CURRENT EFFORTS TOWARD IMPLEMENTATION OF AN URBAN HEALTH STRATEGY: BOSTON

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THE PRESENT HEALTH CARE INFRASTRUCTURE IN BOSTON

The city of Boston is relatively small, with a population of only 600,000. Within those boundaries, there is an inner city that has lacked private physicians for many years. As a result, 25 community health centers have been established in Boston alone. There are virtually no community hospitals in Boston, but there is a plethora of highly sophisticated teaching hospitals in relation to the three medical schools within the city, and these serve both as community hospitals and as tertiary/quaternary referral centers. As the community health centers developed, there were tensions with the teaching hospitals. The hospitals were concerned that the community health centers would decrease the volume of their clinics; this concern was at its height, of course, when Medicaid payments were more generous. The community health centers, on the other hand, understandably felt deprived when they compared their reimbursement rates with those of the hospitals, given the significant overhead costs of the hospitals included in their payments.

An important effort emerged in the mid-1980s, when the teaching hospitals and community health centers put aside their wariness of each other to create the Commonwealth Health Care Corporation. This was a cooperative effort to enlist the Aid to Families with Dependent Children (AFDC) population of Boston in a capitated managed-care program to demonstrate that better care could be given, at least to this segment of the welfare population, with quality, greater

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continuity, and more prudent expenditures. There was willingness on the part of the hospitals to see clinic patients moved out to the community health centers. Surprisingly, the effort was vetoed at the last moment by the governor at the time, Michael Dukakis. It appeared that he was responding to what might be called a welfare rights lobby, which voiced a legitimate concern of the patients who would have been involved. When you are on Medicaid, they felt, about the only freedom you have is to vote with your feet. Their perception of the Commonwealth Health Care Corporation was that this last vestige of individualization would be lost under the managed-care arrangement. I think we—the teaching hospitals and community health centers—have to take as much of the blame as that which we assign to Governor Dukakis. Had we been more perceptive about the concerns of the community involved—and it was more an issue of perception than responsiveness—we might have been able to work out greater understanding of what we were about, and the community might have been reassured enough to give managed care a real try. Had that occurred, the progress of managed care in Massachusetts and perhaps beyond might have been different in both quality and pace.

What was left was a somewhat uneasy truce between community health centers (CHCs) and Boston's hospitals. Some CHCs were better off than others, having become incorporated as part of one hospital or another, and their reimbursement rates were significantly higher than that of their independent brethren—which made for certain internecine tensions as well.

In the early 1990s, data on the higher rates of infant mortality in Boston's inner city raised questions about the health status of the inner-city population. A highly politicized issue, it focused primarily on the access of inner-city residents to hospital care, presumably for delivery and neonatal attention. This was despite the fact that high risk in pregnancy relates to demographic and social components, perhaps as much or even more than that of hospital care. The infant mortality figures used, incidentally, were those that measured the fate of newborns over the entire first year of their lives, which, of course, involved far more than hospital access and hospital care. Certain areas of the inner city were declared "death zones" by the press, and politicians proclaimed a determination to lean on the providers of care as the way to contend with these tragic circumstances. The response of the hospitals was sensible, I am pleased to report. Rather than arguing that the problems primarily lay elsewhere, the hospitals took the viewpoint that, regardless of what other conditions influenced infant mortality, there were things they could do to improve. Prenatal and maternal health efforts were expanded significantly, and community health centers and hospitals worked together to secure better staffing by physicians in the inner-city neighborhoods. Access grew,

and infant mortality rates declined significantly. Retrospective analysis, however, demonstrated that the numbers of low-birth-weight babies born have not decreased appreciably, and that most of the reduction seen in infant mortality is the result of improved technology and improved skills in neonatal intensive care units.

Thus, we realize that much more needs to be done, in a very broad-based way, not only to improve further the access for obstetrical and neonatal care, overall nutrition, and the knowledge acquired by women about their pregnancies and by new mothers about their infants. Out of these realizations has grown a more broad interest in women's health, defined not merely around pregnancy and the postpartum period, but throughout the entire life cycle. Equally important, members of the community are appreciating the significance of this more-rounded view.

