



# The Cambridge Hospital



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

Dear Mr. Healy,

The Cambridge Public Health Commission is pleased to submit the 1998 Public Health Assessment: Improving the Health of Cambridge. This document serves as the annual assessment that provides an important link between The City and the Cambridge Public Health Commission. This assessment is very different from last year's submission. This year, we selected a small number of priority areas and detailed the process by which we will establish priorities, goals, and programmatic oversight. The assessment also contains a condensed version of relevant quantitative data about Cambridge and an update on the Cambridge Agenda for Children project. The document is the first step in a year long process that will lead to measurable outcomes and real benefits to our community.

Though our document largely discusses a planning process, the Commission is pleased to report continued progress on many aspects of health care for Cambridge. 1) This year, we have taken bold steps to launch Network Health, the pre-paid health plan. 2) The Commission has established a unique affiliation arrangement with both Partners Healthcare System and CareGroup. 3) The Commission continues to enhance its integrated delivery system that includes a wide range of community and hospital-based care and public health initiatives.

This document was prepared with able assistance from Virginia Chomitz, Harold Cox, Donna Fox, Lynn Schoeff, Jane Taylor, Jeff Walker and Cheryl Wold.

Our experience with last year's assessment indicated that we were on the right track in preparing information for The City. However, we also learned that the document must include information that can be easily summarized and lead to an ongoing planning and evaluation process. Both concerns are achieved in this submission. We would appreciate all comments about the structure and contents as we prepare future reports.

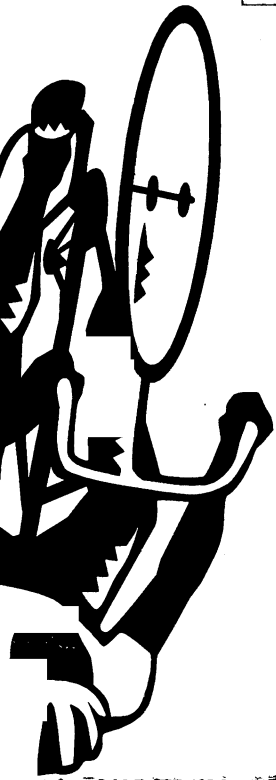
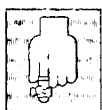
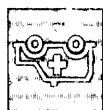
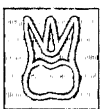
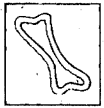
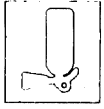
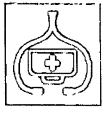
Sincerely,

John G. O'Brien  
Chief Executive Officer

"Health is the extent to which people are able to realize aspirations, to satisfy needs, and to change or cope with the environment." World Health Organization

at a Glance

# The Health of Cambridge

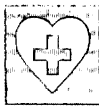
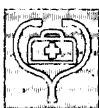


## The Health of Cambridge



### Data Sources

1. Sagar A. and Socolar D., Boston University School of Public Health, 1997
2. Bureau of Family and Community Health, Mass. DPH, 1991-95
3. Health of the City/Harvard Dental School, 1996
4. Immunization Action Project of Cambridge, Chelsea, and Somerville, 1996
5. Mass. Division of Health Care Finance and Policy, 1996
6. Behavioral Risk Factor Survey, DPH, 1995
7. Bureau of Health Statistics, Research and Evaluation, Mass. DPH, 1996  
(Cambridge rates for 1991-1995; Mass rates for 1996)
8. Weapon-Related Injury Surveillance System, Mass. DPH, 1996
9. Cambridge Police Dept., 1997
10. Operation Safe Home, Cambridge Police Dept., FY 1993-95
11. Teen Health Survey, Cambridge Public Schools, 1996
12. Youth Risk Behavioral Survey, Mass. Dept. of Education, 1995
13. Injury Control Program, Mass. DPH, 1994
14. Health and Addictions Research/DPH Bureau of Substance Abuse Services, 1991-93
15. AIDS Surveillance Program, Mass. DPH, Sept. 1, 1997
16. STD Program, Mass. DPH, 1996
17. U.S. Bureau of the Census, 1990
18. Mass. Dept. of Education, Accountability and Evaluation Services, 1995
19. HP 2000 Goals are benchmarks for healthy communities by the year 2000 from Healthy People 2000, Centers for Disease Control and the National Center for Health Statistics.





Health Status Measure	How do we Compare?			How are we Doing?
	Cambridge	Mass.	HP Year 2000 <sup>19</sup>	
<b>Access to Health Care and Prevention Services</b>				
People without health insurance - % of Mass. residents <sup>1</sup>		12.6%	*	• The number of Mass. residents without insurance (766,000) has doubled since 1987.
Prenatal care in first trimester - % of births <sup>2</sup>	89%	89%	90%	• Slightly fewer Black (84%) and Hispanic (85%) women obtained care in the first trimester.
Dental caries in children - % of children <sup>3</sup>	25%	*	20%	• 25% of 1st and 18% of 8th grade school children have untreated cavities.
Immunization by age 2 <sup>4</sup>	80%	74%	90%	• The rate of immunization has increased from 60% in 1993, to 80% in 1996.
Asthma hospitalization rate - per 100,000 ages 1-17 <sup>5</sup>	271.8	206.4	225	• Asthma accounts for a majority of hospital admissions to this age group.
Mammogram - % women age 50+ <sup>6</sup>	*	81%	60%	• 81% of women (age 50+) surveyed reported having a mammogram in the past two years.
Pneumonia/influenza deaths - per 100,000 ages 65+ <sup>7</sup>	332.2	307.3	*	• From 1980 to 1996, pneumonia death rates in Mass. for all ages declined by 12%.
Flu shots among elderly (past year) - % age 65+ <sup>6</sup>	*	59%	60%	• Immunization for bacterial pneumonia and viral influenza reduces morbidity and mortality.

<b>Encouraging Healthier Behaviors</b>				
Births to teens - per 1,000 females age 15-19 <sup>2,7</sup>	14.5	38.4	*	• Cambridge has a rate of teen births which is under half the Mass. rate.
Deaths due to heart disease - per 100,000 <sup>7</sup>	121.9	116.8	100	• From 1980 to 1996, heart disease deaths have declined by 41% in Mass.
Deaths due to cancer - per 100,000 <sup>7</sup>	139.8	130.6	130	• Lung cancer is the leading cause of cancer death for Cambridge residents.
Physical activity - % with little or none ages 20+ <sup>6</sup>	*	51%	15%	• Sedentary lifestyles, obesity, smoking, and poor diet, contribute to heart disease and other adverse health outcomes.
Obesity - % of adults age 20-74 <sup>6</sup>	*	23%	20%	

<b>Preventing Violence</b>				
Homicide - rate per 100,000	3.2	3.5	7.2	• From 1980 to 1996, homicide rates in Mass. declined by 22%.
Weapon violence injuries - rate per 100,000 <sup>8</sup>	24.0	32.3	*	• From 1994 to 1996, violence-related gunshot injuries declined by 41% in Mass.
Domestic violence - number of reports to Police per year <sup>9</sup>	999	*	*	• In Cambridge, 1/3 of the calls for assistance related to domestic violence involve injuries.
Violent crime reports to police - rate per 100,000 <sup>10</sup>	631.5	*	*	• Violent crime has decreased; from 1992 to 1997, 65% fewer violent crimes were reported.
Family violence - % who witness (grade 9-12) <sup>11</sup>	9%	*	*	• 9% report witnessing family violence; 5% report being beaten by a family member.
Physical fighting in past year (grade 9-12) <sup>11,12</sup>	7%	38%	11%	• Of those who fought, more females (18%) than males report fighting with family (7%).

<b>Reducing Injury</b>				
Injury hospitalization - rate per 100,000 <sup>13</sup>	704.6	860.1	*	• Leading causes are falls (42%), self-inflicted injury (9%), and motor vehicle accidents (8%).
Fall-related injury hospitalizations - per 100,000 age 65+ <sup>13</sup>	1837.0	1789.9	*	• Most falls occur in persons age 65+; falls contribute to a decline in health and functioning.
Driving after drinking (grades 9-12) <sup>11,12</sup>	8%	29%	*	• Hospitalization rates for motor vehicle-related injuries are slightly lower than Mass. rates.
Suicide attempts among teens (grades 9-12) <sup>11,12</sup>	7%	10%	2%	• 32% of female and 20% of male Mass. students seriously consider suicide; 10% attempt it.

<b>Reducing Substance Abuse</b>				
Deaths related to tobacco, alcohol, and drugs - % per year <sup>7</sup>		23%	*	• In Mass., 19% of deaths are related to tobacco use; 4% are related to alcohol and drug use.
Alcohol and drug hospital admissions - rate per 100,000 <sup>14</sup>	1097	546	*	• Cambridge rate is higher than that of Massachusetts and other cities and towns.
Binge drinking - past 30 days (grades 9-12) <sup>11,12</sup>	29%	33%	*	• Having 5+ drinks (one occasion, past mo.) is associated with other health risk behaviors.
Cigarette smoking - past 30 days (grades 9-12) <sup>11,12</sup>	13%	37%	6%	• Use of alcohol and marijuana is much more frequent among teens who smoke cigarettes.

