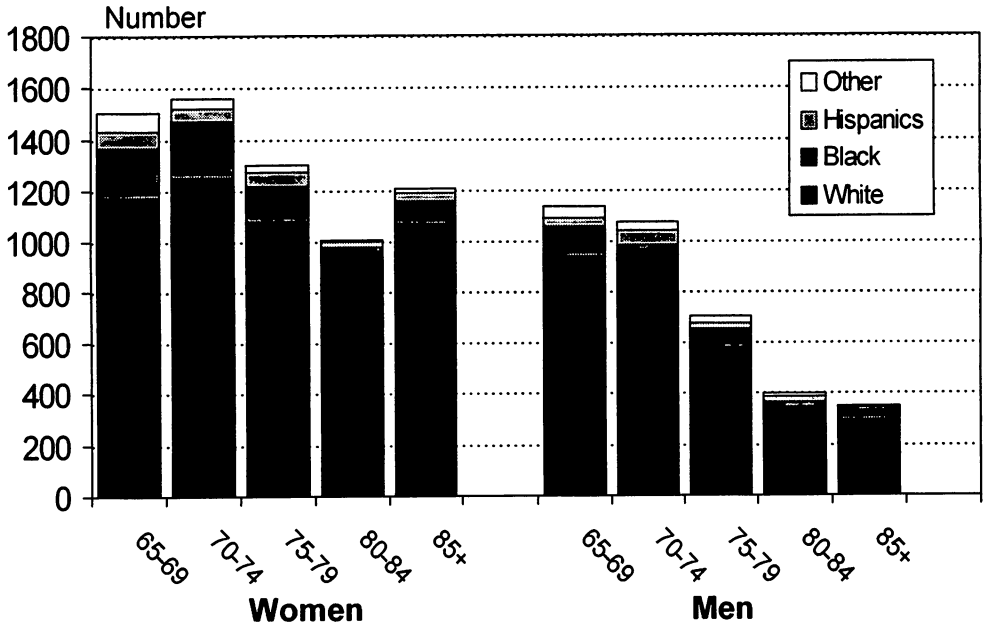


Source: MISER 1997 population projections, MassCHIP, Mass. DPH, v2.2 r201.0 September 12, 1999

In Cambridge in 1997, the peak age group was between twenty-five to twenty-nine years of age, and men outnumbered women in this group. In contrast, women outnumbered men in every age group after age sixty-four.

Figure 3

Cambridge Residents 65 Years and Older By Sex, Race, and Age Group



Source: MISER 1996 estimates, Mass. DPH

In 1996, 67% of Cambridge residents were White and 33% were people of color. The ratio is different among older residents: more than 80% of residents sixty-five years and older were White and less than 20% of that age group were people of color. Among Cambridge residents sixty-five years of age and older, there are more women than men in every age and race category.

Figure 4

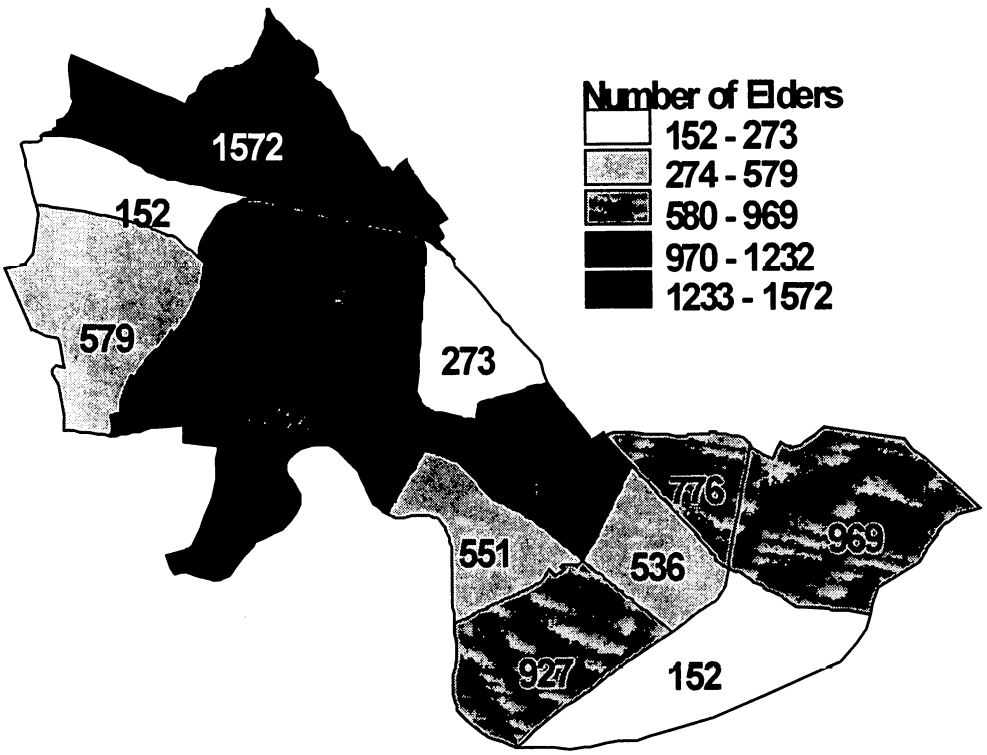
Cambridge Neighborhood Map

1: East Cambridge
2: MIT
3: Wellington-Harrington
4: Area 4
5: Cambridgeport
6: Mid-Cambridge
7: Riverside
8: Agassiz
9: Neighborhood 9
10: Neighborhood 10
11: North Cambridge
12: Cambridge Highlands
13: Strawberry Hill

Figure 5

The Number of Elders in Cambridge

1990 U.S. Census



Total Population age 65 and older N = 9941

There were 9,941 individuals sixty-five years of age or older living in Cambridge in 1990, comprising approximately 10.5% of the total population. The number of elders varied widely by neighborhood. In North Cambridge, there were 1,572 elders, accounting for 15.8% of the residents in that neighborhood. In contrast, only 152 elders were living in the MIT and Cambridge Highlands neighborhoods, comprising 1.5% of the residents in those areas.

Figure 6

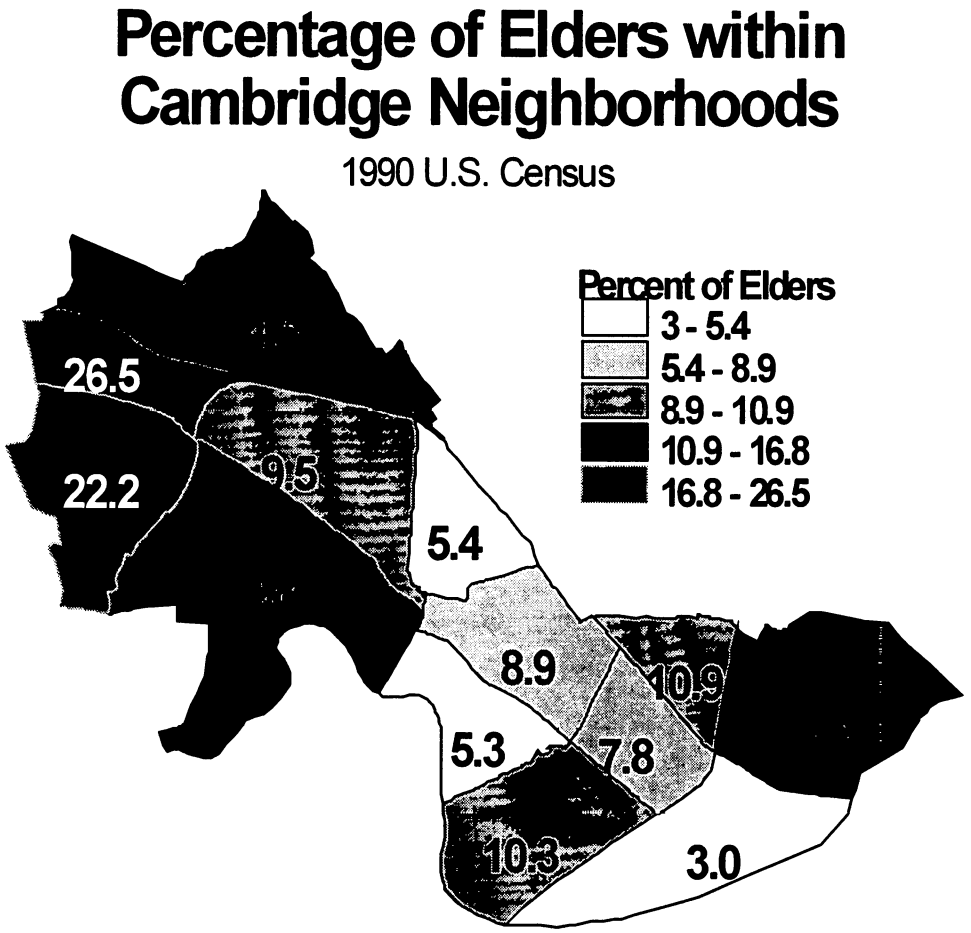
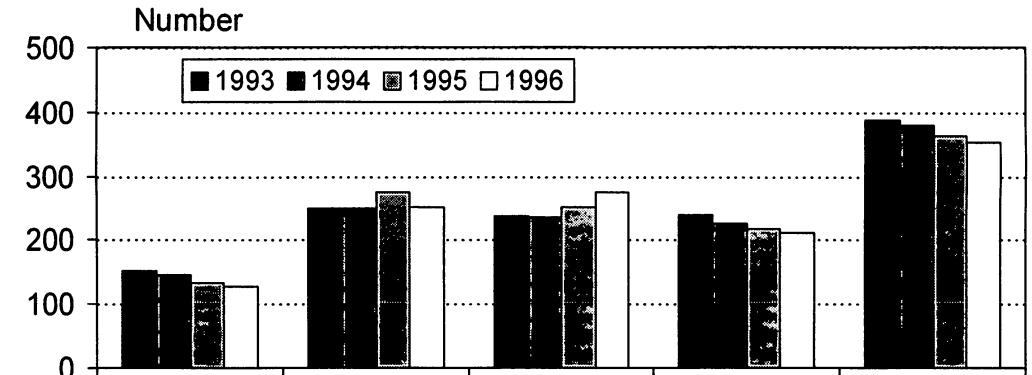

