The Cambridge Hospital

Affiliated with

Harvard Medical School

REPORT OF RECOMMENDATIONS AND FINDINGS

Neighborhood Health Center Planning Group

February 1, 1984

DRAFT

Myron Belfer, M.D.
Connie Buckley, R.N.
Richard deFillipi, Ph.D.
Michael J. Greene, Chairperson
Beverly Gorvine, R.N.
Jill Herold
Robert Lawrence, M.D.
David Link, M.D.
Philip McGovern, M.D.
James Nolan, M.D.
Estelle Paris, R.N.C.
Jean Phillips, R.N.C.
Michael Ryan
Joan Zoref

NHC Planning Group

Report of Recommendations and Findings

I. Summary of Planning Process

A. Purpose

The Neighborhood Health Center Planning Group was convened by Melvin Chalfen, M.D., Commissioner of Health and Hospitals at the request of Robert Healy, City Manager. The Group first met on August 25, 1983, with the task of considering the health care needs in the community against shrinking dollars. The Planning Group was represented by a complement of physicians, nurses and administrative staff from The Cambridge Hospital as well as a representative of the Health Policy Board and the Department of Human Services. After a series of meetings that focused on the costs, services, and efficiencies/inefficiencies of the current system of Neighborhood Health Centers, the Planning Group set out to define the types of alternative Neighborhood Health Center systems that would be developed and evaluated. The Planning Group developed a philosophy and a series of objectives against which each model would have to be measured.

B. Philosophy and Objectives

The philosophy is to provide community based primary care. This philosophy is derived from the inherent nature and the characteristics of a community such as Cambridge. This community has strong neighborhood identity that is ethnically diverse representing strong, but fragmented groups. To meet the health care needs of such a population, the model of health care needs to be dispersed into the community.

Listed below are the goals and objectives of the Neighborhood Health Centers as defined by the Planning Group. Each model developed by the Planning Group was tested against each goal and objective. Throughout the planning process no model was considered unless it met each of these goals and objectives.

1. To provide primary care ambulatory services in geographically, psychologically and economically accessible sites to residents of Cambridge.
2. To design a system that is cost effective and efficient as measured against a cost per visit rate.
3. To design a system that meets school health needs.
4. To develop a system that recognizes the need to provide training and research opportunities for educational programs.
5. To develop a fiscal management system that is both efficient and humane in its policies.
6. To recognize building access, safety, travel time and travel arrangements in developing sites.
7. To provide neighborhood outreach.
8. To provide a feeder network for the Hospital inpatient services.

DRAFT

C. Process

As stated earlier, the Planning Group began its work by taking a close look at the current system and evaluating its strengths and deficiencies. The Group looked at the actual operating costs of the current Health Center System including allocated expenses from the Hospital for those services provided by the Hospital (administration, storeroom, billing, other fiscal services, pharmacy, etc.). On a site by site basis the Group looked at the growth in activity by health center and at an average cost per visit. The Planning Group also spent time looking at issues of geographical access and designated Health Manpower Shortage Areas. While the Planning Group was looking at this data, it was also evaluating those components of the current health center system that would be carried through to any model that was developed. In addition, the Planning Group evaluated components to be added to the system that would improve on the current model or would be essential to the design of a modified health center system.

Initially, the Planning Group decided to look at two alternative Health Center models, Model I (zero-based model) and Model II (consolidation model). To develop these health center models, the first step was to develop a standard model of the optimal health center with a corresponding staffing pattern to suit the needs of health centers based in Cambridge. A model was developed that established space, staffing and productivity standards that would provide a comprehensive and efficient health center and meet the needs of the Health Centers' current patient population. The standard model health center was used to design each alternative Health Center system. Each Health Center System was created to incorporate the following assumptions:

a) The system will combine adult and pediatric medicine at each site to develop an integrated comprehensive primary care system. Each site will provide adult medicine, family practice, pediatrics, Ob/Gyn, family planning, mental health, podiatry, and social service. WIC program activities will be factored into our planning.

b) The system will be designed to include outreach into all of the public schools to provide a program of school health.

c) Locations will be based on access, designated Health Manpower Shortage Areas, travel time, bus routes, ethnic barriers, geographical boundaries, and viability of retaining existing facilities. To ease parking around Neighborhood Health Centers, visitor permits will be made available.

d) The system will provide a van to transport patients to the Neighborhood Health Centers and the Hospital on a prescribed route. This service will be offered by the Hospital at no cost to Cambridge residents. The van will follow a set route and would transport patients from set "bus stops" (i.e., public housing and elder housing) to the Neighborhood Health Centers and the Hospital.

e) Each health center model will allow for growth of the system. Space design and productivity standards will allow for increased activity at all sites. A marketing and promotional plan will be developed in tandem with the development of health centers.

f) To assure appropriate input from the community, a Community Board will be developed. Options for this Board will be a Board for each health center; one Board representing all of the Health Centers; a subcommittee of Health Policy Board's Committee on Hospital and Clinics.

g) Other health care options that complement the health center models will be considered. These will include free-standing "urgi-centers" and group practices sponsored by the Hospital.