COMMUNITY BENEFIT

Heightened awareness of the inter-relationship between hospitals and communities then led the Massachusetts attorney general to focus on "community benefit," that is, what the hospital is doing for the health of the community it claims to serve. Initial responses by hospitals tended to be oriented largely from the hospital's viewpoint alone. Now, there is increasing awareness of, and receptivity to, the perspectives of the community and its advocates; more and more, community views are incorporated into planning in a meaningful way. I believe this represents a maturity not only in the approach of hospitals toward the community, but also a comparable maturity of the approach of the community toward what might legitimately be expected and secured from the hospital.

Concomitantly, many other changes in the environment of health care have led hospitals to understand the paradigm change from their traditional focus on the episodic treatment of the acutely ill to one of clinical and fiscal responsibility for the health of a population. Out of that insight, the practical utility of securing a growing community base within its network of loyalists, and the growing focus on primary care, the forging of better relationships with community health centers has moved up in importance for hospitals. In a city such as Boston, with its surfeit of tertiary care centers, community health center relationships have achieved a high priority, indeed, and, in fact, the hospitals now tend to compete with each other in that regard.

COLLABORATIVE EFFORTS IN URBAN HEALTH

One effective set of relationships has been established by Boston Medical Center, an institution forged from the merger of Boston University Hospital and Boston City Hospital, through the large number of community health centers allied with

Boston City Hospital before the merger. On the other hand, since Boston City Hospital had been virtually synonymous with the Boston Department of Public Health, some awkwardness has been created for the role the Department of Public Health now plays, which is torn in this highly competitive environment between the need to ensure the strength of Boston Medical Center and looking out for the overall population of the city, since not all of the community health centers have the closest of relationships to the city, its health department, and Boston Medical Center. Because of the increasingly competitive environment for hospitals, growing efforts have led to blandishments of one sort or another offered to certain community health centers to switch their allegiance. These range from simply greater responsiveness and cultural sensitivity to an increment in material support for the community health center.

At the same time, growing sophistication with and the extent of managed care are leading to greater collaboration between providers of health care and of social services; this includes working together to review health status problems and develop solutions aimed at the promotion of health and the prevention of illness. One major success story in Boston in the last year or two is that of domestic violence. Boston teaching hospitals worked for a year to develop a common set of goals and a common educational agenda. This has resulted in meaningful extension of awareness and sensitivity to the problem. The educational agenda goes beyond health care providers; hospital and community health center staff are working to educate police officers, lawyers, and others whose sensitivity to this important issue warrants heightening.

Another example is seen in the neighboring city of Cambridge, where Cambridge Hospital, integrated with the Cambridge Department of Public Health, is establishing the Cambridge Institute for Community Health, an organization designed to study in greater depth and sophistication the community health interventions made by the Department of Public Health; the hope is to provide insight not only to the city fathers, but also to other urban areas as well. What is noteworthy about this effort is that it has been established with the two major competing delivery systems in the area, CareGroup, which has the merged Beth Israel Deaconess Medical Center and the Mount Auburn Hospital in Cambridge as major teaching hospitals, and Partners Health Care, the parent corporation of Massachusetts General Hospital and Brigham and Women's Hospital, two other teaching hospitals that are affiliated with Harvard Medical School. Incidentally, these two health care systems are now discussing ways in which they can cooperate with respect to their mutual academic missions of teaching and research even while they compete in the health care market. Whether they will get to community care issues and yet avoid antitrust problems remains to be seen.

Many providers are now gaining awareness that access goes beyond overcoming financial barriers, and the emphasis on improving cultural competence is growing. Cultural competence is defined broadly as the set of skills and the capacity to serve diverse patient populations well and sensitively, with "diverse" including considerations of culture, ethnicity, age, gender, sexual orientation, race, religion, social and economic class, education, and so forth. This becomes increasingly important, it seems to me, as Medicaid moves toward privatizing care through the development of managed-care plans. If we are to treat patients equally, cultural competence is a prime necessity.

All of this gives reason for some optimism without letting down one's guard or diminishing one's zeal for the struggle. However, in Boston, as in many cities, it is inordinately difficult for any individual provider to evaluate the success of its interventions, simply because no individual provider in Boston serves a unique geographic community. When improvements are documented, one can never be certain that the efforts put forth by a concerned institution represented a major cause of that effect, a minor component, or less. Nevertheless, both logic and motivation argue the importance of continuing to lean in the directions of access, responsiveness, and cultural competence.