Percentage of Elders within Cambridge Neighborhoods
1990 U.S. Census
Percent of Elders
3 - 5.4
5.4 - 8.9
8.9 - 10.9
10.9 - 16.8
16.8 - 26.5
26.5
22.2
9.5
5.4
8.9
10.9
5.3
7.8
10.3
3.0
Total Population age 65 and older N = 9941

Figure 7

Medicaid Recipients By Age Group

Cambridge: 1993-1996

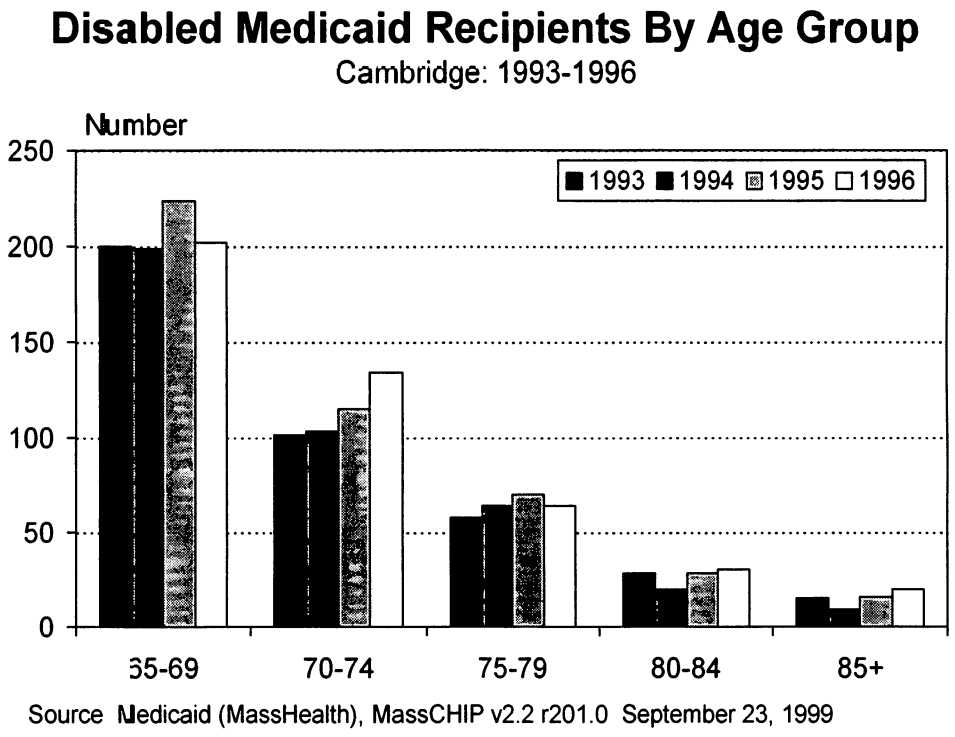


	65-69	70-74	75-79	80-84	85+
1993	152	248	236	238	387
1994	144	248	234	225	379
1995	133	276	251	216	363
1996	126	252	276	211	354

Source: Medicaid (MassHealth), MassCHIP v2.2 r201.0 September 23, 1999

The total number of Medicaid recipients sixty-five years of age and older in Cambridge declined from 1,261 in 1993 to 1,219 in 1996. In each of these years, the greatest percentage of recipients were eighty-five years of age and older.

Figure 8

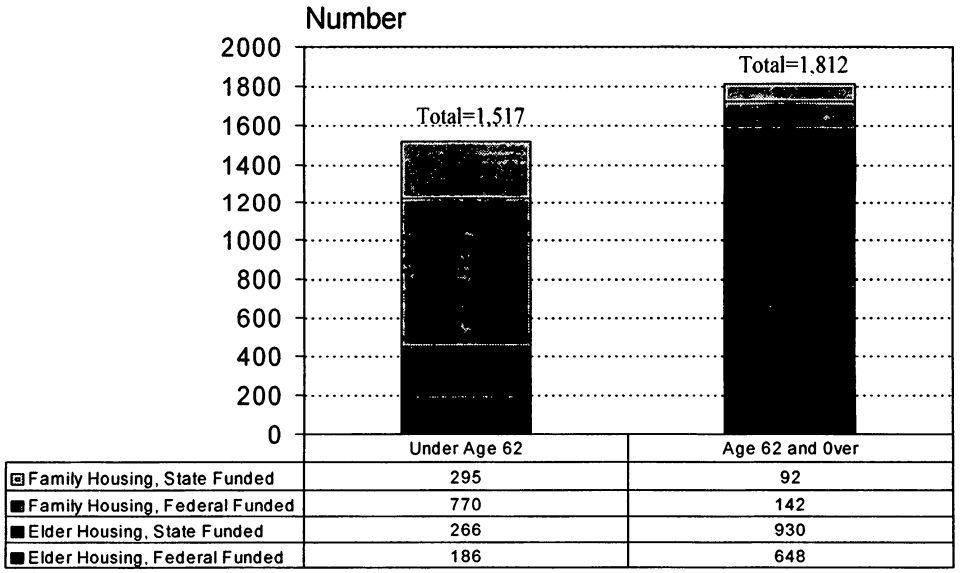


Between 1993 and 1996, most older disabled Medicaid recipients were between sixty-five and sixty-nine years of age, with 200 or more recipients each year in this age group. The number of disabled recipients declined in each of the older age groups, with fewer than fifty recipients each year between age eighty and eighty-four and those eighty-five years of age and older.

Figure 9

Public Housing Units Headed By Elders*

Cambridge: 1998



	Under Age 62	Age 62 and Over
Family Housing, State Funded	295	92
Family Housing, Federal Funded	770	142
Elder Housing, State Funded	266	930
Elder Housing, Federal Funded	186	648

* aged 62+ years

Source: Cambridge Housing Authority, Cambridge, MA

In November of 1998, there were 1,812 households headed by a person sixty-two years of age or older in state and federally funded public housing in Cambridge. Among these households, 1,578 lived in housing designated for the elderly and disabled, and the remainder were in family housing.

ACCESS TO HEALTH AND PREVENTIVE SERVICES

The national health goals for the United States for the year 2000[1] include the objective of ensuring that 95% of the population has a specific source of ongoing primary care to coordinate both preventive and episodic health care. Comprehensive health insurance has a strong influence over access to health care, an important factor in maintaining good health. Comprehensive health insurance includes not only coverage for hospitalization and primary care but also coverage for medications, psychiatric services, eyeglasses, dental care, and long-term care. Individuals who do not have health insurance are less likely to have a regular source of medical care; they have a much lower use of health services including doctor visits, and are more likely to receive care in hospital emergency departments. Individuals without health insurance are more likely to postpone needed care, to be refused care for financial reasons, and to have worse health outcomes. Furthermore, individuals who lack health insurance have more preventable hospitalizations for asthma, pneumonia, complications of diabetes, and other conditions.

The data presented on the next fifteen pages provide statistical information regarding access to care for Cambridge seniors. Data on indicators such as preventable hospital admissions serve as an indirect measure of primary care delivery: hospitalizations for congestive heart failure and bacterial pneumonia, for example, may be prevented if earlier conditions such as hypertension and bronchitis are managed well on an out-patient basis. Collection of data on routine health screening practices (such as breast exams and mammograms, Pap tests, fecal occult blood tests) would also provide important information about access to primary care services.