After establishing these assumptions, the Planning Group set out to develop the alternative health center models and the school health system. Each model was evaluated as it was developed. Modifications to the models were made as the Planning Group looked critically at its proposals and looked at other health center systems. Modifications to earlier models were ongoing as the Planning Group applied changes that were developed with later models. In the end, four models were evaluated: the current model; Model I; Model II; and Model III. The School Health Model was designed to complement each of the alternatives to the current system.

D. Contents

Later in the text each model is described in detail. The steps to arrive at each model is explained along with the process used to attain a consensus for these models. Briefly, the models are:

a) Ten Neighborhood Health Centers - the current configuration.

b) Model I - A four health center model with sites in East Cambridge, Mid-Cambridge/Central Square, North Cambridge, and the Primary Care Unit/Pediatric Practice.

c) Model II - A five health center model with new sites in East Cambridge and North Cambridge, expansion or renovation of Riverside and Neighborhood Family Care Center, and the Primary Care Unit/Pediatric Practice.

d) Model III - A three health center model with new sites in East Cambridge and North Cambridge and the Primary Care/Pediatric Practice expanded as a comprehensive Mid-Cambridge health center.

e) School Health - An outreach health care system to public and parochial schools that is designed for implementation with each of the alternative Health Center Systems.

E. Findings

The Planning Group found that significant savings could be achieved in each of the new models while maintaining the same number of visits as in the current system and providing room for expansion.
Model II was the model preferred by the Planning Group. However, the Group suggested that each model had merits and could meet all objectives and assumptions as outlined at the beginning of the planning process. (See Attachment A for summary analysis of each model's costs.)

II. HISTORY

In 1967, the first Cambridge Neighborhood Health Centers were developed to provide comprehensive primary pediatric health care. These health centers were the brainchild of Philip Porter, M.D. Dr. Porter came to The Cambridge Hospital in 1965 as the Chief of Pediatrics. In this role he was also responsible for school health services in Cambridge. In 1965, Dr. Porter began his work to improve access to health care among the children of Cambridge. He found a community underserved in pediatrics and fostered the use of pediatric nurse practitioners to fill the gap in health care resources. Beginning in 1967, traditional school health nursing was converted to a system that combined the use of nurse practitioners and aides to provide both school health services and comprehensive primary care. Pediatric residents provided back-up to the nurse practitioners. At the time, Dr. Porter was able to implement these services without adding significant new costs to the system. The services were provided at no charge to patients and their families and remained that way until billing was implemented in 1981. Ultimately, five schools had health centers. The fourteen other public schools received health services through public health nurses from the City's Health Department. In addition, the public health nurses provided limited services to five parochial schools. Both of these systems remain in place today.

The Adult/Family Practice health centers first began in 1971. While separate in development from the pediatric program, these health centers were also developed to meet a gap in available health care services in Cambridge. A small grant was obtained to teach nurses to do physical exams. An OEO grant of $70,000 was obtained to staff health centers. At the end of the training three nurses were placed in new health centers (Donnelly Field, Neighborhood Family Care Center, North Cambridge/Fitzgerald) as nurse practitioners. Physician services were provided a few hours a week for Internal Medicine and Ob/Gyn. Community groups obtained model cities and OEO grants to support other services (administration, social service, family planning, mental health, nutrition) and the Hospital (City of Cambridge) supported the clinicians and facilities. Eventually three new sites were added, Cambridgeport in 1973, Riverside in 1975 and North Cambridge in 1977. Donnelly Field moved to a new facility and its name changed to Castriotta. Riverside and Cambridgeport also moved to new facilities. In 1980, all adult services in North Cambridge were consolidated to the North Cambridge Health Center in Jefferson Park.

DRAFT

Billing was implemented in the Adult/Family Health Centers in 1977. A generous sliding fee scale was instituted for Cambridge residents. The decision to implement billing was based on the increased burden on taxpayers to support the system as services and costs grew. An added incentive was based on the Rate Setting Commission disallowance of Hospital costs for the provision of billable services that were not being billed. Over time, the importance of billing has increased as financial resources have become tighter.

The year 1979 saw major changes for the Adult/Family Practice Health Centers. In 1978 parts of Cambridge were designated Medically Underserved Areas and Health Manpower Shortage Areas. These designations allowed the system to seek Federal grant support. At that time Dr. Porter chose not to seek Federal grant support for the Pediatric Neighborhood Health Centers, but the Adult/Family Practice Health Centers sought and received funding for five National Health Service Corps (NHSC) physicians and an Urban Health Initiative (UHA/330) grant. The availability of this funding significantly changed the system. Physicians were available fulltime at the health centers and a night call system was implemented. Grant funds provided money for equipment, support staff, outreach and promotion. By 1981, this growing system met with significant federal cutbacks and with the implementation of Proposition 2½, shrinking local tax dollars.

Proposition 2½ as well as Rate Setting disallowance of health center costs led to implementation of billing in the Pediatric Neighborhood Health Centers.