<b>Preventing AIDS and Sexually-Transmitted Disease</b>				
Death due to AIDS - rate per 100,000 ages 25-44 <sup>7</sup>	43.9	21.7	*	• Cambridge death rates are higher in Black (168.5) and Hispanic (100.5) males, age 25-44.
Persons with AIDS - total number <sup>15</sup>	334	12,504	*	• Cambridge is 6th among the Mass. cities and towns with the highest case rates.
STD (Chlamydia) - rate per 100,000 age 15-19 <sup>16</sup>	656.0	572.0	*	• Rates of Chlamydia among ages 15 to 19 are three times higher than the population as a whole.
Sexual activity - % ever had sex (grades 9-12) <sup>11,12</sup>	44%	46%	15-40%	• Early sexual activity and multiple partners increases risk for pregnancy, STDs, and HIV.
Condom use - last sexual encounter (grades 9-12) <sup>11,12</sup>	78%	56%	60-75%	• Rates of condom use and abstinence have gone up among teens in Mass and Cambridge.

Demographic Vital Statistics	Cambridge	Mass.	Cambridge	Mass.
Total Population <sup>17</sup>	95,802	6,016,425		
Under 15	12%	19%		
15-44	63%	49%		
45-64	14%	19%		
65 and over	11%	14%		
Public school students whose primary language is not English (PLINE)	30.1%	12.5%		
Languages spoken - % PLINE students				
Spanish	34%	53%		
Haitian-Creole	23%	3%		
Portuguese	16%	10%		
Chinese	8%	6%		
Other languages	20%	28%		
Birth rate - rate per 1,000 residents (1991-95 average) <sup>2</sup>			11.3	14.2
Births - number (1991-95 average)			1,083	85,065
Deaths per 100,000 - age-adjusted rate (1996) <sup>7</sup>			396.8	439.6
Education level <sup>17</sup>				
Percentage of residents ages 25 and older:				
Have not received a high school diploma			16%	20%
Highest level is high school diploma			16%	30%
Highest level is some college or associate degree			14%	23%
Highest level is bachelor's degree or higher			54%	27%
Poverty status <sup>17</sup>				
% of population living below the federal poverty line			11%	9%
% of children under 18 living below the poverty line			15%	13%

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**1998 Public Health Assessment:  
Improving the Health of Cambridge**

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**Cambridge Public Health Commission  
January 1998**

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# 1998 Public Health Assessment: Improving the Health of Cambridge

## Health of Cambridge at a Glance

Inserted in Folder

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## Cambridge City Council and City Manager

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

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Anthony D. Galluccio  
Kenneth E. Reeves  
Sheila Doyle Russell  
Michael P. Sullivan  
Timothy J. Toomey, Jr.  
Katherine Triantafillou

Robert Healy, City Manager

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## **Cambridge Public Health Commission Board**

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Eugene Brune  
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William Craig  
Elaine DeRosa  
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### **Neville Manor Board**

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Terry Cline, Ph.D.

William Craig

John Francis

John O'Brien

Estelle Paris, R.N.C.

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### **Acknowledgements:**

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The authors wish to thank John O'Brien and David Bor for their invaluable insight and leadership, as well as Joan Gillis, Lorna McLaren, Brenda Mahnken, Jeff Walker, and Luke Wennik for their diverse roles in the support and completion of this document.

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## Executive Summary

In 1997, the Cambridge Public Health Commission (CPHC) began the annual public health assessment process by providing two comprehensive documents to the City of Cambridge—twelve chapters of statistical health data for the City of Cambridge and 26 chapters describing programs. Through this annual report process, the CPHC described the depth and breadth of the health issues that face residents as well as the wide array of programs and services that have developed in order to address these concerns.

The 1998 Public Health Assessment: Improving the Health of Cambridge provides an opportunity to transform an annual report into a year-round cycle of identifying and prioritizing needs, taking action and measuring progress towards community health improvement. Building on the information we reported last year, we propose to increase the relevance to and commitment of a broader community to the assessment process. In turn, CPHC accountability to City Council and Cambridge residents will be enhanced by:

- Soliciting input from a broader array of community participants
- Maximizing our resources as to address a broad public health agenda, while providing particular focus to a shorter list of priority public health concerns
- Providing a continuous quality improvement framework and tools for identifying action plans and measuring progress in priority health areas
- Developing a more standardized approach to analyzing program information
- Reporting on the progress toward improving community health

Rather than an updated report on all the important public health issues, the 1998 Assessment focuses on six priority health issues for the City of Cambridge. The evidence for these priorities was drawn from the 1997 Public Health Assessment, from the current work of the Boards of the CPHC, from the past work of the Health Policy Board in their 1992 and 1994 APEXPH (Assessment Protocol for Excellence in Public Health) process and the insights of community partnerships (Health of the City, Somerbridge, and others). Each of these groups provides the City with direction-setting and actions to address community health needs.

The six public health issues for focus in 1998 are **Violence Prevention, Access to Health Care, Substance Abuse, HIV/AIDS, Environmental Health, Health Promotion and Disease Prevention**. The rationale for selecting these six priority health issues includes: the relative burden of health issues on the population; level of determined need and priority by community and leadership organizations; programmatic capacity to meet the needs of the community; synergy with strategic priorities of the CPHC in areas of clinical quality improvement and the work of Joint Public Health Board. A few representative examples of progress in each area are also provided in this report.

## 1998 PUBLIC HEALTH ASSESSMENT: IMPROVING THE HEALTH OF CAMBRIDGE

It is important to note that these focus areas represent a partial list of health issues that are vital to a healthy community. The complexity of social and personal health cannot be reduced to a few items, nor can the entire range of factors that affect health. A complex web of people and institutions contribute to a healthy community. We are fortunate in Cambridge to have such a well-functioning system.

**Violence Prevention:** The CPHC has been at the forefront to reduce violence and respond to the community in times of need, and is a fully committed partner in Cambridge's Domestic Violence Free Zone. The broad aim of violence prevention includes all forms of violence, but recognizes the significant threat posed by domestic violence to the health and well-being of so many Cambridge residents. Programming for victims, including children who witness violence, primary prevention to reduce violent behavior at early ages and assistance for perpetrators are all part of a comprehensive response.

**Access to Health Care:** The CPHC has a long standing mission to provide access to high quality health care services. New and ongoing funding mechanisms to assure access to all Cambridge residents are demonstrated by Network Health, a recently developed pre-paid health plan. In addition, CPHC has improved access to the full range of services required to improve and restore health; new efforts to coordinate outreach to particularly vulnerable groups.

**Substance Abuse:** Addiction and abuse of alcohol, tobacco and drugs results in significant social and economic burdens on the community. CPHC providers and programs are participating in several cross-agency collaborations to improve early identification and appropriate treatment and referral of those with substance abuse problems.

**HIV/AIDS:** Coordination between HIV/AIDS service providers and collaborative programs with community partners are facilitated by active involvement of CPHC programs in order to address the complex medical and social needs of people living with AIDS. In addition, CPHC actively engages in outreach and educational efforts to prevent the spread of HIV in populations at risk.

### **Health Promotion and Disease Prevention and Environmental Health:**

Two health priority issue areas, Environmental Health and Health Promotion and Disease Prevention, are currently provided by a broad range of individual programs and agencies. For both issue areas, there is opportunity to move from informal cooperation to a more formal and coordinated level of collaboration in program development and service delivery. For example, CPHC's newly created Division of Community Affairs will work to encourage healthier behaviors through improved education, implementation of core training and oversight of outreach efforts across CPHC programs. Significant gains in effectiveness are expected. The addition of dedicated environmental health staff will

contribute to the Public Health Department's ability to improve capacity in this important health area.

The following describes the organization of the document and how these health priorities are impacted through multiple activities and approaches.

**Health of Cambridge at a Glance** provides a snapshot of Cambridge through health statistics and offers comparison with state and national goals and benchmarks. The statistics are presented under headings that reflect current public health priorities for the community. This publication is inserted in your folder.

**Part 1: Governance** provides essential information about the board structure of the Cambridge Public Health Commission (CPHC).

**Part 2: Overview of the Health Care Environment:** Overview of Health Care Environment focuses on the priority to expand access to health care. This chapter presents the challenges and opportunities for the CPHC in the face of rapid changes in the health care environment on the national, state and industry levels. The recent intensity with which the landscape of medical care in Massachusetts is changing is described, including increased consolidation, fierce competition among managed care organizations for "covered lives" and changes in reimbursement mechanisms.

The number of uninsured has increased to nearly 13%, over 766,000 residents of Massachusetts. Federal reforms to address this problem include the \$24 billion Children's Health Care Program, which will result in new coverage for 2 million children. Reform in Massachusetts includes legislation that establishes more equitable financing system for the Uncompensated Care Pool. The CPHC has established the Network Health Plan, one of the options available to MassHealth recipients. The CPHC has also entered into separate affiliations with Partners Healthcare System and CareGroup. Additionally, CPHC offers an integrated health system that includes a range of clinical programs and public health initiatives.