1 Healthy People 2000 Review, 1998-99. National Center for Health Statistics, 1999
2 U.S. Census, 1998

Table 1

YEAR 2000 OBJECTIVES FOR THE ELDERLY, CAMBRIDGE AND MASSACHUSETTS

* = *Data not available*	Cambridge Rate	Mass. Rate	HP2000 Goal
High Blood Pressure, Controlled			
People 65 years and over	*	47%[1]	50%
65 to 74 years	*	49%	(18-74 years)
75 years and over	*	43%	
Edentulous			
People 65 years and over	*	23%[1]	20%
65 to 74 years	*	19%	
75 years and over	*	28%	
Annual Dental Visit			
People 65 years and over	*	68%[1]	60%
65 to 74 years	*	74%	
75 years and over	*	61%	
Breast Examination and Mammogram (Received within preceding 1 to 2 years)			
Females 65 years and over	*	68%[1]	60%
65 to 74 years	*	76%	(50 years and over)
75 years and over	*	60%	
Pap Test (Received within preceding 3 years)			
Women 65 years and over	*	72%[1]	85%
65 to 74 years	*	80%	(18 years and over)
75 years and over	*	63%	

[1] 1997-1998 Massachusetts Behavioral Risk Factor Surveillance Survey (BRFSS), Mass. DPH.

YEAR 2000 OBJECTIVES FOR THE ELDERLY, CAMBRIDGE AND MASSACHUSETTS *CONTINUED*

* = *Data not available*	Cambridge Rate	Mass. Rate	HP2000 Goal
Fecal Occult Blood Test			
(Received within preceding 2 years)			
People 65 years and over	*	36%[2]	50%
65 to 74 years	*	39%	(over 49)
75 years and over	*	33%	
Proctosigmoidoscopy			
(Ever received)			
People 65 years and over	*	41%[2]	40%
65 to 74 years	*	43%	
75 years and over	*	38%	
Clinical Preventive Services			
Routine checkup[1]			
People 65 years and over	*	91%[2]	91%
65 to 74 years	*	91%	
75 years and over	*	90%	
Pneumococcal vaccine in lifetime			
People 65 years and over	*	54%[2]	60%
65 to 74 years	*	50%	
Influenza Vaccine in the last 12 months			
People 65 years and over	*	66%[2]	60%
65 to 74 years	*	63%	
75 years and over	*	70%	

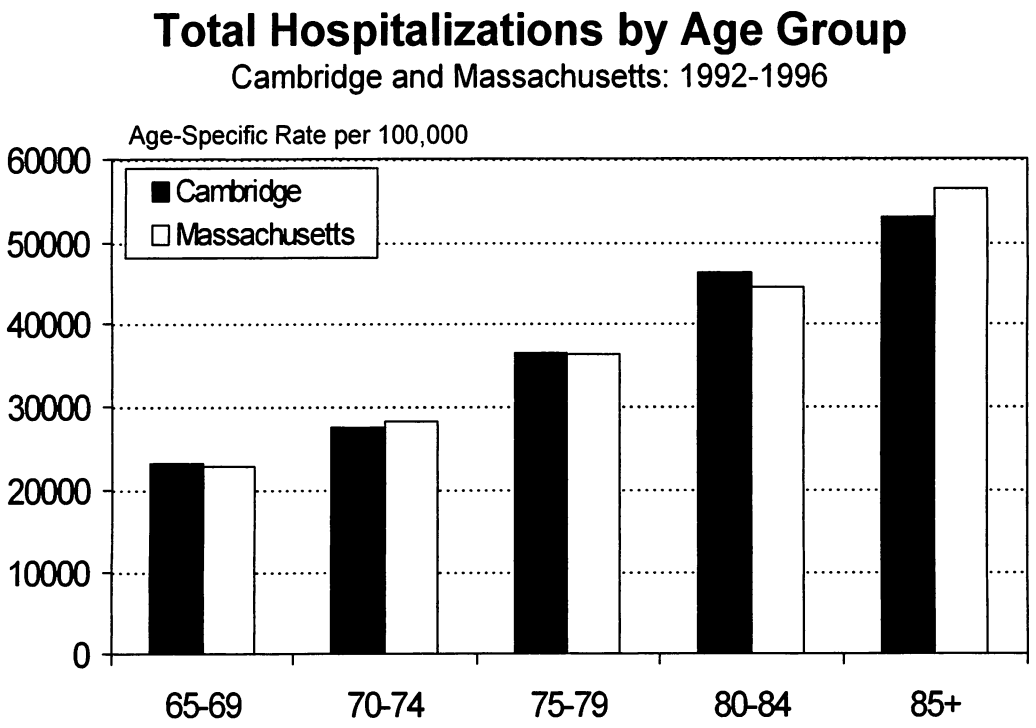
[1]In the last 3 years for people 18-64 and in the last year for people 65 years and over.
[2]1997-1998 Massachusetts Behavioral Risk Factor Surveillance Survey (BRFSS), Mass. DPH.

YEAR 2000 OBJECTIVES FOR THE ELDERLY, CAMBRIDGE AND MASSACHUSETTS *CONTINUED*

	Cambridge Rate	Mass. Rate	HP2000 Goal
* = *Data not available*			
Hip Fractures Among Adults			
65 Years and Older[1] (Per 100,000)	820[1]	874[1]	607
65 to 74 years	269	254	
75 years and over	1,405	1,578	
White female 85 years and over	2,488	3,359	2,177
Proctosigmoidoscopy			
(Ever received)			
People 65 years and over	*	41%[1]	40%
65 to 74 years	*	43%	
75 years and over	*	38%	
No leisure time activity			
People 65 years and over	*	42%[1]	22%
65 to 74 years	*	32%	
75 years and over	*	54%	
People with Difficulty performing Self-care Activities (Per 1000)[2]			
People 65 years and over	120.1	112.2	90
With a mobility limitation (Per 1000)[2]			
People 65 years and over	158.4	146.1	*

[1] National Hospital Discharge Survey, CDC, NCHS for Healthy 2000 goal; Cambridge and Massachusetts data are from Hospital discharges 1996, MassCHIP, Mass. DPH, v2.2 r201.0 October 6 1999.
[2] 1990 Census

Figure 10



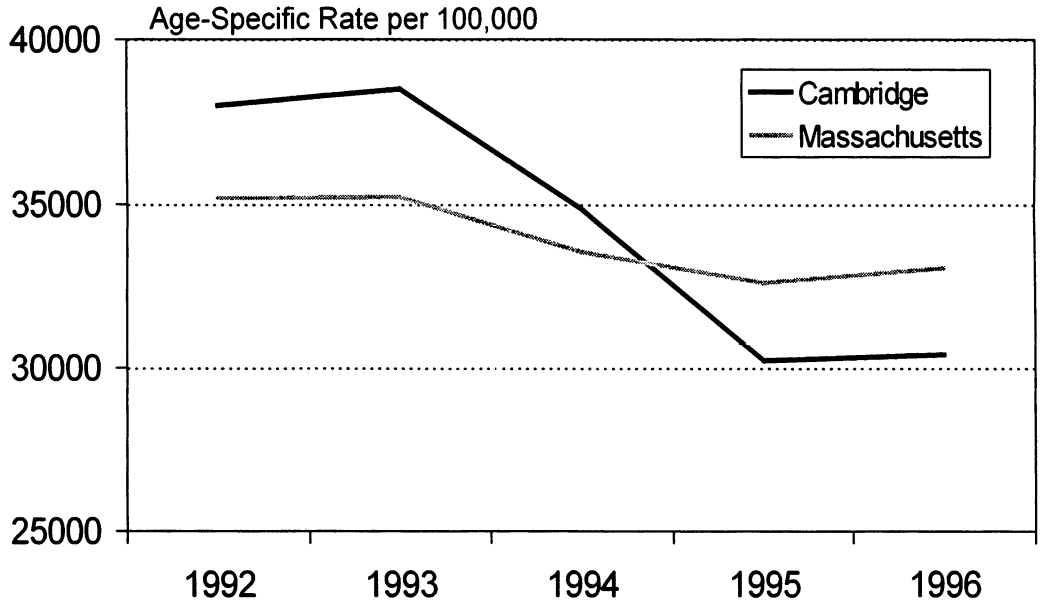
Source: Uniform Hospital Discharge Data Set, MassCHIP v2.2 r201.0 September 23, 1999

Rates of hospitalization increased with age in both Cambridge and Massachusetts. Among residents sixty-five years of age and older, the annual rate of hospitalization increased for each five-year age group. Among those sixty-five to sixty-nine years of age, the rate of hospitalization is just over 20,000 per 100,000. This rate rose to more than 50,000 per 100,000 among those eighty-five years of age and older.

Figure 11

Total Hospitalization Rates 65+ Years of Age

Cambridge and Massachusetts: 1992-1996



Source: Uniform Hospital Discharge Data Set, MassCHIP v2.2 r201.0 September 23, 1999

Between 1992 and 1996, the rate of hospitalization among residents sixty-five years of age and older decreased both in Cambridge and statewide. In Cambridge, total hospitalization rates fell from 38,019 per 100,000 in 1992 to 30,410 per 100,000 in 1996; statewide rates declined from 35,200 to 33,048 per 100,000 over the same period. This 20% decline may reflect changing medical practice rather than improved health of the population.