The Neighborhood Health Center Planning process was established in August 1983 to provide rational planning for the system rather than crisis oriented planning. Their findings develops a system that cuts the tax burden while maintaining the merits of the Neighborhood Health Center system. Over recent years the two programs, the Pediatric Neighborhood and the Adult/Family Health Centers, have become integrated as part of the Hospital's Ambulatory Care Division. The planning process brings this administrative step further by integrating clinical services.

DRAFT

III. The Health Center Models

As stated earlier, the Planning Group spent time developing a standard health center model. The Group looked at productivity at the Harvard Community Health Plan, several neighborhood health centers outside Cambridge, and standards of the National Health Service Corps. Site visits to East Boston, South End, Dimock and Watertown Health Centers helped the group develop clinician productivity standards as well as support staff and space standards. Starting with Model I (zero-based plan) a standard staffing model was developed. This model was used throughout the planning process to develop Model II and Model III.

The space design of the standard health center was based on an initial capacity of 12,500 billable visits a year at a fully staffed site. The model is based on an average of 3,400 billable medical visits per year for each FTE physician and 1,900 billable medical visits per year per FTE nurse practitioner. A model site would have three nurse practitioners generating 5,700 billable visits and two physicians generating 6,800 billable visits, plus three support staff. The support staff would have interchangeable functions. Since the model is predicated on a staffing model of 2 physicians, 3 nurse practitioners and 3 support staff for a site of 12,500, a full-scale site will generate that number of billable visits. The model recommends negotiation or a subcontract for clinical services as a method of seeding physicians in the community. Incorporated in this model is a float system for the provision of coverage for non-productive hours.

The model proposes that space at each site is designed to complement this staffing model.

Waiting Area	= 250 sq.ft. (seating capacity 20)
Exam Rooms (10)	= 800 sq.ft.
Consultation Rooms (3)	= 270 sq.ft.
Lab, supply, dirty and clean utility	= 300 sq.ft.
Record Room	- 175 sq.ft.
Restrooms (2)	= 200 sq.ft.
Work Area (for clinicians)	= 150 sq.ft.
	2,145 sq.ft.=2,600 sq.ft. (to allow flexibility in space design.)

A. Current Configuration (See Attachment B for detailed cost analysis.)

The system would continue the current 10 health centers but would not include new initiatives such as the van and marketing system unless resources are found to cover these increased costs. The 10 sites would be: Kennedy NHC (1,200 visits); Harrington NHC (2,170 visits); Castriotta (6,296 visits); Neighborhood Family Care Center (7,379 visits); Cambridgeport NHC (1,000 visits); Riverside NHC (2,713 visits); King NHC (1,340 visits); Fitzgerald NHC (3,400 visits); North Cambridge NHC (3,306 visits); and Cambridge Rindge and Latin School which would provide all school health. School health services are provided at the Fitzgerald, Harrington, Kennedy, and King Schools by the Health Center staff. Public Health nurses provide school health to the fourteen other public schools and to five parochial schools. Primary care services are provided to adults and children in the Hospital-based Primary Care Unit and Pediatric Practice.

B. Model I (See Attachment C for detailed cost analysis.)

Model I proposes four health centers to be based in East Cambridge/Court House area, Mid-Cambridge/Central Square, North Cambridge/Massachusetts Avenue at Rindge Avenue, and the Primary Care Unit/Pediatric Practice. The School Health Model at the end of Section II is added as part of Model I.

1. East Cambridge - This site would be designed at 100% of the staffing model. The site would combine the billable visits of the Kennedy NHC (1,200 visits), Harrington NHC (2,170 visits), Castriotta NHC (6,296 visits), and (one-third of) Neighborhood Family Care Center (2,462 visits) health centers.

2. Mid-Cambridge - This site would be designed at 80% of the staffing model. The site would combine the billable visits from Cambridgeport NHC (1,000 visits), Riverside NHC (2,713 visits), King NHC (1,340 visits), and two-thirds of Neighborhood Family Care Center (4,917 visits) health centers.

3. North Cambridge - This site would be designed at 50% of the staffing model. The site would combine the billable visits from the Fitzgerald NHC (3,400) and North Cambridge NHC (3,306).

4. Primary Care Unit/Pediatric Practices - Services would continue in these hospital based primary care practices. The site would provide 15,500 billable visits and would expand the development of services for ethnic minorities.

C. Model II (See Attachment D for detailed cost analysis.)

Model II proposes a system of five neighborhood health centers using three existing facilities that are to be expanded or renovate two new facilities. The sites would include Riverside, Neighborhood Family Care Center, a North Cambridge site in Jefferson Park (built by the Housing Authority) or Massachusetts Avenue at Rindge Avenue, an East Cambridge site expanding space at Millers Rivers Apartments (current site of Castriotta) or in the East Cambridge/Court House area, and the Primary Care Unit/Pediatric Practice.

Model II takes a closer look at ethnic and geographical boundaries while applying a minimum staffing/productivity standard to geographical areas of the City. In grouping sites, facilities are maintained where renovations will allow a site to absorb increased activity. New sites are chosen where renovation is not possible.

