CCM-101

City of Cambridge

(AMENDED ORDER NO. 5)

IN CITY COUNCIL

May 13, 1985

COUNCILLOR WOLF

ORDERED: That the proposed reorganization of the Neighborhood Health Centers as outlined to the Committee on Health and Hospitals over the past several weeks be adopted by the City Council and that prior to the implementation of same, a report be submitted to the City Council as to the final location and description of each Health Center.

In City Council May 13, 1985.
Adopted as amended by the affirmative vote of 9 members.
Attest:- Joseph E. Connarton, Acting City Clerk.
A true copy; Joseph E. Connarton

ATTEST:-
Joseph E. Connarton, Acting City Clerk.

The Cambridge Hospital
Affiliated with
Harvard Medical School

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

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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 back-up system for emergency consultations would be designed and coordinated with an identified NHC.

a. Immunization Surveillance - to assure compliance with state law on immunization required for school children.

b. Record Review and Follow-Up - for immunizations and screening programs, as well as other medical or social problems; review results of mandated physicals and interval health histories.

c. Episodic Care - on site treatment of school children; assessment of, consultation on contagious health problems.

d. Consultation - nurse teacher conf. and consultation on screening prog.

e. State-Mandated School Physicals

f. Training - participate in training school personnel on safety issues (playground and special needs classes); training school health aides; assist in using guidelines for emergency care; identification/assessment of, and reporting possible cases of abuse or neglect.

g. Counselling Children - individual or group counselling on health issues.

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 provider (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 clinican 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. Sessions would be defined as two hour blocks - either 8:00 - 10:00 or 10:30 - 12:30. Due to the varying need for on-site health services throughout the school year, sessions may vary accordingly.

School	Enrollment	School Health Sessions Per Week
Haggerty	117	4
Blessed Sacrament	137	1
St. John's	166	1
St. Paul's	46	consult 1
Agassiz	267	4
Fletcher	356	4
Graham-Parks	331	4
Morse	358	4
Roberts	331	4
No. Cambridge Catholic	351	1
St. Peter's	226	1
Kennedy	348	4
Longfellow	429	5
Peabody	451	5
Tobin	610	5
Fitzgerald	503	5
King	481	5
*Harrington	800	5
		58

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.

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.

*A Neighborhood Health Center will be located on site for this school.

RECOMMENDATION FOR NEIGHBORHOOD HEALTH CENTER REORGANIZATION

Summary

The following summarizes the contents of the Neighborhood Health Center Working Group Research Report. The report was written to support the recommendation for reorganization of the Cambridge Hospital Neighborhood Health Centers. The ten Neighborhood Health Centers (NHCs) would be reorganized into a six-center system, operating as part of an interdependent health network with the hospital and its specialty services. Market sensitivity was key to the plan's development and would continue to be so in the implementation and future monitoring of the system.

The proposed reorganization will:

- offer high-quality, comprehensive care in an attractive, professional, convenient setting
- improve service to the current patient popluation
- attract a new, insured market who will better support the system
- provide a new, stable patient base for the hospital while offering continuity of care to all patients in the system
- cost per visit will be decreased by 14.5%
- provide health care for all Cambridge school children through one system of care
- ensure community participation in planning and monitoring the development of the system

BACKGROUND

The Working Group was formed in August, 1983, in response to the growing problems associated with NHCs. The NHCs, located in various sections of Cambridge were experiencing decreased external funding to provide the proper support for community-based services. In addition, the health care environment, as a whole, has become increasingly competitive and market-oriented due to cost-containment pressures and societal changes. The successful hospital, today, must be able to identify opportunities within this environment in order to achieve its goals.

If Cambridge Hospital is to maintain its goal of providing high quality health care to all Cambridge residents it must first withstand cost-containment pressures. Prospective reimbursement has given hospitals an incentive to

increase and improve ambulatory care services. Ambulatory care is a more cost-effective way of delivering services from the perspective of both the hospital and the patient, and provides a stable source of patients for inpatient services. Societal changes are evidenced by the emergence of a more educated and demanding health care consumer. Consumers are feeling the effects of more exlusive insurance policies and less available personal income for health care spending. They "shop" for attractively delivered, and priced, services. They are looking for convenience, affordability and comprehensiveness in one attractive, professional setting. The Hospital must therefore render its current ambulatory services attractive in appearance and efficient in operation. The NHCs are particularly in need of this change.

As a result, tremendous competition for patients exists between the hospital ambulatory care services and other ambulatory care delivery systems, namely, HMO:s, one-stop health centers, free-standing emergency centers, and other hospitals' ambulatory care departments.