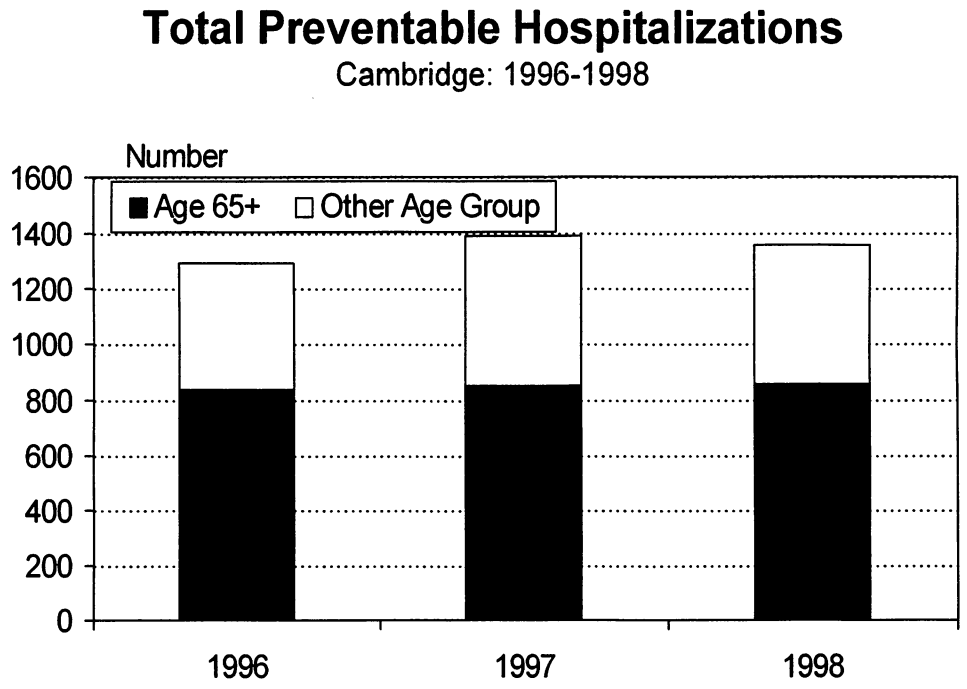
Table 2

Leading Preventable Hospitalizations
Cambridge Residents (age 65+): 1998

Condition	Total Number	Percentage of All Admissions by Age Category (%)				
		65-69	70-74	75-79	80-84	85+
Congestive Heart Failure	279	10.0	14.3	15.8	21.5	20.4
Bacterial Pneumonia	269	7.4	9.3	13.0	12.3	24.5
Kidney/UTI*	163	4.3	9.8	9.8	17.8	23.3
COPD**	140	17.9	16.4	17.1	10.7	10.0
Cellulitis	106	6.6	11.3	8.5	8.5	6.6
Dehydration	100	9.0	6.0	17.0	13.0	24.0
Asthma	98	7.1	7.1	1.0	2.0	1.0
Convulsions	73	11.0	11.0	13.7	6.9	13.7
Diabetes	61	6.6	14.8	13.1	9.8	0.0
Angina	27	14.8	18.5	18.5	7.4	7.4

* UTI: Urinary Tract Infections
**COPD: Chronic Obstructive Pulmonary Disease
Source: Mass. Division of Health Care Finance and Policy

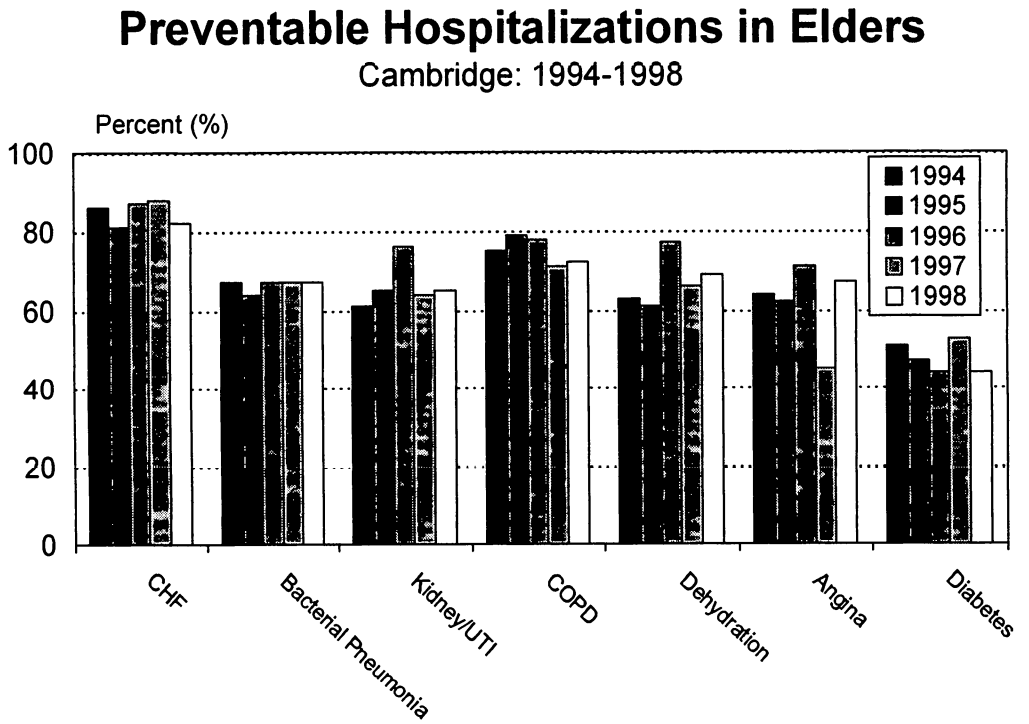
Figure 12



Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

Approximately 60% of all preventable hospitalizations between 1996 and 1998 occurred among individuals sixty-five years of age or older.

Figure 13



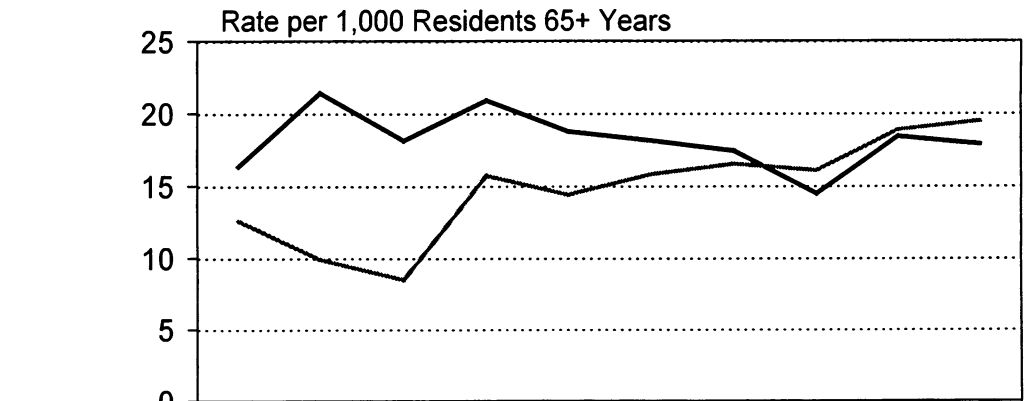
Note: Elders = Individuals age 65 and older
Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

Many preventable hospitalizations could be avoided through effective primary care. Even among older adults whose treatment may be complicated by frailty, some hospitalizations are preventable. Although residents sixty-five years of age or older make up approximately 10.5% of the Cambridge population, they accounted for 40% or more of hospitalizations for diabetes; 60% or more of hospitalizations for angina, dehydration, kidney/urinary tract infection (UTI), and bacterial pneumonia; 70% or more of hospitalizations for chronic obstructive pulmonary disease (COPD); and 80% or more of hospitalizations for congestive heart failure (CHF).

Figure 14

Bacterial Pneumonia Hospitalization Rates 65+ Years of Age

Cambridge and Massachusetts: 1989-1998



	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Cambridge	16.34	21.4	18.14	20.88	18.73	18.09	17.44	14.5	18.4	17.9
Mass.	12.56	9.95	8.52	15.67	14.38	15.78	16.54	16.1	18.8	19.5

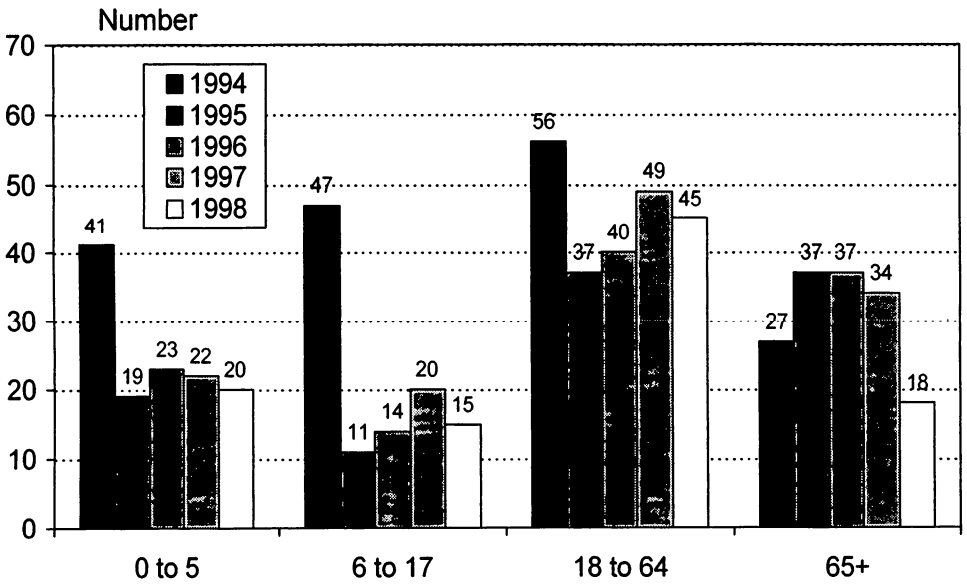
Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

Since 1992, there has been a general decrease in hospitalizations for pneumonia among the elderly in Cambridge. Preventive measures such as influenza and pneumonococcal vaccination, early treatment of bronchitis, and reduced cigarette smoking may be factors in this trend.