The School Health Model at the end of Section III is added as part of Model II.

1. East Cambridge - This site would be designed at 77% of the staffing model. The site would combine Kennedy NHC (1,200 visits), Harrington NHC (2,170 visits), and Castriotta (6,296 visits). If it is possible to expand into additional space at Millers Rivers Apartments, this site would be chosen over a new site. This would be negotiated with the Cambridge Housing Authority.

2. Riverside - This site would be designed at 40% of the staffing model. The site would combine Riverside NHC (2,713 visits), Cambridgeport NHC (1,000 visits) and King NHC 1,340 visits). Riverside is a new and attractive facility. Its foundation can accommodate a second storey. A second floor would be added to expand clinical space.

DRAFT

3. NFCC - This site would be designed at 59% of the staffing model. The site would combine adult and pediatrics (7,409 visits) by renovating the existing health center to provide a single registration/intake area. Renovations would improve patient flow and appearance of physicial plant.

4. North Cambridge - This site would be designed at 53% of the staffing model. The site would combine North Cambridge NHC (3,306 visits) and Fitzgerald NHC (3,400 visits). The site would occupy the space that the Cambridge Housing Authority has planned to build in Jefferson Park or a new site on Massachusetts Avenue at Rindge Avenue.

5. Primary Care Unit/Pediatric Practice - Services would continue in these hospital based primary care practices. The site would provide 15,500 billable visits and would expand the development of services for ethnic minorities.

D. Model III (See Attachment E for detailed cost analysis.)

This model proposes three sites using one existing facility (with renovations) and two new or expanded facilities. In this model the Primary Care Unit (PCU) and hospital based Pediatric Practice (Cambridge Pediatrics) are modified to develop the practices on Cahill I and II into a more comprehensive health care practice. The Hospital based practices become a Mid-Cambridge NHC. There is a North Cambridge site in Jefferson Park (built by the Housing Authority) or on Massachusetts Avenue at Rindge Avenue. The third site is in East Cambridge expanding space at Millers Rivers Apartments (current site of Castriotta) or in the East Cambridge/Court House area.

This health center model arrives at three sites by applying staffing/productivity standards to geographical areas of the City. Like Model I and Model II, in grouping sites, sites are maintained where facilities can be renovated to absorb increased activities and new sites are chosen where renovation is not possible. Modification of the productivity standard is applied to House Staff practicing in the PCU.

The School Health Model at the end of Section III is added as part of Model III.

1. PCU/Pediatric Practice - These primary care practices based at the Hospital would be expanded to include (or expand current) Ob/Gyn, Social Service, Mental Health, Family Planning, WIC, and Podiatry services in addition to Internal Medicine, Family Practice and Pediatrics. Cahill II would be renovated to expand the Pediatric Practice to absorb the increased activity. The PCU would be able to absorb the increased activity without renovation. Additional provider and support staff is incorporated in the model.

   This Mid-Cambridge site would combine the billable visits from Cambridgeport NHC (1,000 visits), Riverside NHC (2,713 visits), King NHC (1,340 visits) and two-thirds Neighborhood Family Care Center (4,917 visits). Particular emphasis would

DRAFT

be placed on expansion of Latino Clinic and development of a Haitian Clinic to assure a transfer of the NHC atmosphere for all patients including ethnic minorities. A sliding fee scale would be added to this site. The van service would be expanded to facilitate patient movement from areas south of Massachusetts Ave. and around NFCC to the Hospital.

2. East Cambridge - This site would be designed at 100% of the staffing model. The site would combine Kennedy NHC (1,200 visits), Harrington NHC (2,170 visits), Castriotta NHC (6,296 visits) and one-third of Neighborhood Family Care Center (2,462 visits). If possible, the health center would expand into additional space at Millers Rivers Apartments. This would be negotiated with the Cambridge Housing Authority.

3. North Cambridge - This site would be designed at 100% of the staffing model. The site would combine North Cambridge NHC (3,306 visits) and Fitzgerald NHC (3,400 visits). The site would occupy the space that the Cambridge Housing Authority has planned to build at Jefferson Park or a new site on Massachusetts Avenue at Rindge Avenue.

E. The School Health System

The School Health System is redefined as part of Model I, and Model II and Model III NHC Models. These NHC models combine services for children and adults into one system of health care. School health is developed as a system of "outreach" to the schools from NHCs. This system integrates school health services into one comprehensive model. The current separate systems of public health nurses and pediatric neighborhood health centers are merged to provide school health services. This system provides services to the 14 public schools and 5 parochial schools presently served by two separate systems.

The Planning Group proposes a system that both meets State DPH regulatory needs and creates an ongoing presence in the schools. This system would be designed to reflect the intensive level of mandatory service delivery required at the beginning of a school year and a regularly scheduled nursing presence at each school throughout the school year.