The Hospital can only survive these pressures by adopting a competitive, market-driven approach to management and planning. Current services must be analyzed in terms of reimbursement and actual cost to provide those services. The current service market who use the services and the potential service market who could use the services must be assessed. Proper space utilization, attractiveness of surroundings, customer relations, communications and administrative systems must be reviewed and enhanced..

The hospital has been assessing many of its services as part of its strategic plan. The NHC system has been one of the ambulatory services perceived as a real opportunity for attracting a new market, as well as improving services to the population it now serves. An improved NHC system could provide a stable, self-sufficient patient base for the entire Cambridge Health System, i.e., the hospital and health centers working in an integrated network to support each other. The NHCs, if operated efficiently and physically improved, could offer the kind of attractive, convenient care demanded by today's health care market. The hospital-based health centers would have an advantage over free-standing health centers and HMOs in that continuity of care - from ambulatory care to inpatient care and back -is built right in.

Finally, the chances for realizing this opportunity are great due to the results of a recent market analysis which indicates that the sought-after market does indeed exist in the Health System's service area. Demographically, the population considered to be the Hospital's potential service market has significantly changed. A younger, more mobile population has begun to replace the population which existed in the same area ten years ago. Median income has risen in some sections. Some sections have retained much the same demographic makeup as it had in 1970. Each market segment demands a slightly different set of health services. All

demand an attractive and professional mode of delivery.

METHODOLOGY

In assessing NHC services, the task of the interdisciplinary Working Group was to make a recommendation, to the City Manager, for reorganization which would lessen dependence on external funding by creating a competitive health care system based on sound planning and marketability.

The group arrived at several options, initially. By examining the current NHC system and its competitors, and by defining the goals and objectives of the NHCs, the group developed a standard health center from which to begin developing the various alternatives. School Health and Transportation plans were developed separately but incorporated into each NHC System model configuration.

Model II, the five-center model considered to be the most accessible, cost-effective and comprehensive by the Working Group, was presented to the community in a series of meetings held at several health centers and schools during March of 1984. The community, however, voiced considerable concerns about closing sites, co-location of services, staffing and billing problems.

RECOMMENDATION

Reflecting those concerns, the Group modified the model it had proposed to one of a six-center plan, Model IV. The six centers include:

1. Harrington School (incorporating Kennedy)
2. Castriotta
3. Riverside School (incorporating King)
4. Neighborhood Family Care Center
5. Cambridgeport
6. North Cambridge (a new site for the current, temporary site of co-located North Cambridge and Fitzgerald School)

Each health center would offer a comprehensive set of both adult and pediatric services, tailored to the market each would be expected to serve. The afore-mentioned market study would be used to plan and monitor services with respect to significantly altered demographics of the service area. Median income has risen and a young, working, mostly single population has moved into many parts of Cambridge over the last decade. Other sections have retained much of the same demographics as had been seen in 1970. Resources would be budgeted for monitoring and analyzing market changes so as to appropriately adjust services and promotion accordingly. Direct mailings, satisfaction surveys and informational brochures will ensure publicity and attract new patients to the health center.

The costs of Model IV as compared to the current configuration are outlined in Table 8 (attached). Itemized costs of Model IV are described in Attachment K (attached). Visits have been conservatively projected at higher levels given the market potential which had been projected in the market study. The Model is so structured, however, to allow for 15-20% expansion in visit number should this be experienced once the system is in operation. Funding is expected to come from increased patient revenues and savings incurred from more efficient operations in the health center system.

The School Health system is being proposed as a system of "outreach" to the schools by a designated, scheduled nursing presence at each school throughout the school year. Each clinician would serve as a facilitator for assessing special health needs and for providing mandatory services. The clinicians will train school health-aides in basic emergency and safety guidelines. The school health aides will also provide clerical support for immunization review. Costs of the School Health proposal are included in the total costs of Model IV.

The six sites will be renovated and constructed to achieve a consistently attractive and professional look with well-planned use of space for clinical and administrative needs. The finishes and signage will portray a clear connection between the health centers and to the hospital. Integrated, automated registration terminals will streamline the patient registration and billing procedures. As the information link to the hospital's billing and registration is strengthened, vast improvements are expected for the current problems.

The Group has presented Model IV to the community and received much more positive feedback, although attendance at the August meetings was less than that of the first series of meetings in March, 1984. Community participation will be continually encouraged in the ongoing development and planning of the system. Site-specific community boards or a community subcommittee of the Hospital/[illegible] Subcommittee of the Health Policy Board are the proposed methods of ensuring the community voice.