Figure 15

Asthma Hospitalizations by Age and Year

Cambridge: 1994-1998



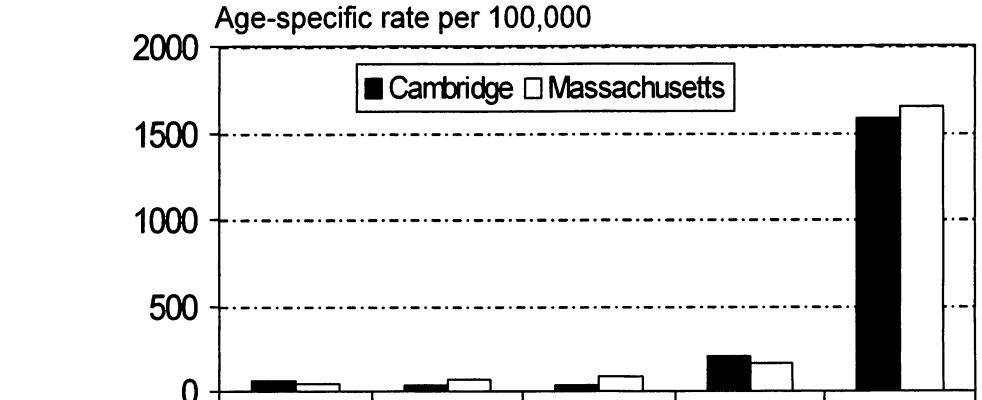
Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

The number of asthma hospitalizations for people under sixty-five years of age peaked in 1994. However among people sixty-five years of age and older, while only twenty-seven individuals were hospitalized due to asthma in 1994, hospitalizations increased in subsequent years followed by a sharp decrease in 1998.

Figure 16

Hospitalizations Due to Falls by Age

Cambridge and Massachusetts: 1998

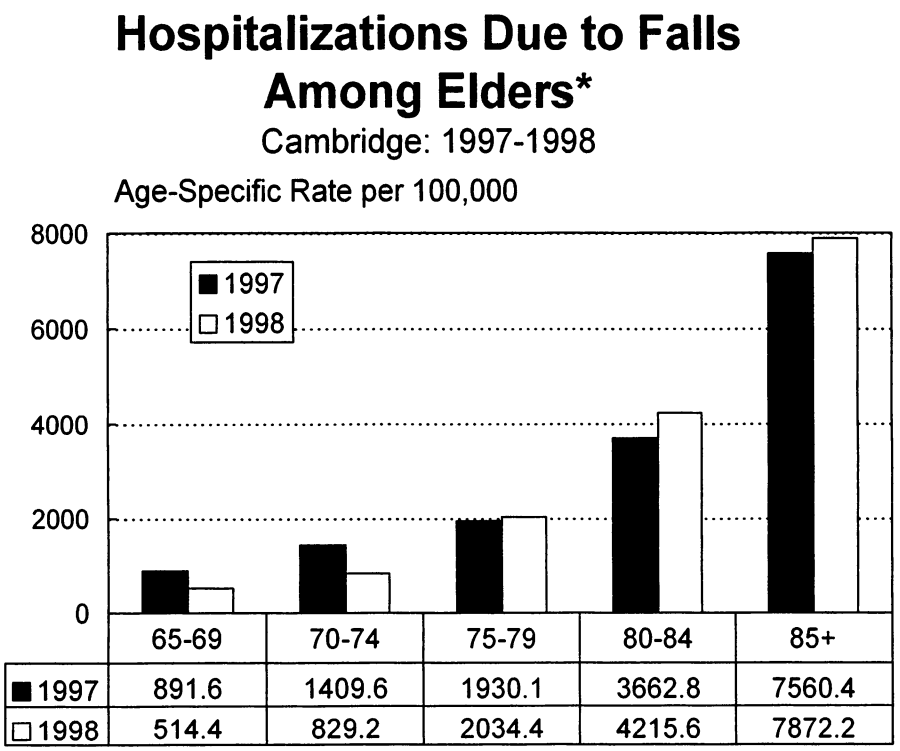


	0-14	15-24	25-44	45-64	65+
Cambridge	59	31	31	204	1578
Massachusetts	46	68	85	164	1650

Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

The rate of hospitalizations for falls increased dramatically with advancing age. In Cambridge and statewide the rate is consistently low for residents less than sixty-five years of age (below 223 per 100,000). For individuals sixty-five years of age and older, the rate jumps to approximately 1,578 per 100,000 Cambridge residents and 1,650 per 100,000 Massachusetts residents.

Figure 17



	65-69	70-74	75-79	80-84	85+
■1997	891.6	1409.6	1930.1	3662.8	7560.4
□1998	514.4	829.2	2034.4	4215.6	7872.2

*Elders = Individuals age 65 and older

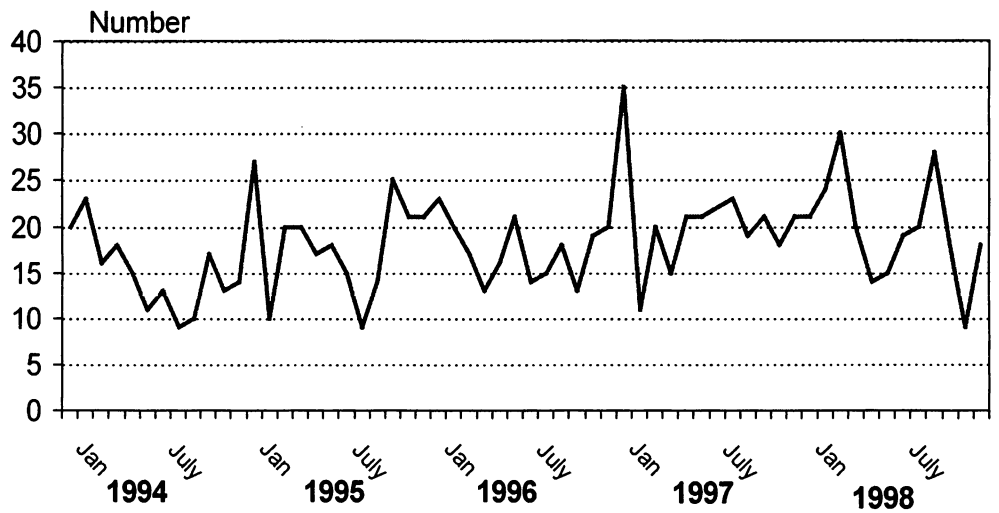
Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

The number of hospitalizations due to falls increased with age among older Cambridge residents. The largest number of hospitalizations for falls occurred among individuals eighty-five years of age or older.

Figure 18

Fall-Related Hospitalizations Among Elders*

Cambridge: 1994-1998



Note: Elders = Individuals age 65 and older

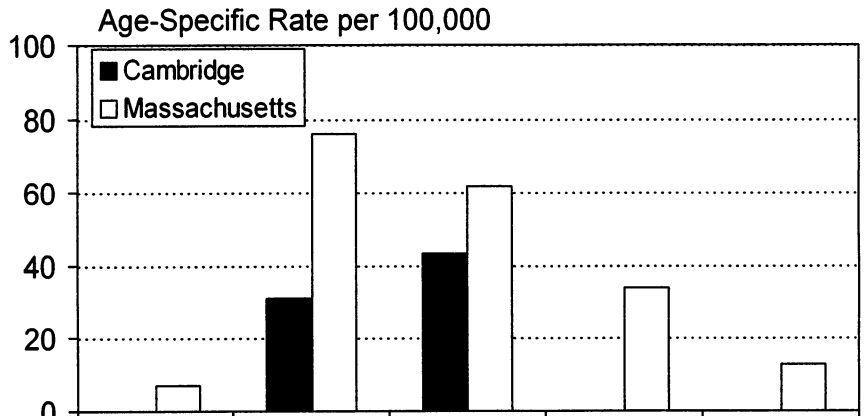
Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

Fall-related hospitalizations among Cambridge residents sixty-five years of age and older showed only a small increase during the winter months when ice and snow can make walking outdoors more hazardous. These data are consistent with the results of a Health of the City study of hospitalizations for falls conducted at the Cambridge and Somerville Hospitals, which found that 83% of falls among the elderly occurred indoors.