1. Mandatory Services

a. Mandatory physicals - would be provided at kindergarten (or at school entry) and in the 9th grade. School physicals would be provided at no charge to those children who are not seen in a private physician's office. These physicals would take place on a scheduled basis at the schools or NHCs. Teams of clinicians would provide thorough physical examinations. These school health physicals would be more comprehensive than required by law. The scheduling and completion of these physicals would be designed and delivered in a setting that meet the need for privacy for the children. The exam would include basic (but not mandatory) laboratory tests.

b. Immunizations - Prior to the beginning of the school year, clerical support would be provided to review all immunization records for the 19 schools in the school health system. Approximately 90-120 hours of clerical time would be provided for record review and organization of records. By the second or third week of the school year this review would be completed and the school health program would schedule clinical time for those children whose immunization records are incomplete. This system would accommodate kindergarten, new entry, and 9th grade (immunization booster) school children. This system would be designed and arranged with the input from the School Department.

c. Vision and Hearing Testing and Scoliosis Screening - This would remain a function of the School Department. The School Health program would be responsible for follow-up for children who fail these screenings.

2. On-Site Services

A nursing presence would be designed for each school. This clinician would serve as a "facilitator" for services to school children. The clinician would serve several functions on-site. In addition, a backup system for emergency consultations would be designed and coordinated with an identified NHC.

a. Immunization Surveillance - to assure completion of all required immunizations to all children at that site.

b. Record Review - for immunizations, scoliosis screening, as well as other medical or social problems.

c. Eposidic Care - on-site treatment of school children as well as mandatory physicals.

d. Consultation - to school personnel on overall school health and individual health issues. This would include consultation for "766" Core Evaluations.

e. Training - to fulltime on-site school personnel to function as health aides to provide first aide and triage. The School Department would provide a stipend to their staff for performing these duties. The aides would be School personnel who do not have classroom obligations. This would assure availability. The aides would be designated at one of two levels. At the first level, they would be trained by Neighborhood Health Center staff. At the second level, they would be individuals who have completed EMT training. These individuals would receive a higher stipend.

In addition, the clinician's role would be as the coordinator for the site in identifying children's health needs; as the coordinator of appropriate referrals to a primary care providers (who would then serve as the primary health care coordinator for the child); and as the health

care monitor for the site. As a coordinator of care, the clinician would also assist the school in the management of contagious health problems. NHC and Hospital personnel would be available for back-up and consultation for these problems.

The Planning Group solicited input from several groups to assess school health needs and to define on-site presence. From its discussions, the Planning Group determined that the hours 8:00 a.m.-12:30 p.m. (during the school year) are the preferred times for school health services. Actual hours of school health services will be based on enrollment.

Enrollment

0 - 100 - 1 session - weekly
101 - 200 - 2 sessions - weekly
201 - 400 - 3 sessions - weekly
401 - 600 - 4 sessions - weekly
601 - 800 - 5 sessions - weekly

Sessions would be defined as two hour blocks - either 8:00 - 10:00 or 10:30 - 12:30.

School	Enrollment	School Health Sessions Per Week
Haggerty	117	2
Blessed Sacrament	137	2
St. John's	166	2
St. Paul's	46	consult 1
Agassiz	267	3
Fletcher	356	3
Graham-Park	331	3
Morse	358	3
Roberts	331	3
No. Cambridge Catholic	351	3
St. Peter's	226	3
Kennedy	348	3
Longfellow	429	4
Peabody	451	4
Tobin	610	5
Fitzgerald	503	4
King	481	4
Harrington	800	5
		57

Services at CRLS would be designed to provide fulltime coverage during the school year. The NHC system would provide 1.5 FTE clinicians and 2 FTE aides.

DRAFT

The system would be designed to provide accessible school health in all 19 schools with a coordinated system or primary and specialty care back-up regardless of the site of school enrollment.

IV. Evaluation of Models and Potential of the System

Each of the newly developed models allows for growth in the system, new initiatives, and cost savings. Each model meets all of the objectives and assumptions developed in the early stages of the planning process (see Section I). Unlike the proposed models, the current configuration represents a system of annual spiralling costs leaving no room for new initiatives.

Model I, Model II and Model III all allow for expansion of services, a broad marketing and promotion plan, a revamping of the billing, and improved access through use of a van.

As the Planning Group met and reviewed each model it suggested some modifications in the role of medical directors and clinical coordinators, the use of support staff, the merit of viewing the PCU as a health center, and the merits of subcontracting services to seed physicians in underserved areas.

In evaluating the models, the Planning Group viewed the opportunity for change as a positive step. It was a chance to change and improve aspects of the system that were fragmented or inefficient and to support improvements in the system that were too costly to fund while running ten health centers. In addition, it was an opportunity to develop a single school health system for the entire City.

V. Recommendations

After discussing the merits of each model the Neighborhood Health Center Planning Group is proposing adoption of Model II. This model is responsive to ethnic barriers, achieves significant savings and responds to market forces by suggesting subcontracting as a way to seek physician practices.

Model II is accessible and comprehensive with room for growth; is cost effective and efficient; provides outreach to the schools for school health; allows for integration with training programs; uses a streamlined billing system; improves on access of the current system through the use of a van; includes neighborhood outreach; and provides a feeder network for hospital inpatient services.