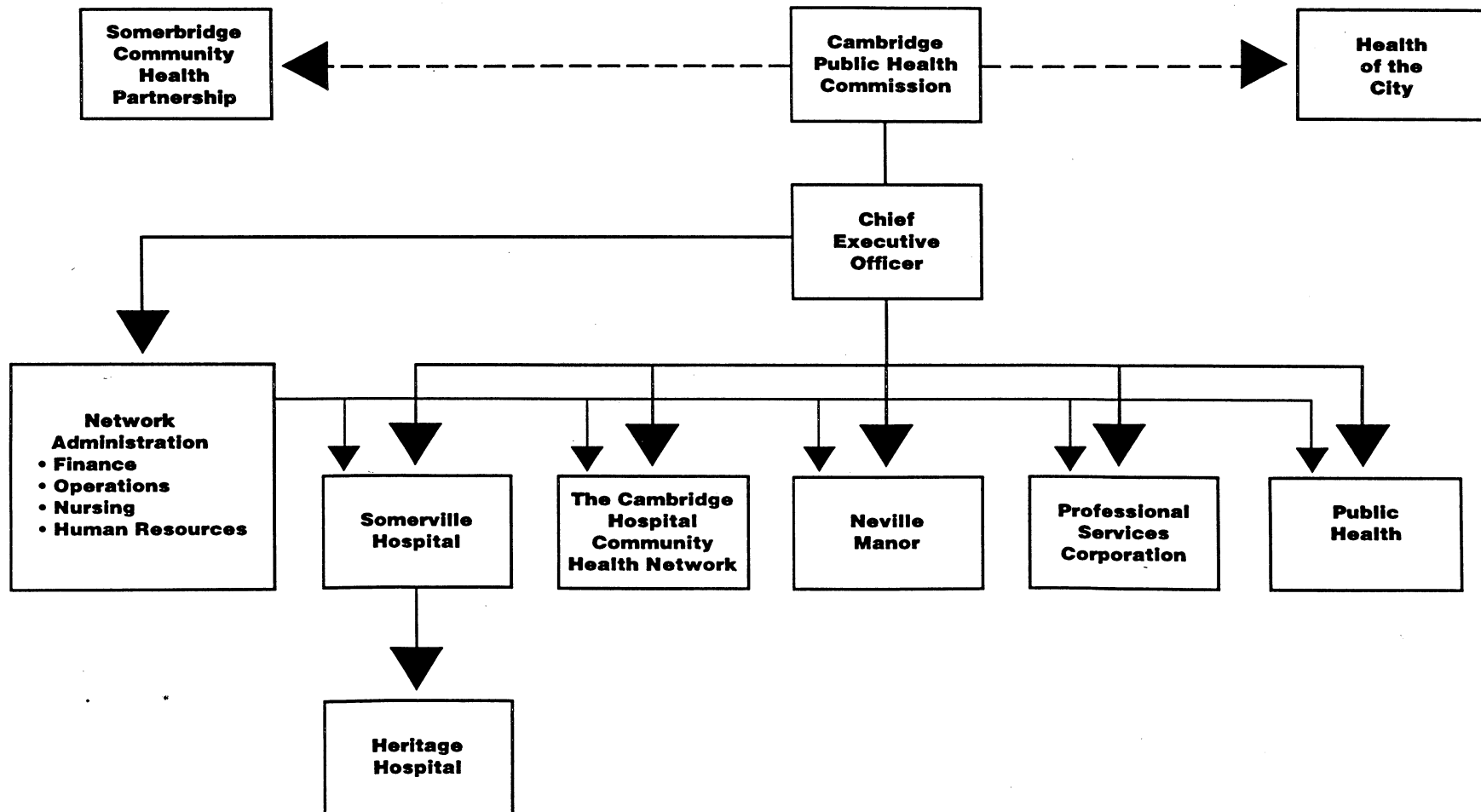
**Part 3: A Continuous Process for Community Health Improvement** reflects the commitment of the CPHC to the goal of improvement. Continuous quality improvement methods are useful to clarify and focus program aims and standardize reporting and measurement techniques. Thus, they are excellent tools for working in the complex setting of community health improvement.

This report describes the pilot year initiative, during which the Cambridge Public Health Department will facilitate priority-setting and measurement of health improvement work by convening existing experts and working groups from the six public health issue areas. It is hoped that concerned consumers and residents will also participate in the process. Regular reports to the Cambridge Public Health Commission are planned throughout the pilot year.

A pilot for testing the model in the area of substance abuse was established in December with an existing, cross-agency working group – The Cambridge Prevention Coalition, and is described in this report. Lively, rich discussion and enthusiasm for Assessment model were evident. Next steps will include prioritizing, group formulation of goals, measurements and action steps. This model has generated enthusiasm and a platform from which to work together. The model will be improved and customized according to the needs of different issue area work groups.

**Part 4: The Cambridge Agenda for Children.** This chapter provides an update on a collaborative effort to establish measurable goals and objectives to affect the lives and health of Children in Cambridge. Organized around the needs of an age-defined target population, the Agenda for Children was spearheaded by the CPHC, the School Department and the Human Service Department, and builds on work started 10 years ago by the Cambridge Policy on Children, Youth and Families. The agenda project will elicit community input on a variety of issue areas, establish common goals, and develop a process to implement and evaluate the progress.

# CAMBRIDGE PUBLIC HEALTH COMMISSION NETWORK ORGANIZATIONAL STRUCTURE



## **Part 1. Governance**

The efforts of the Cambridge Public Health Commission (CPHC) to serve Cambridge are facilitated by a governance structure that provides policy oversight to each part of the system. (See Governance chart on previous page.)

**The CPHC**, chaired by Richard deFilippi, Ph.D., is responsible for:

- *Meeting the challenge of the changing health care environment*
- *Ensuring the continuous delivery of quality health care to the residents of the Commonwealth of Massachusetts within the Commission's services area*
- *Coordinating outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation and long term services to create a comprehensive and integrated continuum of care to promote health and well being in the Commission's service areas*
- *Educating physicians and caregivers*

Standing committees of the commission include: The Joint Hospital Board, the Joint Public Health Board, The Professional Services Corporation Board and the Neville Manor Board.

**The Joint Hospital Board**, chaired by Terry Cline, Ph.D. , is responsible for:

- *Serving as the governing body of The Cambridge Hospital and The Somerville Hospital*

This board has two subcommittees: Credentials and Quality Improvement.

**The Joint Public Health Board**, co-chaired by Mary Ann Hart, R.N., and Jack Hamilton, are responsible for:

- *Assessing community health status for Somerville and Cambridge and availability of resources to meet identified needs*
- *Developing policy to support proposals that encourage better health through resource allocation and advocacy*

## 1998 PUBLIC HEALTH ASSESSMENT: IMPROVING THE HEALTH OF CAMBRIDGE

- *Assuring that needed services are available through the CPHC and community partnerships*

Subcommittees of the board include the Geriatrics Task Force, the Women's Health Task Force, the Cambridge Public Health Subcommittee and School Health Task Force.

**The Neville Manor Board**, chaired by Neil Rosenburg, is responsible for:

- *Recommending and/or approving institutional policies including, but not limited to, end-of-life arrangements and involvement in managed and subacute care*
- *Participating in strategic planning efforts*
- *Monitoring operations, requesting and reviewing financial and other operating indicators, approving operating and capital budgets and providing financial stewardship*

**The Professional Services Corporation Board**, chaired by Richard deFilippi, Ph.D., is responsible for:

- *Providing financial, organizational and administrative oversight of the corporation's business activities and property*

## **Part 2. Overview of the Health Care Environment: Strategies and Key Initiatives of the Cambridge Public Health Commission**

The first part of this overview chronicles the changes in health care at the national and state levels and describes the strategies and major initiatives of the Cambridge Public Health Commission (CPHC). Amidst revolutionary change in the health care environment, the core mission of the CPHC is to provide quality health care services and meet community need. The CPHC stands behind our tradition of providing access to all persons regardless of their ability to pay.

### **A. The Health Care Environment**

#### **The Health Care Industry**

The trend of consolidation has defined the health care marketplace of the last decade and has recently intensified. Through strategies such as mergers, acquisitions, affiliations and formation of integrated delivery systems, providers are attempting to enhance health care resources for patients and bargaining power with payers.

A snapshot of Massachusetts medical centers since 1990 provides examples of rapid change in the health care industry: 16 announced mergers; 23 acquisitions; 16 holding company affiliations and 29 contractual affiliations. Parallel trends toward consolidation have included the growth of Health Maintenance Organizations (HMOs). The development of powerful regional health care networks (such as Partners and CareGroup) have changed the pace at which affiliations take place. These networks have emerged as dominating forces whose strategic relationships have strengthened their negotiating positions with insurers. This has gradually led to changes in patient care as well as the management of the health care dollar.