Figure 19

Self-Inflicted Injury Hospitalizations by Age

Cambridge and Massachusetts: 1998



	0-14	15-24	25-44	45-64	65+
■ Cambridge	*	31	43	*	*
□ Massachusetts	7	76	62	34	12.7

* =less than five cases

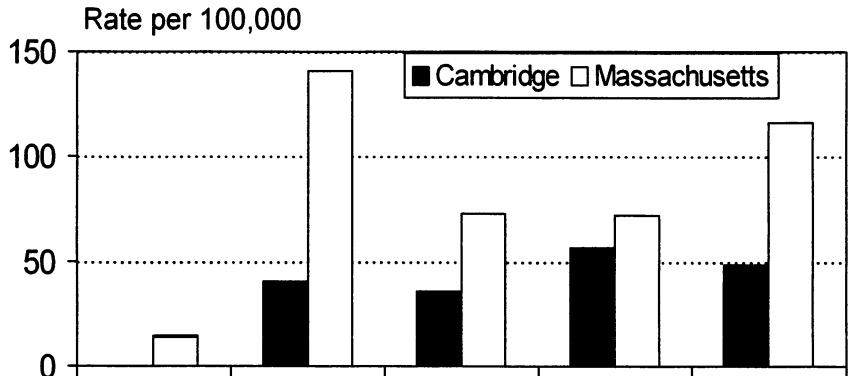
Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

Rates of hospitalization for self-inflicted injury in Cambridge were highest in the twenty-five to forty-four age group. There were no reported hospitalizations for self-inflicted injury for Cambridge residents younger than fourteen or older than sixty-four.

Figure 20

Motor Vehicle Injury Hospitalizations by Age

Cambridge and Massachusetts: 1998



	0-14	15-24	25-44	45-64	65+
■ Cambridge	*	41	36	57	49
□ Massachusetts	15	141	73	72	116

* =less than five cases

Source: Uniform Hospital Discharge Data Set, Division of Health Care Finance and Policy

Rates of motor vehicle injury hospitalizations were lower in Cambridge than rates statewide in all age groups, including those sixty-five years of age and older.

MORTALITY

Heart disease and cancer were the leading causes of death for Cambridge residents sixty-five years of age and older between 1993 and 1997. Cancer accounted for slightly more deaths before age seventy-five, while heart disease was the leading cause of death for individuals seventy-five years of age and older. For residents sixty-five years of age and older, the death rates for these conditions were higher for males than females, and for Blacks than Whites.

The next ten pages provide mortality data regarding heart disease and cancer, as well as other causes of death for residents sixty-five years of age or older, including influenza and pneumonia, chronic obstructive pulmonary disease, diabetes, cerebrovascular disease, motor vehicle-related injuries, and self-inflicted injuries.

Table 3

YEAR 2000 OBJECTIVES FOR THE ELDERLY: CAMBRIDGE AND MASSACHUSETTS

* = *Data not available*	Cambridge Rate	Mass. Rate	HP2000 Goal
Suicide[1]			
Age specific per 100,000			
People 65 years of age and older	9.8	8.8	10.5
Motor Vehicle Crash Deaths[1]			
Age specific per 100,000			
People 65 years of age and older	9.8	14.2 (70 years and older)	20.0
Fall-Related Deaths[1]			
Age specific per 100,000			
People 65 to 84 years	13.8	17.5	14.4
People 85 years of age and older	106.0	159.2	105.0

[1] Mortality 1993-97, MassCHIP, v2.2 r201.0, October. 29, 1999

Table 4

LEADING CAUSES OF MORTALITY, CAMBRIDGE RESIDENTS(AGE 65+): 1993-1997

Age	Cause of Death	Number	Age-Specific Rate per 100,000
65-74 years	Cancer	229	867.8
	Heart Disease	189	716.2
	COPD	38	144.0
	Diabetes	27	102.3
	Influenza/Pneumonia	19	72.0
	Cerebrovascular Disease	14	53.1
	Chronic Liver Disease/Cirrhosis	11	41.7
	Unintentional Injury[1]	7	26.5
	Atherosclerosis	2	7.6
	Suicide	1	3.8
	All Other Causes	117	495.8
	Total	654	2478.0
75-84 years	Heart Disease	278	1637.2
	Cancer	214	1260.3
	COPD	49	288.6
	Influenza/Pneumonia	49	288.6
	Cerebrovascular Disease	40	235.6
	Diabetes	32	188.5
	Unintentional Injury[1]	11	64.8
	Chronic Liver Disease/Cirrhosis	5	29.5
	Atherosclerosis	1	5.9
	Suicide	1	5.9
	All Other Causes	193	1142.0
	Total	873	5141.3
85+ years	Heart Disease	333	4410.6
	Cancer	130	1721.9
	Cerebrovascular Disease	89	1178.8
	Influenza/Pneumonia	81	1072.9
	COPD	27	357.6
	Diabetes	26	344.4
	Unintentional Injury[1]	16	211.9
	Atherosclerosis	6	79.5
	Suicide	3	39.7
	Chronic Liver Disease/Cirrhosis	2	26.5
	All Other Causes	264	3520.0
	Total	977	12940.4

[1] Includes motor vehicle-related deaths.

Source: Mortality (Vital Records), MassCHIP, Mass. DPH v2.2 r201.1, September 23, 1999

Table 5

LEADING CAUSES OF DEATH BY RACE/ETHNICITY AND GENDER AMONG ELDERS, AGED 65+, CAMBRIDGE: 1993-1997

		Race/Ethnicity*			
		Total	**White**	**Black**	**Hispanic**
All Causes					
Total	n	2501	2155	291	17
	rate	4892.4	5090.4	5290.9	906.7
Males	n	1051	889	127	11
	rate	5762.1	5862.2	7236.5	1538.5
Females	n	1450	1266	1640	6
	rate	4410.0	4659.6	4379.2	517.2
Heart Disease					
Total	n	800	689	97	6
	rate	1564.9	1627.5	1763.6	320.0
Males	n	337	284	43	5
	rate	1847.6	1872.7	2450.1	699.3
Females	n	463	405	54	<5
	rate	1408.2	1490.6	1441.9	*
Cancer					
Total	n	573	482	74	5
	rate	1120.9	1138.5	1345.5	266.7
Males	n	272	225	34	<5
	rate	1491.2	1483.7	1937.3	*
Females	n	301	2570	40	<5
	rate	915.5	945.9	1068.1	*

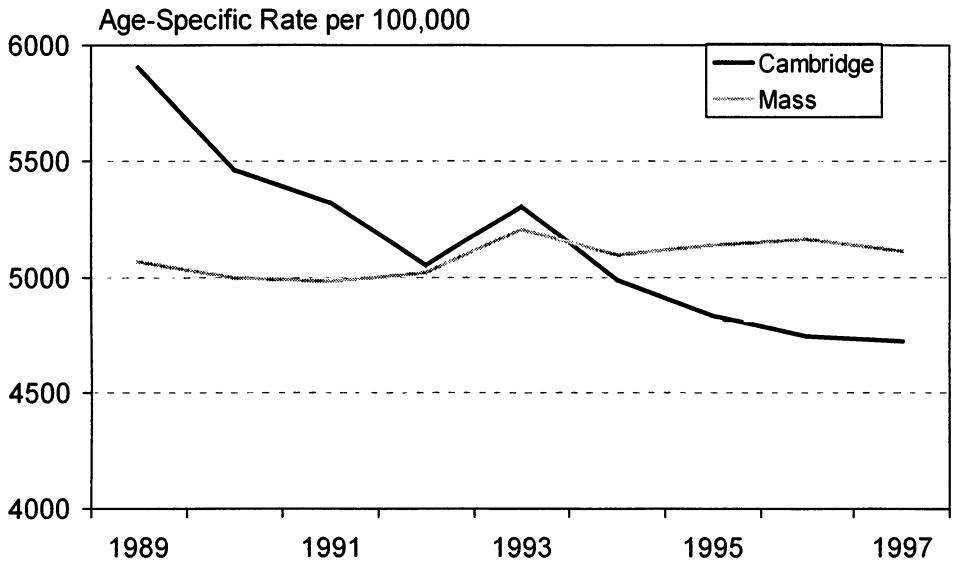
Rates are age, sex, and race specific per 100,000 residents based on 1996 MISER population estimate. The number of deaths s summed between 1993 to 1997.
*Cannot report for categories with small numbers (<5).