ATTACHMENT A

NHC Planning Group

Summary Budget Sheet

	Current Configuration	Model I (Zero-Based)	Model II (Consolidation)	Model III
Base Budget	2,780,262	2,607,829	2,598,815	2,367,193
School Health Nursing	135,240	173,000	173,000	173,000
Total Plan Cost FY'85	2,915,502	2,780,829	2,771,815	2,540,193
Less Non-Recurring	0	(245,575)	(268,100)	(177,050)
Total Operating Costs	2,915,502	2,535,254	2,503,715	2,363,143
Variance to Current Configuration	0	380,248	411,787	552,359

DRAFT

ATTACHMENT B

NHC Planning Group

Current Configuration

Human Resources		NHC (26,340 visits)	PCU/Pedi. Office Practice (12,500 visits)	TOTAL (38,840 visits)
Medical	- P.C. Attending M.D.'s	139,984	202,220	342,204
	Ob/Gyn Attending	24,883	0	24,883
	Mid-Level Practitioner	740,324	46,995	787,319
	Residents	0	0	0
	Subtotal	905,191	249,215	1,154,406
Psych.	- Psychiatrist	32,396	0	32,396
	Other Psych. Professionals	145,670	0	145,670
	Subtotal	178,066	0	178,066
Allied	- Podiatry	0	0	0
	Nutritionist	19,161	0	19,161
	Social Worker	44,215	0	44,215
	Subtotal	63,376		63,376
Support	- Med. Recept./Asst.	287,894	73,587	361,481
	Driver	0	0	0
	Subtotal	287,894	73,587	361,481
Admin.	- Med. Director	0	27,082	27,082
	Head RN Practitioner	64,162	0	64,162
	Hosp. Based Admin.	57,803	16,435	74,238
	Subtotal	121,965	43,517	165,482
	Total S & W	1,556,492	366,319	1,922,811
	Fringes	264,176	65,637	329,813
	Human Resource Total	1,820,668	431,956	2,252,624
Operating Costs				
	Rent	31,720	0	31,720
	M&S and Other Supplies	16,921	16,440	33,361
	Communication	0	0	0
	Utilities	1,950	0	1,950
	Courier	10,296	0	10,296
	Total Operating Costs	60,887	16,440	77,327
	Indirect Allocation	273,892	296,163	570,055
	Total Program Costs	2,155,447	744,559	2,900,006
Capital				
	Equipment	5,142	10,354	15,496
	Van	0	0	0
	Renovation	0	0	0
	Total Capital Costs	5,142	10,354	15,496
	Total Marketing Costs	0	0	0
	Total All Costs	2,160,589	754,913	2,915,502
	Less Non-Recurring	0	0	0
	Net Operating Costs	2,160,589	754,913	2,915,502

DRAFT

NHC Planning Group

MODEL I

(Zero-Based Model)

ATTACHMENT C

Cost Components	East Cambridge (12,128 visits)	Mid Cambridge (9,970 visits)	North Cambridge (6,706 visits)	PCU/Pedi. Practice (15,500 visits)	School Health	TOTAL (44,304 visits)
Human Resources						
Medical - P.C. Attending M.D.'s	120,000	96,000	60,000	202,220	0	478,220
Ob/Gyn Attending	20,000	20,000	20,000	0	0	60,000
Mid-Level Practitioner	109,681	91,273	63,661	46,995	144,167	455,777
Residents	3,100	3,100	3,100	0	0	9,300
Subtotal	252,781	210,373	146,761	249,215	144,167	1,003,297
Psych. - Psychiatrist	11,667	11,667	11,666	0	0	35,000
Other Psych. Professionals	15,667	15,667	15,666	0	0	47,000
Subtotal	27,334	27,334	27,332	0	0	82,000
Allied - Podiatry	0	0	0	0	0	0
Nutritionist	6,240	6,240	6,240	0	0	18,720
Social Worker	6,587	6,587	6,586	0	0	19,760
Subtotal	12,827	12,827	12,826	0	0	38,480
Support - Med. Recept./Asst.	53,917	44,377	30,067	73,587	0	201,948
Driver	5,000	5,000	5,000	0	0	15,000
Subtotal	58,917	49,377	35,067	73,587	0	216,948
Admin. - Med. Director	7,333	7,333	7,334	27,082	0	49,082
Head RN Practitioner	10,747	10,747	10,746	0	0	32,240
Hosp. Based Admin.	22,520	22,520	22,518	16,435	0	83,993
Subtotal	40,600	40,600	40,598	43,517	0	165,315
Total Salary & Wage	392,459	340,511	262,584	366,319	144,167	1,506,040
Fringes	78,492	68,102	52,517	65,637	28,833	293,581
Human Resource Total	470,951	408,613	315,101	431,956	173,000	1,799,621
Operating Costs						
Rent	39,000	39,000	39,000	0	0	117,000
M&S and Other Supplies	15,095	12,076	7,548	16,440	0	51,159
Communication	7,200	7,200	7,200	0	0	21,600
Utilities	2,340	2,340	2,340	0	0	7,020
Courier	1,400	1,400	1,400	0	0	4,200
Total Operating Costs	65,035	62,016	57,488	16,440	0	200,979
Indirect Allocation from Hospital	51,046	51,046	51,045	296,163	0	449,300
Total Program Costs	587,032	521,675	423,634	744,559	173,000	2,449,900
Capital						
Equipment	8,525	8,525	8,525	10,354	0	35,929
Van	8,334	8,334	8,332	0	0	25,000
Renovation	65,000	65,000	65,000	0	0	195,000
Total Capital Costs	81,859	81,859	81,857	10,354	0	255,929
Total Marketing Costs	25,000	25,000	25,000	0	0	75,000
Total All Costs	693,891	628,534	530,491	754,913	173,000	2,780,829
Less Non-Recurring	(81,859)	(81,859)	(81,857)	0	0	(245,575)
Net Operating Costs	612,032	546,675	448,634	754,913	173,000	2,535,254