Managed care continues to grow in Massachusetts. Approximately 2.7 million people, more than 60% of who have private insurance, belong to HMOs. The fastest growth in managed care is taking place in the Medicare and Medicaid populations that the CPHC has traditionally served and there is fierce competition among HMOs to gain "covered lives." Marketing targeted to enroll new members is intense, as illustrated by high media and marketing expenditures among the state's managed care plans.

#### **Growth in the Uninsured**

The growing number of people who lack health insurance in Massachusetts remains a concern. According to the latest data available from the U.S. Census Bureau, analyzed by Boston University School of Public Health's Access and Affordability Monitoring Project, approximately 776,000 Massachusetts residents – one person in eight – lacked health insurance in 1996.

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The rise in the number of uninsured has occurred despite economic growth. Between 1992 and 1996, the number of uninsured individuals increased by approximately 23% despite a 9% increase in the number of jobs. A recent study by the Harvard School of Public Health found that 64% of uninsured adults in Massachusetts were employed. The majority of the workers were uninsured because their employers did not offer plans or because they could not afford their share of the premium.

The CPHC continues to provide services to a large uninsured population. Approximately 39% of the CPHC's Fiscal Year 1997 patient service revenue (\$57 million) is derived from uninsured patients. In addition, the CPHC provides significant services to patients who are covered under public programs, with 28% and 17% of our patient service revenue from Medicare and Medicaid, respectively.

### **Health Care Financing and Policy: Federal Health Care Reform**

The federal Balanced Budget Act of 1997 (BBA) contains a number of provisions that impact health care. This legislation presents both opportunities and challenges for the Cambridge Public Health Commission (CPHC).

The BBA established a federal framework for several key health care programs. A new \$24 billion Children's Health Care Program has been established – the single largest health care initiative since the creation of Medicare and Medicaid over 30 years ago. The Congressional Budget Office estimates that this program will result in new coverage for approximately two million children. Funding to states became available on October 1, 1997; its allocation is based on each state's share of uninsured children below 200% of the federal poverty level, with a floor established such that no state will receive less than two million dollars in any fiscal year.

Under this act, health care providers like the CPHC are permitted to operate Medicare-managed care plans. Provider-sponsored health plans are therefore able to apply for direct contracts with Medicare to provide comprehensive medical care to beneficiaries. With less onerous state and federal regulations than apply to traditional HMOs or other insurance entities, providers are allowed expedited entry into managed care.

Provisions amending Medicare and Medicaid make it easier for both beneficiaries and providers to participate in managed care programs. With the CPHC's current payer mix highly concentrated in both programs, our preparation for and participation in managed care is crucial to our future viability and continued relationships with many of our patients.

However, the Balance Budget Act also contains reductions in key federal funding resources for safety net institutions (those which care for a disproportionate share of free care patients) such as the CPHC. Such payments to safety net providers in both the

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Medicare and Medicaid programs have been cut substantially. Overall, there is \$116 billion net savings in Medicare over the past five years, \$44 billion of which comes from fee-for-service payments to hospitals.

### **Changes in Reimbursement**

Health care providers are also experiencing reductions in reimbursement from traditional commercial insurers and HMOs. This was recently exemplified in Massachusetts by Blue Cross' request to reduce rates of reimbursement to hospitals in order to eliminate its direct contribution to the Uncompensated Care Pool (UCP).

Since 1994, health insurance premiums have generally increased at a rate lower than the medical inflation rate. In Massachusetts, family HMO premiums fell on average by 1.5% in 1996. Price driven pressures and reduced payment trends are expected to intensify. This means reduced reimbursement to providers through various restrictions on coverage (such as limiting hospital stays).

### **Massachusetts Health Care Reforms**

In July 1997 the state legislature enacted Chapter 47, which significantly revised contributions to the Uncompensated Care Pool (UCP), the primary reimbursement mechanism for free care services provided by hospitals and health centers. This legislation seeks to establish a more equitable financing system for the UCP, with funding to be shared by hospitals, insurers, the business community and state government.

Revisions to the UCP were precipitated by several factors. In recent years, the cost of free care provided by Massachusetts hospitals has far exceeded the amounts available through the UCP. This fiscal year, the cost approached \$500 million, while the private sector funding for the UCP had been capped by the state at \$315 million. While the new law maintains this cap, it earmarks a \$100 million portion as a contribution by insurers through a surcharge on health care services provided at hospitals. In addition, the Commonwealth will increase its share from \$15 million to \$30 million; there will be a \$70 million contribution from the federal government.

In tandem with other state health reform efforts, the Commonwealth has sought to reduce the number of uninsured individuals through several new health care access initiatives. MassHealth (formerly known as Medicaid), was expanded in July of 1997 to provide coverage to an additional 135,000 individuals. The MassHealth waiver expands access to health care for more low-income families, pregnant women, children and persons with disabilities by liberalizing the income guidelines for eligibility from 100% of the Federal Poverty Level (FPL) to 133%. Pregnant women and children under age one are eligible up to 185% of the poverty level. In addition, MassHealth coverage is extended for the first time to a new category of long-term unemployed individuals.

In response to these changes, the CPHC has created the Network Health Plan to help place the City of Cambridge on the forefront once again. Network Health is now one of eleven managed care health plan options available to MassHealth recipients, implemented through a direct contracting program with the Massachusetts Division of Medical Assistance. Many of our former “free care” patients are eligible for this new program and are being encouraged to apply for Network Health.

Further health care expansions on the horizon include an extension of MassHealth eligibility to children up to age 18 and pregnant women whose family income is under 200% of the FPL.

### **Access to Health Care by Immigrants**

Despite these notable health care expansions, access to service remains a concern for many uninsured individuals, especially for immigrants. Immigrants have extremely limited eligibility for coverage under the recent health care expansions and some are eligible only in certain emergency circumstances.

Many health care systems, like the Cambridge Public Health Commission (CPHC), which have provided health care to immigrants will therefore continue to rely on the Uncompensated Care Pool (UCP) for reimbursement for these services.

Over the last year, the CPHC has seen a chilling effect on immigrant access to health care services, spurred in part by a policy of the Immigration and Naturalization Service (INS) which views the Massachusetts UPC as a public benefit. Immigrant patients may fear that using free care services may lead the INS to reject applications for legal status and thus they may be deterred from seeking health care.

The CPHC, along with members of the Massachusetts Hospital Association and members of the immigrant advocacy community, has been working with the INS to resolve this problem. The goal is to determine that payment for services by the UCP will not be considered grounds for rendering an individual ineligible for permanent resident status. The CPHC will continue to provide health care services to all patients without regard to their ability to pay, their country of origin, or their immigration status and will employ the highest standard in protecting patient confidentiality, as permitted by law.

The Cambridge City Council has set an admirable example in its support of immigrant health access with adoption of the Council resolution in recent months. Collaboration between the CPHC and the City Council on this important matter sets a strong precedent.

**B. The Key Initiatives of the Cambridge Public Health Commission (CPHC)**

The CPHC is well positioned for health care access expansion efforts and policy debates on both the state and federal levels. The CPHC has traditionally served the intended beneficiaries of the initiatives of MassHealth and children's health care. The CPHC's participation in access expansion efforts is crucial to meet the needs of patients and to our future viability. While programs directed at low-income populations pose both challenges and risks for the CPHC, we are poised to be full participants in the roll-out of these expansions:

1. The launching of Network Health, the CPHC provider sponsored pre-paid health plan, is the centerpiece of efforts to expand health care access in the Massachusetts managed care environment. On July 1, 1997, the Massachusetts Division of Medical Assistance entered into a direct contract with CPHC to provide comprehensive benefits to MassHealth beneficiaries through Network Health. This agreement was the result of three and a half years of planning between CPHC and the state. The addition of the capitated managed care program supplemented a CPHC fee-for-service program called Network Health (Plan A) that began enrolling members in August 1995. With a current membership of approximately 8,500 in the two programs, Network Health is a health care option for both MassHealth members and for uninsured individuals who are not eligible for MassHealth. Network Health is the platform from which the CPHC will explore managed care opportunities in other markets, including potential to develop a similar provider sponsored organization for Medicare in the coming months.

2. The CPHC integrated health care coverage across the communities of Cambridge and Somerville, which has strengthened our market position. The CPHC currently provides a comprehensive range of health care services through the Cambridge Hospital, Somerville Hospital, Heritage Hospital, Neville Manor Nursing Home and 16 community health centers. The CPHC has made significant steps to integrate our systems of care (including a system-wide information program, a unified medical staff and integration of our clinical systems and departments) with cost effectiveness in mind, in order to make the organization more attractive to managed care contractors.

3. The CPHC's reorganization to a public authority made it possible for the recently announced Memoranda of Understanding to affiliate separately with Partners Healthcare System and CareGroup. This model is unique in Massachusetts. It is expected that the definitive agreements with each of these major systems will be complete by the end of January 1998. The CPHC is pleased to have reached these landmark agreements and about the potential for a collaborative development of an Institute for Community Health, to promote public health in the Cambridge and Somerville communities.