Source: Mortality (Vital Records), MassCHIP, Mass. DPH v2.2 r201.1, September 23, 1999

Figure 21

Death Rate of Elders

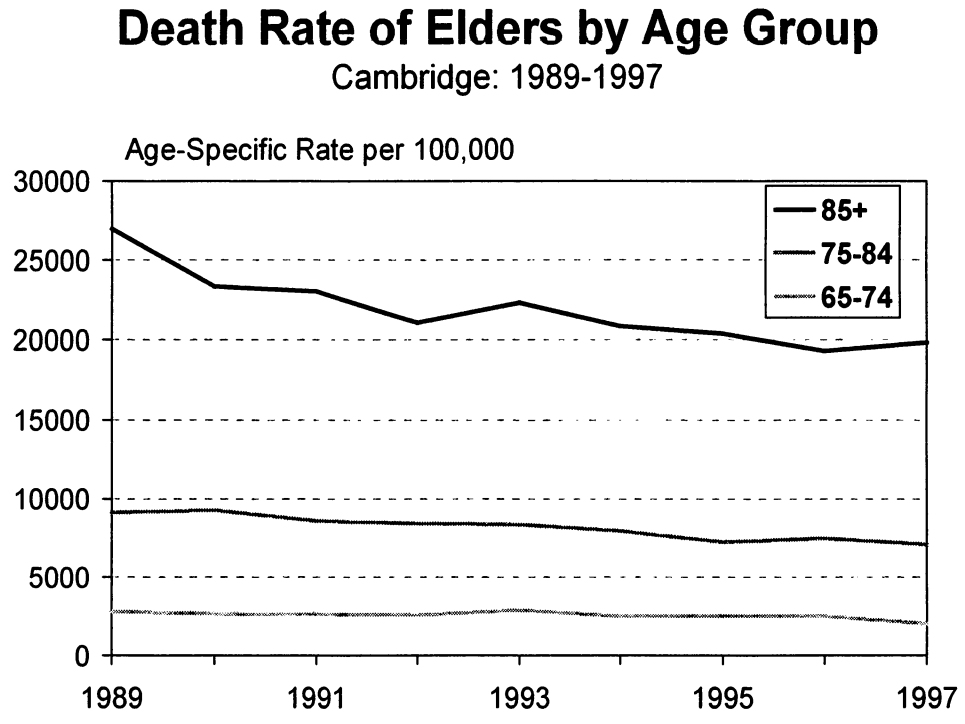
Cambridge and Massachusetts: 1989-1997



Source: Mortality (Vital Records), MassCHIP, Mass. DPH v2.2 r201.1, September 23, 1999

Between 1989 and 1997, the age-specific death rate for Cambridge residents sixty-five years of age and older fell from 5,902 to 4,724 per 100,000. During the same period, the age-specific death rate for Massachusetts remained at approximately 5,000 per 100,000.

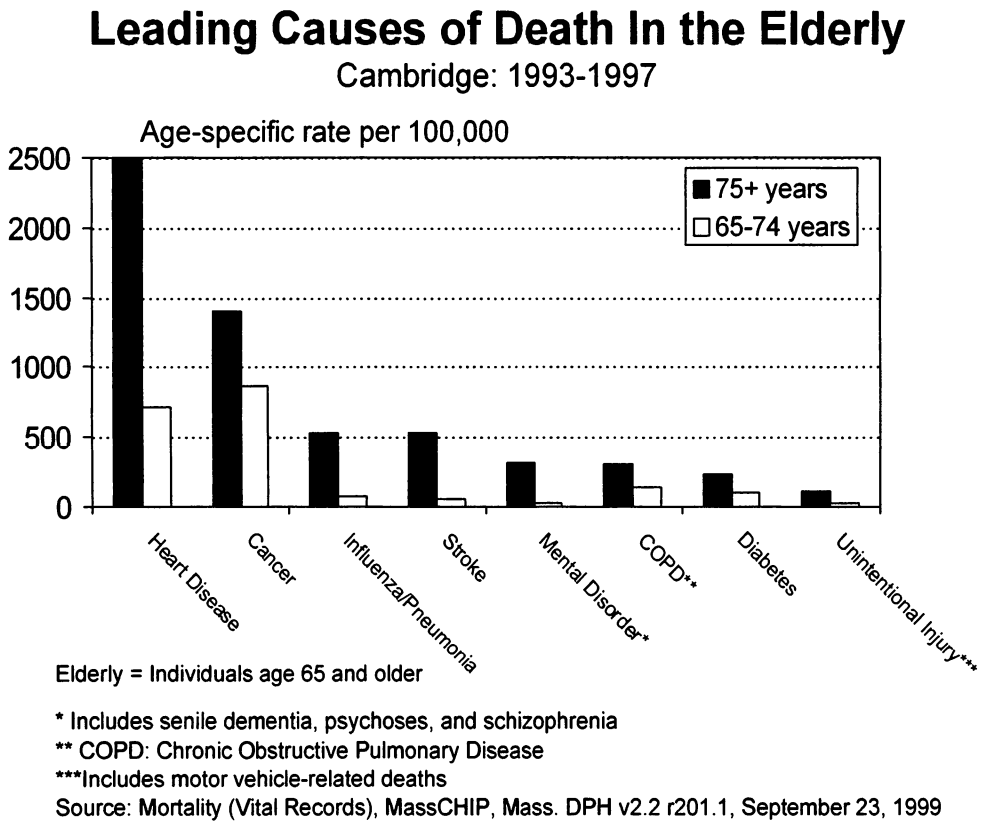
Figure 22



Source: Mortality (Vital Records), MassCHIP, Mass. DPH v2.2 r201.1, September 23, 1999

The age-specific death rate for Cambridge residents sixty-five years of age and older decreased between 1989 and 1997. The sharpest decline was among individuals eighty-five years of age and older: that rate decreased from 17,835 to 12,806 deaths per 100,000.

Figure 23

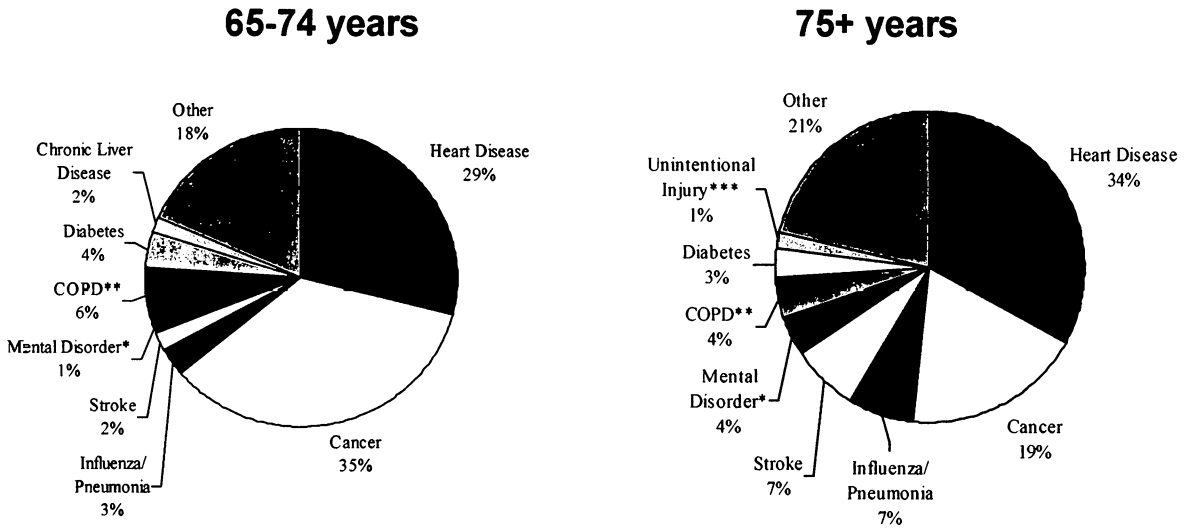


Heart disease and cancer were the leading causes of death for Cambridge residents sixty-five years of age and older from 1993 to 1996. More individuals in the age group sixty-five to seventy-four died of cancer than heart disease, but among those seventy-five years of age and older, there were almost twice as many deaths from heart disease as from cancer.

Figure 24

Causes of Death Among Residents Aged 65 Years and Over

Cambridge: 1993-1997



* Includes senile dementia, psychoses, and schizophrenia
** COPD: Chronic Obstructive Pulmonary Disease
***Includes motor vehicle-related deaths
Source: Mortality (Vital Records), MassCHIP, Mass. DPH v2.2 r201.1, September 23, 1999

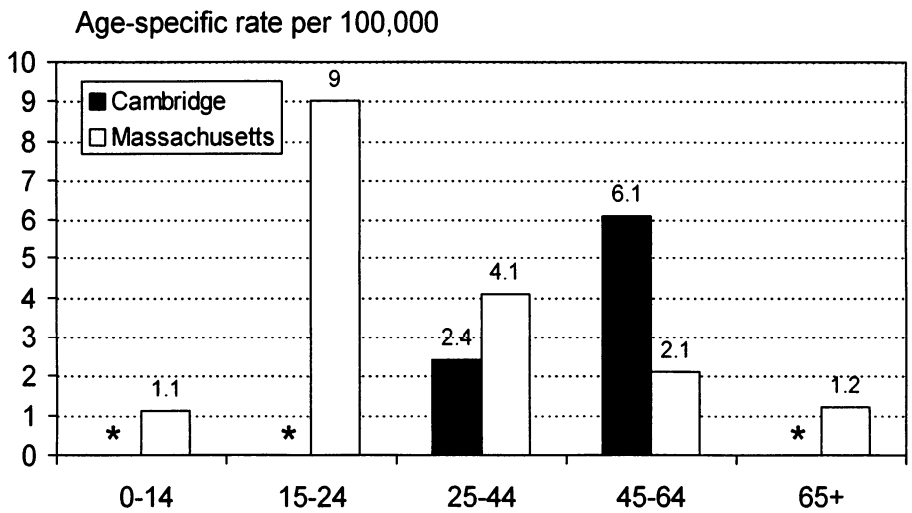
Heart disease and cancer were the leading causes of death among Cambridge residents sixty-five years of age and older between 1993 and 1997. Cancer was the primary cause of death for individuals between sixty-five and seventy-four years of age. For individuals seventy-five years of age or older, heart disease was the most common cause of death.