DRAFT

NHC Planning Group

MODEL II

(Consolidation Model)

ATTACHMENT D

Cost Component	East Cambridge (9,666 visits)	NFCC Windsor (7,409 visits)	Riverside (5,053 visits)	North Cambridge (6,706 visits)	PCU/Pedi. Practice (15,500 visits)	School Health	TOTAL (44,334 visits)
Human Resources							
Medical - P.C. Attending M.D.'s	92,400	70,800	48,000	63,600	202,220	0	477,020
Ob/Gyn Attending	15,000	15,000	15,000	15,000	0	0	60,000
Mid-Level Practitioner	88,498	67,944	45,980	60,812	46,995	144,167	454,396
Residents	2,325	2,325	2,325	2,325	0	0	9,300
Subtotal	198,223	156,069	111,305	141,737	249,215	144,167	1,000,716
Psych. - Psychiatrist	8,750	8,750	8,750	8,750	0	0	35,000
Other Psych. Professionals	11,750	11,750	11,750	11,750	0	0	47,000
Subtotal	20,500	20,500	20,500	20,500	0	0	82,000
Allied - Podiatry	0	0	0	0	0	0	0
Nutritionist	4,680	4,680	4,680	4,680	0	0	18,720
Social Worker	4,940	4,940	4,940	4,940	0	0	19,760
Subtotal	9,620	9,620	9,620	9,620	0	0	38,480
Support - Med. Recept./Asst.	43,054	32,980	22,429	29,373	73,587	0	201,423
Driver	3,750	3,750	3,750	3,750	0	0	15,000
Subtotal	46,804	36,730	26,179	33,123	73,587	0	216,423
Admin. - Med. Director	5,500	5,500	5,500	5,500	27,082	0	49,082
Head RN Practitioner	8,060	8,060	8,060	8,060	0	0	32,240
Hosp. Based Admin.	16,890	16,890	16,889	16,889	16,435	0	83,993
Subtotal	30,450	30,450	30,449	30,449	43,517	0	165,315
Total Salary & Wage	305,597	253,369	198,053	235,429	366,319	144,167	1,502,934
Fringes	61,119	50,674	39,611	47,086	65,637	28,833	292,960
Human Resource Total	366,716	304,043	237,664	282,515	431,956	173,000	1,795,894
Operating Costs							
Rent	39,000	16,000	0	23,400	0	0	78,400
M&S and Other Supplies	11,623	8,906	6,038	8,000	16,440	0	51,007
Communication	7,200	7,200	7,200	7,200	0	0	28,800
Utilities	2,340	2,340	2,340	2,340	0	0	9,360
Courier	1,400	1,400	1,400	1,400	0	0	5,600
Total Operating Costs	61,563	35,846	16,978	42,340	16,440	0	173,167
Indirect Allocation from Hospital	38,285	38,284	38,284	38,284	296,163	0	449,300
Total Program Costs	466,564	378,173	292,926	363,139	744,559	173,000	2,418,361
Capital							
Equipment	8,525	8,525	8,525	8,525	10,354	0	44,454
Van	6,250	6,250	6,250	6,250	0	0	25,000
Renovation	65,000	20,000	85,000	39,000	0	0	209,000
Total Capital Costs	79,775	34,775	99,775	53,775	10,354	0	278,454
Total Marketing Costs	18,750	18,750	18,750	18,750	0	0	75,000
Total All Costs	565,089	431,698	411,451	435,664	754,913	173,000	2,771,815
Less Non-Recurring	(79,775)	(34,775)	(99,775)	(53,775)	0	0	(268,100)
Net Operating Costs	485,314	396,923	311,676	381,889	754,913	173,000	2,503,715