...GET COMPONENTS	OPERATING	ALLOCATED	(NON-PROD.)	CAPITAL	TOTAL COSTS	RIVERSIDE/ KING	NPCC	NO. CAMB./ FITZGERALD	CASTRIOTTA	KENNEDY/ HARRINGTON	CAMBRIDGE-PORT	FLOAT (NON-PROD.)	TOTAL COSTS
Human Resources													
Medical - P.C. Attending MD's	215,295				215,295	34,725	55,560	27,780	69,450	13,890	13,890		215,295
- Ob/Gyn Attending MD's		62,505			62,505	13,890	13,890	13,890	13,890		6,945		62,505
- Mid-level Practitioner	337,480		77,620		415,100	46,020	76,700	76,700	46,020	61,360	30,680	77,620	415,100
- Resident MD		18,600			18,600	3,100	3,100	3,100	3,100	3,100	3,100		18,600
Sub-Total - Medical	552,775	81,105	77,620		711,500	97,735	149,250	121,470	132,460	78,350	54,614	77,620	711,500
Psychiatry - Psychiatrist		35,000			35,000	5,833	5,833	5,833	5,833	5,834	5,834		35,000
- Other Psych. Prof.		47,000			47,000	7,833	7,833	7,833	7,833	7,834	7,834		47,000
Sub-Total - Psychiatry		82,000			82,000	13,666	13,666	13,666	13,666	13,668	13,668		82,000
Allied - Podiatry		15,000			15,000	3,000	3,000	3,000	3,000		3,000		15,000
- Nutritionist		18,720			18,720	3,120	3,120	3,120	3,120	3,120	3,120		18,720
- Social Worker		39,126			39,126	6,521	6,521	6,521	6,521	6,521	6,521		39,126
Sub-Total - Allied		72,846			72,846	12,641	12,641	12,641	12,641	9,641	12,641		72,846
Support - Med. Recept./Asst.	222,600		37,842		260,442	31,800	51,675	27,700	39,750	31,800	19,875	37,842	260,442
- Driver		15,000			15,000	2,500	2,500	2,500	2,500	2,500	2,500		15,000
Sub-Total - Support	222,600	15,000	37,842		275,442	34,300	54,175	30,200	42,250	34,300	22,375	37,842	275,442
Admin. - Medical Director		22,000			22,000	3,667	3,667	3,667	3,667	3,667	3,665		22,000
- Head Nurse Pract.		64,480			64,480	10,747	10,747	10,747	10,747	10,746	10,746		64,480
- Hosp. Based Admin.		67,558			67,558	11,260	11,260	11,260	11,260	11,259	11,259		67,558
Sub-Total - Admin.		154,038			154,038	25,674	25,674	25,674	25,674	25,672	25,670		154,038
TOTAL Salary and Wage	775,375	404,989	115,462		1,295,826	184,016	255,406	223,651	226,691	161,631	128,969	115,426	1,295,826
DD 20% Fringe to S & W	155,075	80,996	23,092		259,163	36,803	51,081	44,730	45,338	32,326	25,793	23,092	259,163
TOTAL HUMAN RESOURCES	930,450	485,985	138,554		1,554,989	220,819	306,487	268,381	272,029	193,957	154,762	138,554	1,554,989
Operating Costs													
- Rent	65,500				65,500		20,000	45,500					65,500
- M & S Supplies	36,225				36,225	5,285	9,055	8,200	7,545	4,530	1,510		36,225
- Communication	43,200				43,200	7,200	7,200	7,200	7,200	7,200	7,200		43,200
- Utilities	14,040				14,040	2,340	2,340	2,340	2,340	2,340	2,340		14,040
- Courier	4,200				4,200	700	700	700	700	700	700		4,200
TOTAL Operating Costs	163,165				163,165	15,525	39,295	64,040	17,785	14,770	11,750		163,165
Indirect Hosp. Allocation		153,137			153,137	25,523	25,523	25,523	25,523	25,523	25,522		153,137
TOTAL PROGRAM COSTS	1,093,615	639,122	138,554		1,871,291	261,867	371,305	357,944	315,337	234,250	192,034	138,554	1,871,291
Capital													
- Equipment				15,000	15,000	2,500	2,500	2,500	2,500	2,500	2,500		15,000
- Van				25,000	25,000	4,167	4,167	4,167	4,167	4,166	4,166		25,000
- Renovation				210,000	210,000	72,000	76,000		36,000	45,000	8,000		237,000
TOTAL Capital Costs				250,000	250,000	78,667	82,667	6,667	42,667	51,666	14,666		277,000
TOTAL MARKETING COSTS	75,000				75,000	12,500	12,500	12,500	12,500	12,500	12,500		75,000
TOTAL ALL COSTS	1,168,615	639,122	138,554	250,000	2,196,291								2,183,291
LESS NON-RECURRING - Van													
- Renovation					(285,000)	(88,667)	(92,667)	(12,667)	(26,667)	(61,666)	(24,666)		(285,000)
- 2/3 Mo. Exp.													
NET OPERATING COSTS	1,168,615	639,122	138,554	250,000	1,911,291	264,367	373,865	360,444	317,837	236,750	194,534	138,554	1,911,291
												Outage	(93,000)
												TOTAL	1,818,291
												School Health	140,000
												Net Operating Costs	1,958,291