There were 649 deaths in Cambridge in 1997: of those deaths, 485 (75%) were individuals sixty-five years of age or older, and 205 (32%) were residents eighty-five years of age or older.

Figure 25

Homicide Rate by Age

Cambridge and Massachusetts: 1993-1997



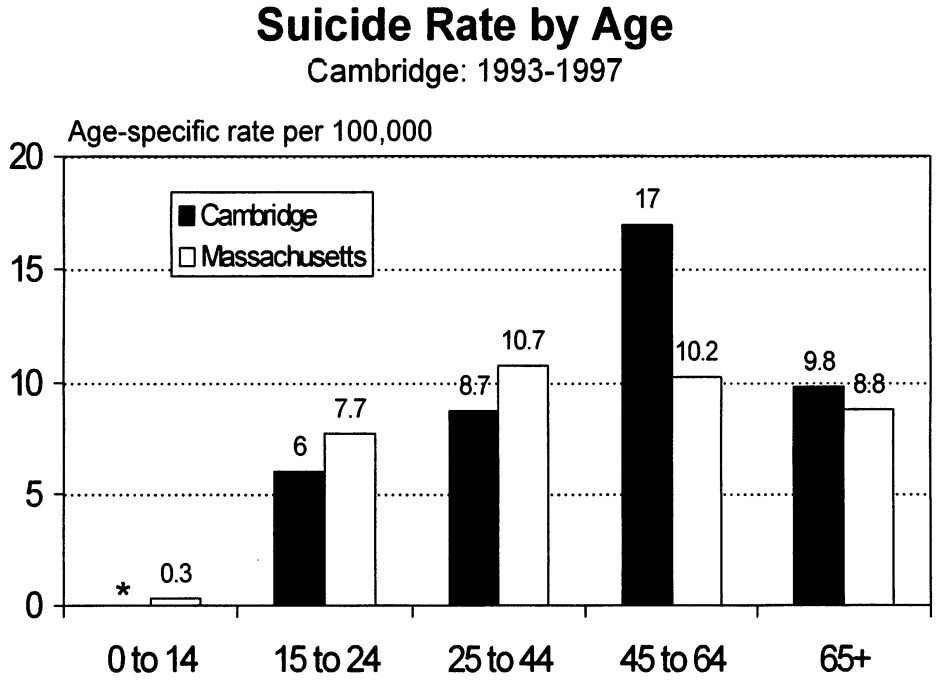
* Column not shown because total number is less than 5

Total number of homicides for Cambridge 1993 to 1997 = 13.

Source: Mortality (Vital Records), MassCHIP, Mass. DPH, v2.0 r201.0, September 23, 1999.

The homicide rate was lower among those sixty-five years of age and older than the rate among Cambridge residents twenty-five to sixty-four years of age. The rate in Massachusetts was 1.2 homicides per 100,000 in this older group. It was not possible to calculate a meaningful rate for homicides among Cambridge residents sixty-five years of age and older because the number of homicides in this age group is too small.

Figure 26



* Column not shown because total number is less than 5

Total number of suicides for Cambridge, 1993 to 1997 = 44.

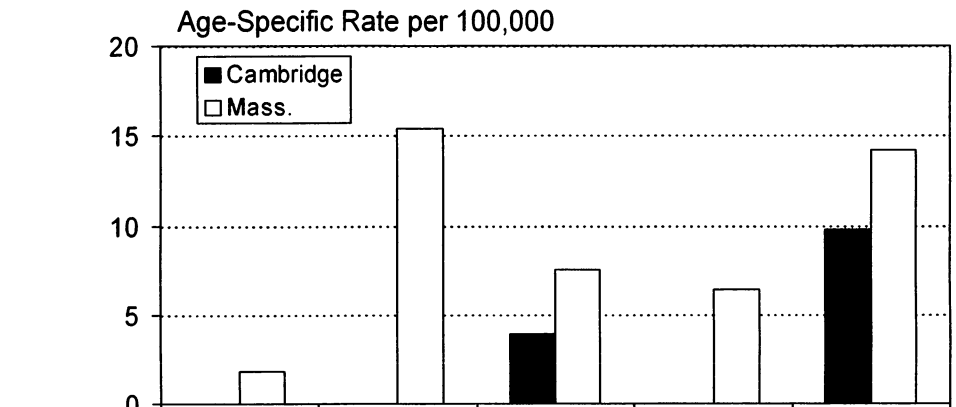
Source: Mortality (Vital Records). MassCHIP v2.2 r201.0, September 23, 1999.

Among people sixty-five years of age and older, the suicide rate was 9.8 per 100,000 in Cambridge, and 8.8 per 100,000 statewide between 1993 and 1997. During this time period there were a total of forty-four suicides by Cambridge residents, including five suicides among elders. With such small numbers, the rates could be unstable and caution should be used in comparing rates by age group.

Figure 27

Motor Vehicle-Related Death Rate by Age

Cambridge and Massachusetts: 1993-1997



	0-14	15-24	25-44	45-64	65+
■Cambridge	*	*	3.9	*	9.8
□Mass.	1.8	15.4	7.5	6.4	14.2

* n < 5

Total number of motor vehicle-related deaths for Cambridge 1993 to 1997 = 18.

Source: Mortality (Vital Records), MassCHIP, Mass. DPH, v2.2 r201.0, September 23, 1999.

Motor vehicle-related deaths were consistently lower in Cambridge than statewide; however, in Cambridge the rate of motor vehicle-related death was highest among residents sixty-five years of age and older.

Appendix: Data Sources

Massachusetts Department of Public Health

AIDS Surveillance Program
Bureau of Communicable Disease Control
305 South Street
Jamaica Plain, MA 02130

Bureau of Substance Abuse Services
250 Washington Street
Boston, MA 02108

Childhood Lead Poisoning Prevention Program
470 Atlantic Avenue
Boston, MA 02210

Division of Sexually Transmitted Disease Control
Bureau of Communicable Disease Control
305 South Street
Jamaica Plain, MA 02130

Massachusetts Community Health Information Profile
(MassCHIP)
250 Washington Street
Boston, MA 02108

Registry of Vital Records and Statistics
Bureau of Health Statistics, Research and Evaluation
470 Atlantic Avenue
Boston, MA 02210

Additional State Source

Division of Health Care Finance and Policy (Uniform Hospital Discharge Data Set)
Two Boylston Street
Boston, MA 02116

Local Sources

Cambridge Housing Authority
675 Massachusetts Avenue
Cambridge, MA 02139

Local Sources - *continued*

Cambridge Community Development Department
(1990 U.S. Census data, MISER estimates)
57 Inman Street
Cambridge, MA 02139

Charles River Watershed Association
2391 Commonwealth Avenue
Auburndale, MA 02466

Teen Health Survey
Cambridge Public Schools
159 Thorndike Street
Cambridge, MA 02141

Access and Affordability Monitoring Project
Boston University School of Public Health
715 Albany Street
Boston, MA 02118

Publications

Annual Crime Report 1998
Cambridge Police Department
5 Western Avenue
Cambridge, MA 02139

Behavioral Risk Factor Surveillance System (BRFSS): 1997/1998
Bureau of Health Statistics, Research and Evaluation
Massachusetts Department of Public Health
250 Washington Street
Boston, MA 02108

Healthy People 2000 Review 1998-99
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics
6525 Belcrest Road
Hyattsville, MD 20782

Miscellaneous

Data Center of the Metropolitan Area Planning Council
60 Temple Place
Boston, MA 02111

U.S. Environmental Protection Agency
Environmental Quality
Center for Environmental Information and Statistics
http://www.epa.gov/ceisweb1/ceishome/ceis_home.html

Notes:

5.

cambridge 2000

CITY OF CAMBRIDGE • EXECUTIVE DEPARTMENT

Robert W. Healy, City Manager *Richard C. Rossi, Deputy City Manager*

January 24, 2000

To The Honorable, The City Council:

Please find attached for your information, the 2000 Cambridge Public Health Assessment, received from the Cambridge Health Alliance.

Very truly yours,

Robert W. Healy
City Manager

RWH/mec
Attachment

795 Massachusetts Avenue, Cambridge, Massachusetts 02139 Voice: 617.349.4300 Fax: 617.349.4307 TTY: 617.349.4242 Web: www.ci.cambridge.ma.us

Cc 5 125

Re 2000 Cambridge
Pul Assessment.

S-12

In City Council January 24, 2000

Referred to Health + Environment Committee and City Manager for any action on motion of Councillor Reeves.