Affiliating with these two larger, regional health care systems is critical for the CPHC in several ways. The CPHC's ability to continue to fulfill our mission is dependent upon high quality health care, cost effectiveness and adequate payment for services delivered to

our patients. Partners and CareGroup have strength in numbers of participating patients, which constitutes significant bargaining leverage to obtain managed care contracts at favorable payment rates. Systems like the CPHC's, which has a small share of the private payer market, are at a disadvantage in negotiations with managed care organizations if unaffiliated. Larger systems also have the extensive cash reserves necessary to fund primary care practices, program development and capital needs for their affiliates. Additionally, large networks have the capacity to develop highly integrated delivery systems that provide a continuum of care with state-of-the-art information technology to support clinicians.

The dual affiliation agreements with the Partners and CareGroup health care systems will allow the CPHC to serve the best interests of our patients and community by ensuring access to extensive resources. Rather than entering into an exclusive agreement with either system, the CPHC will be able to maintain its close clinical and academic ties with both systems. Patient care and referral paths will be preserved by these relationships. The ability of our primary care providers to continue to see their patients, access specialists and tertiary hospital services as they have in the past will be maintained.

The CPHC has taken a number of actions to ensure its financial viability and its ability to continue to serve the health care needs of the citizens of Cambridge.

4. The CPHC's integrated health system includes public health initiatives which aim to generate organized community efforts that address public interest in health by applying technical knowledge to prevent disease and promote health. Public health initiatives within the commission include a wide range of activities that fall within the three core elements of public health: assessment, policy development and assurance. The chart on page 14 identifies public health activities within the commission.

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<i><b>Core Functions of Public Health<sup>1</sup></b></i>	<i><b>Resources<sup>2</sup></b></i>
<p><u><i>Assessment</i></u></p> <ul style="list-style-type: none"> <li>• assess health needs periodically and systematically</li> <li>• investigate occurrences of adverse events</li> <li>• analyze the determinants of health</li> </ul>	<ul style="list-style-type: none"> <li>• Health Information Unit, Public Health Dept., Institute for Community Health</li> <li>• Public Health Dept., Clinical Services</li> <li>• Health Information Unit, Partnerships, Institute for Community Health</li> </ul>
<p><u><i>Policy Development</i></u></p> <ul style="list-style-type: none"> <li>• advocate and build constituencies</li> <li>• set priorities for public health legislature</li> <li>• develop plans and policies to achieve priorities</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Services, Partnerships</li> <li>• Joint Public Health Board</li> <li>• Joint Public Health Board, (All)</li> </ul>
<p><u><i>Assurance</i></u></p> <ul style="list-style-type: none"> <li>• manage and coordinate resources</li> <li>• implement programs</li> <li>• evaluate programs and assure quality</li> <li>• inform and educate the public</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Services, Public Health Dept.</li> <li>• Clinical Services, Public Health Dept.</li> <li>• Clinical Services, Institute for Community Health, Health Information Unit</li> <li>• All</li> </ul>

<sup>1</sup> Adapted from Public Health Practice Program Office, Center for Disease Control, 1991.

<sup>2</sup> Clinical Services: The Cambridge Hospital (TCH), Somerville Hospital, Community Health Centers  
Partnerships: Somerbridge, Health of the City, Kids Council, Prevention Coalition, Somerville Health Agenda and others

## **Part 3: A Continuous Process For Community Health Improvement**

### **I. Introduction and Overview**

The 1997 Public Health Assessment, Parts I and II provided a comprehensive picture of the health issues in Cambridge and the programs available to residents. The reports provided valuable information for assessing health needs and program implementation. Part I provided a thorough compilation of health statistics on Cambridge residents. Chapters in Part II were written by individuals well versed in their specific subject area. Each writer collected data regarding Cambridge-based programs and wrote a “SWOT” analysis, identifying Strengths, Weaknesses, Opportunities and Threats.

The 1998 Public Health Assessment builds on the lessons learned from the 1997 reports. However, this year the Cambridge Public Health Commission (CPHC) will describe the pilot of an annual process for moving the work of the Cambridge public health community forward. This pilot represents an organic, continuous quality improvement model that requires yearly review and input from community stakeholders, Cambridge City Council and the CPHC. The goals of a continuous process for community health improvement are:

- Focus the assessment on a few priority public health areas in order to maximize resources and provide accountability on issues requiring the most attention.
- Solicit input and facilitate on-going collaboration on each priority health area from a spectrum of stakeholders and community partners, most of whom are actively working on the issue.
- Provide a continuous quality improvement framework for representatives in each public health priority area to use in jointly identifying and prioritizing key issues, common goals, and strategies.
- Provide the tools and build commitment from stakeholders within each priority area to measure the progress towards one or two goals.
- Develop a more standardized reporting structure which facilitates objective analysis and promotes creative resource allocation both within and across priority areas.
- Ultimately, provide accountability for the CPHC community health improvement work to City Council and the residents of Cambridge.

The intent of this iterative process is not to create more work for providers and community partners, nor does it presuppose that collaborative, goal-setting work is not already in progress. To the contrary, a mix of institutions, individuals, coalitions and taskforces are currently contributing to the core functions of public health (discussed in Part II). This on-going, inclusive process will facilitate community-wide direction for health improvement work.

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The 1998 revisions are pivotal because we need to convert the assessment from an annual report to a dynamic, day-to-day collaboration. The CPHC is developing a sustainable process in order to meet its obligations to the Cambridge City Council and to the people of Cambridge. The continuous process for community health improvement will permit the CPHC to build upon previous work, to acknowledge gains, to learn from mistakes and to identify emerging concerns. The process to be piloted this year is significantly different from the way last year's report was assembled.

- In 1998 the CPHC narrows the focus of our assessment to six selected priority health issues – violence prevention, access to health care, substance abuse, HIV/AIDS, environmental health and health promotion and disease prevention – which are discussed in Section Two.
- The CPHC will pilot a year-long process based on continuous improvement tools and involving community partners. The model for this community health improvement process and the schedule for implementation are discussed in Section Three.
- The CPHC will facilitate this process to build on the analyses from last year. A recent pilot exercise in issue identification and priority setting for the area of substance abuse was conducted during an expanded Cambridge Prevention Coalition meeting. The results were very encouraging – group members appreciated the framework used to examine the priority health issues and engaged in productive discussion. The SWOT analysis and themes running through the 1997 Assessment provided the basis for this work. This initial community involvement in the public health assessment and planning process is also described in Section Three.

The 1999 annual assessment report to the City Council will report on the effectiveness of the model during the pilot year and the results of the collaborative group process.

## II. Prioritizing Health Issues

### A. Introduction

The prioritization of the following six health issues for the City of Cambridge was drawn from the 1997 Public Health Assessment, with important contributions from Boards of the Cambridge Public Health Commission (CPHC), from the past work of the Health Policy Board in their 1992 APEXPH (Assessment Protocol for Excellence in Public Health) process, and the insights of community partnerships (Health of the City, Somerbridge, and others) – all of which have facilitated direction-setting and action to address community health needs.

#### *Six public health issues for focus in 1998:*

- Violence Prevention
- Access to Health Care
- Substance Abuse
- HIV/AIDS
- Environmental Health
- Health Promotion and Disease Prevention

These major areas represent only a partial list of issues that are vital to a healthy community. The complexity of social and personal health cannot be reduced to a few items, nor can the entire range of factors that affect health. A web of many individuals and institutions make up a healthy community, and we are fortunate to have such a well-functioning system in Cambridge.

Health risk is not uniform. While the entire population is affected by the aforementioned health issues, there are sub-populations who may be at increased risk for poor health. Public health must focus on groups and individuals with the highest need and those who may possess the fewest personal or economic resources to address their needs. For example, persons who are either unemployed or under-employed, or whose employers do not provide health care insurance make up a target population for Access to Health Care. There are other populations such as immigrants and non-English speakers, for whom strategies to enhance access are needed.

Priorities should evolve as needs change. Many issues are not mentioned because the level of effort and resources are sufficient to maintain positive outcomes, or because great strides have been made in addressing the issue. An example is the area of childhood immunization, deemed the number two issue (paired with adequate primary care for children) by the Health Policy Board in their 1992 Assessment. The CPHC has seen a dramatic increase in the proportions of children fully immunized by age two, up from 60% in 1993 to 90% in 1996, due to the funding and collaborative programming of the Immunization Action Project. Certainly, rates of immunization need to be continuously monitored as an important marker of child health to assure that they are at or exceed the

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90% mark. If this goal is not maintained, immunization must again receive extra attention.

To develop a systematic plan involving broad sectors of the community and to measure CPHC's effectiveness at meeting the challenges inherent in these issues, it is necessary to prioritize a shorter list of very important areas of health and disease reduction.

### **B. Rationale**

The following general criteria were used to select the six areas of focus for the coming year. As the 1998 process continues, these criteria will also help to target populations (youth, elders, young parents) and other key programmatic themes (access to services, capacity to provide prevention education and medical care, ability to measure and evaluate programs) for improvement goals.