DRAFT

NHC Planning Group

MODEL III

ATTACHMENT E

Cost Components	East Cambridge (12,128 visits)	North Cambridge (6,706 visist)	PCU/Pedi. Practice (25,470 visits)	School Health	TOTAL (44,304 visits)
Human Resources					
Medical - P.C. Attending M.D.'s	180,000	63,600	377,634	0	621,234
Ob/Gyn Attending	20,000	20,000	20,000	0	60,000
Mid-Level Practitioner	3,989	52,769	50,983	144,167	251,908
Residents	2,325	2,325	0	0	4,650
Subtotal	206,314	138,694	448,617	144,167	937,792
Psych. - Psychiatrist	11,667	11,666	11,667	0	35,000
Other Psych. Professionals	15,667	15,667	15,666	0	47,000
Subtotal	27,334	27,333	27,333	0	82,000
Allied - Podiatry	0	0	0	0	0
Nutritionist	6,240	6,240	6,240	0	18,720
Social Worker	6,587	6,586	6,587	0	19,760
Subtotal	12,827	12,826	12,827	0	38,480
Support - Med. Recept./Asst	50,430	26,580	100,167	0	177,177
Driver	5,000	5,000	5,000	0	15,000
Subtotal	55,430	31,580	105,167	0	192,177
Admin. - Med. Director	7,333	7,333	34,416	0	49,082
Head RN Practitioner	10,747	10,747	10,746	0	32,240
Hosp. Based Admin.	22,519	22,520	38,954	0	83,993
Subtotal	40,599	40,600	84,116	0	165,315
Total Salary & Wage	342,504	251,033	678,060	144,167	1,415,764
Fringes	68,500	50,207	127,985	28,833	275,525
Human Resource Total	411,004	301,240	806,045	173,000	1,691,289
Operating Costs					
Rent	39,000	23,400	0	0	62,400
M&S and Other Supplies	15,095	8,000	27,825	0	50,920
Communication	7,200	7,200	0	0	14,400
Utilities	2,340	2,340	0	0	4,680
Courier	2,400	2,400	0	0	4,800
Total Operating Costs	66,035	43,340	27,825	0	137,200
Indirect Allocation from Hospital	76,569	76,568	296,163	0	449,300
Total Program Costs	553,608	421,148	1,130,033	173,000	2,277,789
Capital					
Equipment	8,525	8,525	16,354	0	33,404
Van	8,334	8,333	8,333	0	25,000
Renovation	65,000	39,000	25,000	0	129,000
Total Capital Costs	81,859	55,858	49,687	0	187,404
Total Marketing Costs	25,000	25,000	25,000	0	75,000
Total All Costs	660,467	502,006	1,204,720	173,000	2,540,193
Less Non-Recurring	(81,859)	(55,858)	(39,333)	0	(177,050)
Net Operating Costs	578,608	446,148	1,165,387	173,000	2,363,143

DRAFT

CITY OF CAMBRIDGE

CAMBRIDGE, MASSACHUSETTS 02139
Tel. 498-9011

EXECUTIVE DEPARTMENT
ROBERT W. HEALY
City Manager

February 13, 1984

To the Honorable, the City Council:

During the past year the health care system of the City of Cambridge has been under increasing financial pressure from a variety of its traditional sources of support. In addition to Proposition 2½, Cambridge Hospital and affiliated neighborhood health centers have been subject, since July 1, 1983, to Massachusetts General Laws Chapter 372, a hospital cost containment act. These legislative initiatives, coupled with the continuing shrinkage in Federal funds supporting specific programs in the health care system and the continuing underutilization of a number of sites within the neighborhood health center system, prompted my request to Dr. Melvin Chalfen, Commissioner of Health and Hospitals, that a committee be established with the specific task of evaluating the present system and developing alternatives which would be more responsive to the system's new financial environment.

The Neighborhood Health Center Planning Group first met August 25, 1983, and over the past six months has evaluated the present system, viewed alternative health center models, developed objectives and specific performance standards and designed a series of alternatives to the present system. The process of the group's study, the options it developed and its recommendations are presented in the attached Working Draft of the Report of Recommendations and Findings of the Neighborhood Health Center Planning Group.

This draft report has been distributed to and will be discussed by the Cambridge Health Policy Board at a scheduled February 28, 1984 meeting. Copies will be distributed to neighborhood health center staff prior to a general staff meeting to be scheduled by the end of February. Hospital Administrator, Michael Greene, will be scheduling several community public meetings for the first two weeks in March. Comments and input from these forums will be incorporated into a final version of the Plan document.

During this period of public review of the draft report it would be appropriate for the Cambridge City Council to consider the draft. I would ask the Council to convene a meeting of the Committee on Health and Hospitals during February to generate the comments of members of the City Council on this draft. Together with input from the Health Policy Board, neighborhood health center staff and public comments, a final version of the Plan will be prepared as a basis for future directions for the neighborhood health center system.

Very truly yours,

Robert W. Healy
City Manager

RWH/mbf

Agenda Item Number Five

S-85

Re: enclosing a copy of a Working Draft of the Report of Recommendations & Findings of the Neighborhood Health Center Planning Group.

Request for Hearing
in
February

Copy put aside for Committee to be sent when Committee is constituted.
2/16/84 mch

In City Council,

February 13, 1984

2/13/1984
Referred to the
Comm. on Health
and Hospitals
when
Constituted