Table 8

CURRENT NHC SYSTEM STATS
Model IV vs. Current Configuration

	ACTUAL CURRENT	MODEL IV	Variance
otal Visits per Year:	29,999	33,350	3,351
OST COMPONENTS			
Direct (S & W, fringes, other)	1,391,291	1,368,991	
School health	135,240	140,000	
ndirect Allocation	532,482	412,300	
Total Operating:	2,059,013	1,921,291	(137,722)
Equipment	5,142	15,000	
Transportation	0	25,000	
Renovations	0	210,000	
Total Capital:	5,142	250,000	244,858
Total Marketing:	0	75,000	75,000
TOTAL ALL COSTS:	2,064,155	2,246,291	
ess non-recurring: an, renovation, 2/3 of the market costs)	0	285,000	
T OPERATING COSTS	2,064,155	1,961,291	(102,864)
erage Cost per Visit:	$68.64	$58.81	(9.83)

At this time, Mr. Oliver Farnum, Chairman of the Health Policy Board, stated that the Board fully endorses the recommendation for the reorganization of the health centers and urged favorable consideration by the Committee and the City Council.

At this time, Councillor Wolf submitted the following motion:

ORDERED: That the proposed reorganization of the Neighborhood Health Centers as outlined to the Committee on Health and Hospitals over the past several weeks be adopted by the City Council.

and the motion -
Carried.

The hearing was adjourned at 6:28 p.m.

For the Committee,

Vice-Mayor Francis H. Duehay
Chairman.

City of Cambridge

In City Council May 13, 1985

The Health and Hospitals *Committee* conducted a public hearing on Thursday, May 9, 1985 beginning at 5:30 p.m. in the City Council Chamber, City Hall. The purpose of the hearing was to review and consider the proposed reorganization of the Neighborhood Health Centers.

Vice-Mayor Duehay, Chairman of the Committee, opened the hearing by outlining the past history of the meetings which the Committee has held regarding this issue.

At this time Councillor Vellucci questioned whether or not money has been placed in the Hospital budget for FY-86 for the operation of the Health Center at the Kennedy Elementary School in East Cambridge. He further questioned whether or not the proposed reorganization included relocating the other Health Centers in East Cambridge.

Mr. Michael Green, the Hospital Administrator, responded by stating there was sufficient money within the budget for next year to maintain the Kennedy School Center. He further stated that the proposed reorganization does, in fact provide for "co-locating" the Kennedy School/Harrington School and Miller River sites to a new location directly opposite the Miller River Apartments on Cambridge Street.

Mr. Green further stated that this particular change could be implemented by November of 1985, while the changes within the North Cambridge and Mid-Cambridge neighborhoods will take approximately one year.

Councillor Wolf questioned the level of staffing at each clinic. Mr. Greene responded by stating that he anticipates each clinic with 12,500 visits will have two physicians, two nurse practicioners and three support staff. Councillor Wolf further questioned if any community group was opposed to the reorganization. Mr. Greene responded by stating that although the community meetings which his staff held throughout the City, were not well attended, he believes the feedback they did receive is positive.

Vice-Mayor Duehay questioned whether or not the municipal employees are using the Cambridge Hospital for medical care. Mr. Greene responded by stating that he hopes to market the Hospital in such a way that will encourage more employees into going to the Hospital when in need of medical treatment.

At this time, Elaine DeRosa of Somerville/Cambridge Economic Opportunity Committee, stated she strongly supports a concept of advisory councils for each new neighborhood health center in order to ensure community participation.

Both Vice-Mayor Duehay and Councillor Wolf agreed and requested that Mr. Green provide a proposal within the recommendation for the reorganized centers for representative boards which will interact with the Hospital and Health Policy Board.

7. S-365

REPORT

Committee on Health & Hospitals

Re: proposed reorganization of the Neighborhood Health Centers.

In City Council,

May 13, 1985

5/13/85
Placed on File
See Order #775
Adopted as
amended this
date.