#### **Identification of these six important health issues:**

- Considers the **relative burden of health issue on the population** using standard measures (morbidity, mortality, risk behavior, health care utilization) along with other sources of information. Targets specific populations within each issue as appropriate. (Please refer to Part I of the 1997 Public Health Assessment, The Health of Cambridge and the 1998 Health of Cambridge at a Glance, both enclosed, for health data.)
- Considers the **programmatic capacities** of the CPHC, alone and in collaboration, to **fulfill the core public health functions** for the City of Cambridge. (Please refer to Part II of the 1997 Public Health Assessment for data concerning the specific capacities to address the issues).
- Reflects **areas of determined need and priority by community and leadership organizations**. The health issues reflect areas where considerable energy is being devoted.
- Creates **synergy with the strategic priorities of the CPHC** in areas of clinical quality improvement.
- **Supports the CPHC's prioritization process** and, with as much breadth and specificity as required, supports further creation of action plans for improvement in each health area.

## **C. Description of the Priority Public Health Issues**

### **1. Violence Prevention**

For many years, the Cambridge community has identified the issue of violence prevention as a critical area of need. The spectrum of violent behavior is broad, ranging from bullying in school to domestic violence to other forms of violent crime. In response, diverse members of the community have united to advocate and develop action plans around this issue. The following highlights from the widespread community effort to reduce violence:

- The Health Policy Board ranked violence as the number one issue for Cambridge in 1992.
- Health of the City convened a Violence Prevention Task Force.
- The Cambridge Police Department began a Domestic Violence Unit to improve the assistance provided to victims of domestic violence.
- The Cambridge Hospital hire a violence prevention coordinator for the City in 1994.
- The Cambridge City Council unanimously adopted a resolution calling for a Domestic Violence Free Zone in 1994.
- Community representatives, including victims, professional service providers, and other advocates came together to formulate a longitudinal framework for making Cambridge a Domestic Violence Free Zone.
- The Men of Color Task Force facilitated violence prevention programming and promoted health to young men of color deemed at risk for being victims and perpetrators of violence.
- The City Manager convened the heads of all City departments to plan and implement city-wide recommendations, which range from victim services to targeted education.

Any violence, particularly homicide, brings unspeakable pain to a community. In response to crises brought about by two separate homicide incidents, the Cambridge Public Health Commission (CPHC) provided support to members of the community who needed assistance. The CPHC was part of a community-wide response to help members of the community deal with the trauma and grief they suffered as a result of these homicides. Professionals from the CPHC, in conjunction with other organizations, were able to provide services directly to members of the community and those in a position to help others such as teachers, counselors, and youth workers. Continued efforts are taking place to assure that such an effective response plan will be in place should another violence-related crisis arise.

Through the efforts of many, the occurrence of violence in Cambridge has declined, which is true for the Commonwealth as a whole. Rates of homicide, violent crime, and violence-related injuries are lower than state averages and averages in many other communities.

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However, domestic violence and abuse remains a threat to the health and safety of many people in our community, particularly women, children (themselves harmed by or witness to violence) and care-dependent adults such as frail elders. The Cambridge Police Department receives approximately 800-1000 calls each year for assistance specifically related to domestic violence. 9% of high school students (9<sup>th</sup>-12<sup>th</sup> grades) at Cambridge Rindge and Latin report witnessing family violence.

Last year's assessment emphasized the strong and effective network of direct service providers, the long-term commitment of the advocacy community, the presence of prevention education in the public and private sector and leadership opposing violence throughout the City. However, more work is required to effectively measure progress, communicate the violence-prevention message to the community and to assure the viability of services for victims and perpetrators in the non-profit sector. Continued support for multi-pronged efforts with respect to community violence is key, as is increased collaboration between service providers and advocates.

### **2. Access to Health Care**

(see also Chapter Two of the 1998 Public Health Assessment)

In Massachusetts, nearly 13% of the population is without medical insurance. On the state level, recent expansions of access to health care through Medicaid, the Children's Medical Security Act and the stabilization of the Uncompensated Care Pool (or Free Care Pool) helped to form an important safety net for those without a regular source of health insurance. Many jobs recently added to the Massachusetts economy are without benefits such as health insurance, affecting the ability of the individual and their families to obtain necessary services. The Cambridge Public Health Commission (CPHC) has long identified access to health care as a key part of its mission. Through the Network Health plan and population-based services the CPHC has strengthened the availability of universal health care services for the City and surrounding area.

The CPHC combines forces with other community organizations to reach out to improve access to care. For example, while partnering with the North Cambridge Center for Families and other organizations, the CPHC's Public Health nurses made nearly 100 home visits to Cambridge residents with newborns, helping to assure a healthy start for infants and young families. Somerbridge Community Health Partnership worked on access to care with immigrants and members of the immigrant advocacy community in response to welfare reform.

There is evidence that access to health care on the local level has improved. Eighty-nine percent of women who give birth each year in Cambridge get prenatal care in their first trimester. Women whose prenatal care is funded by public sources are nearly as likely to receive timely and adequate prenatal care as those with private insurance. As mentioned previously, immunization rates among children have vastly improved, which indicates improvements in accessing primary pediatric care. However, access to primary

care services is crucial to providing high quality and cost-effective care to uninsured and insured alike. Many people who lack insurance do not establish a regular source of primary care and are more likely to receive care that is necessitated by acute illness. There were nearly 1,400 hospitalizations of Cambridge residents in 1995 which may have been prevented with the optimal mix of improved health behaviors and timely, quality medical attention.

### **3. Substance Abuse**

Harm and ill-health effects of substance abuse are an enormous burden to the community. In Massachusetts, an estimated 19% of all deaths are related to tobacco use and 4% are due to abuse of alcohol and other drugs. Approximately 1,100 hospitalizations of Cambridge residents each year are for substance abuse related illness. This is quite costly because many of these admissions are not covered by insurance. In Cambridge, 1996 rates of recent (30-day) cigarette smoking among teens in grades 9-12 at Cambridge Rindge and Latin Schools (CRLS) was 13%; rates of recent alcohol and marijuana use in Cambridge was 42% and 26% compared to 53% and 32%, respectively, in Massachusetts. Cambridge rates surpassed 1992 levels by nearly 10% for alcohol and 13% for marijuana. Similar rates of increase were seen among Massachusetts teens. In addition, rates of recent binge drinking among CRLS students was 29%.

There has been progress in the area of substance abuse control. Area primary care providers are being trained, through collaborative efforts between the CPHC and the Cambridge Prevention Coalition, Department of Human Services Programs, to more effectively detect and treat alcohol problems of their patients. Somerbridge has convened area substance abuse treatment providers to help establish a dialogue to better understand the gaps in access to services.

It is crucial to focus on preventing substance abuse before it starts, particularly among young people, to avoid the costs associated with treating and managing illness and addiction down the road. The available prevention education services are insufficient to meet the need in all age groups, or they are dependent on external funding to be maintained. Treatment services are generally geared toward acute care and detoxification for individuals with chronic substance abuse problems. They are often not available in different languages or often do not meet the needs of special populations. Many providers, educators, and advocates are collaborating through the efforts of organizations such as the Cambridge Prevention Coalition and Somerbridge Community Health Partnership. It will take increased collaboration and strategic planning to understand and address the gaps in the service-delivery system and to truly advance a more prevention-oriented agenda in the substance abuse area.

#### **4. HIV/AIDS and Sexually Transmitted Disease**

The AIDS epidemic represents one of the most significant threats to health. While recent advances in treating those infected with the Human Immune Deficiency Virus (HIV) are encouraging, the disease manifestations of HIV are still fatal. To date, there have been over 330 Cambridge residents among the 12,194 Massachusetts residents diagnosed and reported to have AIDS. AIDS is the leading cause of death among 25-44 year olds in Cambridge (approximately 44 deaths per 100,000), which is significantly higher among persons who are Black (168.5) and Hispanic (100.5). Many Cambridge residents are infected in their teens, twenties and thirties. While more adolescents are abstaining from sex or using condoms during sexual activity, rates of chlamydia among 15-19 year olds are three times higher than the population as a whole.

Important examples of the program facilitated by the CPHC are a collaborative grant with Cambridge Cares about AIDS and Concillio Hispano, to assist patients who may have trouble adhering to complex medication protocols. CPHC has established regular meetings between HIV/AIDS service providers to help them better coordinate and innovate their work.

Transmission of HIV is preventable through a variety of public health measures. Reaching out to individuals at risk remains a challenge that requires constant effort. Persons living with AIDS continue to identify areas where more resources are needed: affordable and decent housing for individuals and families; treatment on demand for individuals who need detoxification and acute inpatient services and increased collaboration between service organizations.

#### **5. Health Promotion and Disease Prevention**

From 1980 to 1996, Massachusetts deaths due to heart disease declined by 41% and stroke declined by 42%. These changes are due in large part to the adoption of healthier lifestyles (e.g., smoking cessation, physical activity, reducing fat and alcohol intake) and the improved medical management of hypertension, cholesterol and other coronary and risk factors. However, there remains an estimated 50% of deaths each year that could be prevented through the adoption of healthier lifestyles, routine screenings and preventive medical care. While the prevalence of smoking among adults has decreased, adolescents are still initiating tobacco use at early ages. Obesity, associated with many chronic and acute medical conditions, has increased in the U.S. In 1995, nearly one quarter of adults in Massachusetts report being obese and 51% report getting little to no physical activity. The prevalence of obesity is 14% among children (age 6-11), 12% among adolescents (age 12-17) and 35% among adults (age 20+) in the United States.

CPHC's commitment to chronic disease reduction is shown through the support of enhanced health promotion and screening initiatives. Improvements in the method prevention and management of childhood asthma initiated by the CPHC are among the

most innovative in Massachusetts. In addition, Health of the City has initiated innovative collaborative programming in the areas of improving nutrition and increasing physical activity among children.

There are critical areas where medical and public health expertise must come together to reduce risk factors for chronic diseases and the related onset of acute illness. As with many health issues, some risks for disease cannot be changed, others are difficult to reverse once established and still others can be prevented all together. Education about good nutrition, exercise and other health habits goes hand-in-hand with providing smoking cessation, weight loss assistance, screening and other care. Through a combination of prevention and effective and timely medical care, many chronic diseases such as heart disease, respiratory disease, hypertension and cancers, can be reduced resulting in improved health outcomes and quality of life.

## **6. Environmental Health**

Environmental health comprises aspects of human health, including quality of life, that are determined by physical, chemical, biological, social and psychological factors in the environment. Ensuring a clean environment and reducing potentially dangerous exposures, along with responding to crises, are all part of an effective public health system. The City of Cambridge engages in a variety of programs intended to protect residents from environmental threats to health. Although enforcement and oversight of these programs rests in several departments in the City, there is a continued need for public health leadership to address environmental health issues, including better coordination and integration of environmental health information being collected by various City departments.

### **III. The Model for a Continuous Process of Community Health Improvement**

#### **A. The Assessment Model**

The model represents an annual cycle designed to involve a cross section of interested stakeholders, to improve the health of Cambridge residents and to facilitate the public health assessment process.

<i>Activities / Tasks</i>	<i>Process or Methods</i>
Identify public health priority areas <sup>1</sup> , population-specific concerns and common themes <sup>2</sup> for facilitating analysis of progress within each priority area.	The Cambridge Public Health Commission (CPHC), City Council and Sub-committee will review and revise annually.
Develop or identify a cross-agency collaborative infrastructure of providers and stakeholders in each priority area.	The CPHC representatives will facilitate convening process. Some priority areas are already served by boards or groups – for other areas, groups of service providers or community stakeholders will have to be convened. We anticipate that groups will discuss these assessment issues quarterly.
Share information on major changes in the environment that directly affect each specific area – such as discovery of new treatment modalities, changes in Federal priorities or loss of specific programs.	The CPHC will facilitate this process with issue-area groups described above.

*Chart continued on next page.*

<sup>1</sup>Priority areas for 1998: 1) violence prevention; 2) access to health care; 3) substance abuse; 4) HIV/AIDS; 5) environmental health, 6) chronic disease prevention

<sup>2</sup>Analysis themes for 1998: 1) access to services; 2) health promotion and disease prevention activities; 3) treatment services; 4) measurement and program evaluation; 5) communication, 6) cultural and linguistic competence; 7) community and interagency collaboration; 8) research and program/policy development and 9) funding.

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<i>Activities / Tasks</i>	<i>Process or Methods</i>
Assess issue-specific Strengths, Weaknesses, Opportunities, and Threats (SWOT analysis) across analysis themes.	The CPHC will facilitate this process with issue-area groups described above.
Select one or two priorities within topic areas, goals, strategies and measures of success, both global and incremental within priority area. Identify opportunities for communicating progress to stakeholders and community.	The CPHC representatives with issue-area groups described above will facilitate this process. There is significant variation among groups in terms of their current level of organization, program funding, and planning apparatus, so the groups will have very different agendas throughout the year.
Implement new action steps and measurement protocols. Continue with on-going work.	Agencies, individuals and groups within each priority area will continue their work and implement any changes identified.
Reevaluate the priorities, goals, action and measurement strategies in each subject area.	The CPHC will facilitate this process with issue-area groups described above, with input from City Council.
Reevaluate the model for a continuous process for community health improvement.	The CPHC will facilitate this process with issue-area groups described above, with input from City Council.
Summarize and report on the work of each group. These reports will provide the basis for the annual Public Health Assessment.  Evaluate resource allocation based on strategies identified as successful and continued gaps.	The CPHC representatives for each priority area will be responsible for convening, facilitating and reporting on the work of the group. The joint Public Health Commission Board, Cambridge City Council, as well as the Cambridge Public Health Sub-committee will play an active role in this process through updates and possibly public forums.

## **B. Schedule for 1998 Public Health Assessment Process**

The following is a tentative schedule of activities for the pilot year of the continuous process of community health improvement. The Cambridge Public Health Commission (CPHC) recognizes that the plan outlined below is ambitious for a first year pilot and that the rate of implementing this model of continuous improvement will vary considerably among groups. Therefore, the 1999 Public Health Assessment report will report on progress toward implementing the model, as well as a critique of the process and the information solicited through out this process.

### **First Quarter**

During the first quarter (January through March 1998), CPHC representatives plan to convene a working group for each of the six priority areas – Violence Prevention, Health Promotion and Disease Prevention, HIV Care and Prevention, Access to Health Care, Substance Abuse, and Environmental Health. Existing groups will provide the basic infrastructure when possible (such as the Cambridge Prevention Coalition for Substance Abuse) or groups will be assembled to represent the major service providers and community stakeholders (for example Health Promotion and Disease Prevention).

The six groups or individuals will review the 1997 Assessment in terms of major changes in their issues area and will identify progress and continued areas of weakness within each of the analysis themes. The groups will begin to identify priorities, interim goals and appropriate measures of progress within each issue area.

During the first quarter, the CPHC staff will provide an update to the Cambridge City Council on the continuous Cambridge Health Assessment process to date.

### **Second And Third Quarters**

Groups will reconvene in the 2<sup>nd</sup> and 3<sup>rd</sup> Quarters (April through September, 1998), to finalize action steps and measurement tools for each priority-area and begin implementation. For most priority areas, the CPHC anticipates only modest refocusing of program activities. However, significant changes are expected in the type and level of information that will need to be collected by most programs. Program and activity evaluation was identified as a universal area for improvement in the 1997 Assessment.

### **Fourth Quarter**

During the fourth quarter (October through December), the groups or individuals will again convene to revisit the progress made over the first three quarters, and assess whether it will be useful to institute this community process on an ongoing basis. There will be many questions to address, such as the best ways to engage and involve the CPHC staff in this ongoing process, how to maximize public involvement and the CPHC accountability to the public while maintaining focus and progress toward goals, and how to identify and use valuable parts of the process to refine and meet emerging needs. The annual Public Health Assessment Report will be produced by the CPHC staff with contribution from members of the six priority issue groups. The cycle begins again at this time, with planning for the following year.

## C. Community Involvement in Public Health Assessment and Planning

### **Example: Substance Abuse**

There is great value to be gained by involving other service providers in the goal-setting process in order to improve the health of the Cambridge. Collaboration in strategic planning and program development can lead to more effective relationships among organizations, thus enhancing productivity. An inclusive process designed to elicit such involvement has been described in the previous section. Such a process was piloted in the area of substance abuse and appears below.

### **A Pilot in Substance Abuse**

The Cambridge Prevention Coalition (CPC) has assembled an advisory group that consists of representatives from many substance abuse prevention and treatment organizations in the city, as well as individuals representing consumers and non-English speakers. This Coordinating Committee is an extremely productive group that has been meeting regularly for a number of years. Since this group is well-versed in the issues of substance abuse and already exists, it was chosen as a pilot for testing the inclusive process for the Public Health Assessment in the area of substance abuse. The Cambridge Public Health Commission (CPHC) plays a significant role in the CPC. The Coordinating Committee is chaired by a CPHC staff member and has several other active members who are CPHC staff, executive or board members. The CPC has been a vital partner with the CPHC in many important prevention and research projects.

When approached with the proposal to pilot the new model, the Executive Committee of the CPC saw an exciting opportunity to take the lead seeking provider-community input for inclusion in the 1998 Public Health Assessment. This is significantly different from the way last year's report was assembled when the report was compiled strictly by individuals knowledgeable in their specific subject areas. Each writer collected data regarding Cambridge-based programs and wrote a SWOT analysis of the subject area, identifying strengths, weaknesses, opportunities and threats. Although attempts were made to check the analysis against other data – “expert opinions,” etc., feedback opportunities were not built into last year's process.

In order to make the most of the occasion of assembling community members, a great deal of preparation was required. The CPC Executive Committee designed a process that encouraged maximum involvement of the substance abuse provider-community:

- *Participation was expanded to include non-CPC members at the initial meeting.* Programs that do not ordinarily send representatives to the CPC Coordinating Committee meetings were contacted and invited to participate in the initial exercise.
- *Executive Committee members did extensive planning to maximize productivity at the initial meeting.* Preparation included careful design of an exercise to elicit feedback on the analysis from the 1997 Public Health Assessment, to identify major changes since last year and to identify continued areas of weakness.

## 1998 PUBLIC HEALTH ASSESSMENT: IMPROVING THE HEALTH OF CAMBRIDGE

- *Next steps identified.* The group will reassemble to prioritize areas of concern, to establish interim goals and to develop measures of progress toward those goals.

In December of 1997 the expanded CPC Coordinating Committee met and began this process with the exercise cited in step two above. The preparation for that meeting entailed reviewing the major themes identified in last year's Assessment and separating out the SWOT analysis from the 1997 Substance Abuse chapter. Strengths, weaknesses, opportunities and threats were identified for each of the following sub-groups:

- Access to Services
- Communication
- Community and Interagency Collaboration
- Cultural and Linguistic Competence
- Funding and Resources
- Health Promotion and Disease Prevention
- Measurement and Program Evaluation
- Research and Program Development
- Treatment and Clinical Services
- Funding

Participants were actively engaged and quite enthusiastic about the project. The results were more rich and comprehensive than anything the CPHC staff could have produced on its own. For example:

- A strength identified under *Access to Services*: "Primary care practices are better able to identify, treat and refer patients because of training in screening and motivational interviewing – building an access point for substance abuse treatment."
- A weakness added to the *Cultural and Linguistic Competence* list: "There has been a decrease in the ability to provide individual and group counseling to linguistic populations, due to loss of funding and Massachusetts Department of Public Health trend away from culturally-specific services."
- An opportunity identified for *Health Promotion and Disease Prevention*: "Public Health nurses can start including substance abuse awareness in elderly housing sites where they are already working by building on current relationships."
- A threat added to *Measurement and Program Evaluation*: "Managed care providers and health care systems are usually interested in services that produce immediate, measurable results and benefits. This may lead to under-funding and under-valuation of prevention efforts with long term effects that are difficult to measure."

As with the first meeting, the CPC Executive Committee will carefully plan the next phase of this project. The tasks will be to engage the group members in a review of the analysis to date, to identify areas of weakness that require the attention of the group or of individual programs and to prioritize those areas. Goals related to those areas will be articulated by the group, methods of measuring progress towards those goals, and action steps will be developed.

## **PART 4: The Cambridge Agenda For Children**

### **I. Introduction**

The six priorities identified in this document are issue-specific areas for public health improvement. In addition to convening groups around specific topics, another strategy for approaching these priorities is to address them within a population. This is an approach taken by those CPHC programs which are designed to meet the needs of specific populations such as men of color, elders and adolescents. The six identified priorities help to shape the work and establish objectives for such programs.

**The Cambridge Agenda for Children** can be seen as a population-based approach to public health and is also another example of inclusive planning in which the CPHC is engaged with Cambridge City Departments. This project is the most vivid example of the leadership of these organizations coming together to identify specific priorities, develop measurements and action plans and to show progress from year to year. It is also a project that reflects and addresses the six priority areas identified in this report, particularly as these issues affect the lives and health of children.

In the Analysis chapter of the 1997 Public Health Assessment, Part II, “collaboration” was identified as an important common theme. It can be described as a complex, difficult process requiring the establishment of common goals and leading to creative redefinition of existing work relationships. “The challenge is to seize the opportunity to enhance collaboration...and align organizational goals so that limited resources are secured and maximized and the public health needs of Cambridge residents are met.” (Page 13).

The Cambridge Agenda for Children is just that sort of opportunity, as well as a powerful example of the scope of accomplishment that is possible when organizations work together.

The Agenda for Children had its inception during discussions between the leadership of the Public Health Department and the Department of Human Service Programs, and quickly expanded to include the leadership of Cambridge Public Schools and the Cambridge Community Foundation. The project began late in the spring of 1997 as a relatively modest plan to assemble existing task forces for the purpose of reducing duplication of planning efforts. It has since grown into a call to action for citizens, service providers and public officials. The charge is to work together to improve the lives of children in Cambridge through the development of common goals and action plans.

The overarching goal of the Agenda for Children is to develop strategies toward building “Healthy Children – Success in School – Strong Community.” The successful development and implementation of those strategies will be dependent upon building a strong alliance, with open communication among all facets of the community.

The Agenda for Children is building upon work that began ten years ago with the development of the Cambridge Policy on Children, Youth and Families. The former effort launched a number of successful initiatives that addressed problems such as hunger, access to health care, child care, adolescent pregnancy and substance abuse. As the CPHC accomplished some of the goals, the momentum from a decade ago had begun to wane. The Agenda for Children brings the opportunity to regroup, redirect and re-energize our efforts on behalf of Cambridge's children.

## **II. Steps Toward Building A Common Agenda**

### **Building Support and Enthusiasm**

Acknowledging and reaching out to stakeholders is an essential first step of any project dependent upon community participation. For the Agenda for Children to be meaningful to the lives of children and families, it must create opportunities for individuals and groups to make contributions to the development of goals. The success of this effort depends upon the investment of broad array of participants. The Agenda for Children will employ a number of mechanisms to engage the full range of community members. Various outreach methods will be matched with particular needs of our diverse community.

The Agenda for Children project began with a meeting of community leaders that convened on September 10, 1997. Sixty individuals attended, representing task forces and community groups working on children's issues in Cambridge. The purpose of this initial meeting was to enlist these key community representatives in enthusiastic partnership and to begin the process of developing common goals.

The general consensus reached at the meeting was that the Agenda for Children will focus on a short list of goals, build upon previous successes and will be crafted with input from a wide range of community members. Subsequently, a plan was developed to engage many types of groups, making a special effort to reach out to Cambridge residents who are not likely to attend a large forum-style event. Emissaries will be trained to go to existing community groups to present the concept and elicit input regarding the Agenda.

Stakeholders in the well-being of children include parents, religious organizations, tenant organizations, neighborhood associations, youth groups, business people, representatives of linguistic, cultural and ethnic groups, educators, health care and human service providers and political leaders. Some of the planned outreach efforts include:

- Community groups will be invited to participate through presentations offered at their regular meetings.
- Children and adolescents will participate through existing activity groups or through focus groups arranged at their facilities.
- Parents will be sought out in their own communities and organizations, through presentations offered in their neighborhoods.
- Business leaders will be enlisted through the Chamber of Commerce.
- Task forces with long histories of successful work will be engaged in discussion and planning.

By rallying the whole city we can bring the human and financial capital of citizens and service providers together to achieve measurable progress in helping all of our children reach their full potential.

**Building on Past Successes**

The current work is being built upon the foundation laid by the Indicators Project. In the course of that effort, benchmark objectives toward the goal of supporting healthy and successful children were identified jointly by the Healthy Children's Task Force (of the Health of the City) and by the Kids' Council (established by the Policy on Children, Youth and Families).

The potential Agenda for Children goals which will be discussed with community members address the following areas:

- School readiness
- Primary care
- Literacy
- Physical activity
- Substance abuse
- Violence prevention

All these issues are critical to children and families in our community, and although the task of addressing these areas is enormous, it is achievable.

**Measuring Our Successes**

It is crucial that, immediately following the establishment of common goals, we focus our effort on identifying action steps and measurable objectives. We must establish a timeline and a system for meeting these objectives. It is imperative that the Cambridge Public Health Commission (CPHC) offers staff resources to educate other stakeholders in the value, language and tools of measuring these efforts.

Many effective and exciting projects in the past decade have had positive impact on the lives of children in our city. The CPHC, Cambridge Public Schools and the Department of Human Service Programs, along with an array of community-based agencies, have developed outstanding curricula. Although much of this good work has been collaborative, our community has now previously experienced the current level of shared commitment among the three departments. Our task is to harness this energy, engage with the community and build on the promise of our future generations.



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5.

EXECUTIVE DEPARTMENT  
ROBERT W. HEALY  
City Manager

RICHARD C. ROSSI  
Deputy City Manager

January 26, 1998

To The Honorable, The City Council:

Please find attached for your information the Cambridge Public Health Commission annual 1998 Public Health Assessment: Improving the Health of Cambridge.

Very truly yours,

Robert W. Healy  
City Manager

RWH/mec  
attachment

Consent Agenda #5

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Relative to the Cambridge Public Health  
Commission Annual 1998 Public Health  
Assessment: Improvement the Health of  
Cambridge.

In City Council January 26, 1998  
All items carried forward to be a part  
of City Council Meeting of  
February 2, 1998 on motion of  
Councillor Sullivan.

In City Council February 2, 1998

Referred to  
Health and  
Hospitals  
Committee on  
motion of  
Councillor Sullivan