Beth Israel Deaconess Medical Center, now a year into its merger, and its parent corporation, CareGroup, are operating with the philosophy that most care is local, belongs in the community, and must include emphasis on the promotion of health and the prevention of illness. That may sound altruistic for a tertiary and quaternary research-intensive major teaching hospital of Harvard Medical School, but it is clear-eyed in the face of today's understanding of both the economics of health care delivery and the rationale for what makes the most sense. It is our belief that the delivery system we are forming will emerge larger, as well as more effective, under this philosophy, and that, while relatively fewer patients per capita will need to be referred to Beth Israel Deaconess Medical Center for tertiary or quaternary care, there will ultimately be a larger population of doctors and their patients affiliated with us, leading to mutual benefit. Thus, at Beth Israel Deaconess Medical Center, we look explicitly for opportunities to merge community benefit and strategic missions.

Toward that end, we are working in partnership with community health centers to bolster their strength to ensure that the inner-city neighborhoods and special populations have access to the resources appropriate to local care delivery and that these are culturally appropriate. The leadership of the community health centers is better positioned to shape care for the diverse inner-city communities and to identify the broader array of services appropriate to their community, services that extend beyond those in the traditional primary care practice in a

middle-class community or in a teaching hospital. We work with the community health centers to provide health education, social services, and various forms of outreach tailored to meet the specific needs of those respective communities.

Boston's Beth Israel Deaconess has affiliations with seven community health centers; the first five are Dimock in Roxbury; Fenway, which caters to both a gay and lesbian community and the elderly; South Cove, which cares primarily for members of the Asian community; Joseph Smith in Allston/Brighton, where a white working class population is in the majority; Sidney Borum, located in the center of Boston and dealing with vulnerable youth and young adults, particularly runaways and also members of the gay and lesbian community. Two other affiliations are unusual. One is with the Outer Cape Community Health Center in Provincetown and Wellfleet at the tip of Cape Cod, which serves both general primary care needs and a gay and lesbian population; and the Bowdoin Street Community Health Center, which moved its relationship from Carney Hospital in Dorchester to Beth Israel before the merger for a variety of reasons, material and otherwise. Having taken operational and financial responsibility for the Bowdoin Street Community Health Center in 1995, Beth Israel Deaconess Medical Center recognized its challenges related not only to a location in one of the neediest sections of Dorchester, but also the fact that the Bowdoin Street center had been squeezed into an abandoned branch bank building, which it had long outgrown. We have just completed a \$3.8 million project to build a new health center three times the size of the earlier building and far more functional. The center itself acquired the land adjacent to its old site, which was helped in part by the donation of some city-owned land as well; our medical center paid for the construction. The net result is not only a significant expansion of both health and social service programs, but also a major contribution to the economic revitalization of the community, in part because many of the resources and workers utilized in the construction came from within the community itself.

For all the community health centers—none of the others is owned by Beth Israel Deaconess Medical Center—we provide financial, technical, and programmatic support, particularly in strengthening and expanding primary care services. Increasingly, we are working as well with the community health centers on community-based public health programs. One area of strong emphasis is in maternal health, and we provide financial support to the community health centers for social workers, midwives, and other workers in the area. We also undertake the responsibility of recruiting obstetricians to work in inner-city neighborhoods, giving them and all center-based physicians hospital privileges and their patients hospital access no different from that of private practitioners and their patients in more affluent neighborhoods.

Perhaps our most difficult challenge relates to the effort to become more culturally competent. We have expanded our interpreter services, have significantly increased translated materials in the hospital, and have conducted cultural sensitivity training among our own hospital staff.

INNOVATIVE EFFORTS

Not all our efforts are directed only to the community health centers with which Beth Israel Deaconess Medical Center is affiliated. Our Family Van project, which is based in a Winnebago van appropriately outfitted, moves each day to a different inner-city area; its staff is joined by some from the nearby community health center, not necessarily one of ours. The Family Van offers health education and outreach, with a particular focus on reproductive health. It is designed to recruit into the health care system individuals who do not seem to have the social wherewithal, even within their own neighborhood, to travel to the community health center. Always accepted, the Family Van appears to be increasingly welcomed, and therefore increasingly effective, and its program is being replicated in other cities as well.

Another interesting effort has just begun with our own community health centers. The WELL Program, which stands for Women Enjoying Longer Lives, was designed to increase the delivery of preventive care to inner-city women between the ages of 40 and 65, a generally neglected segment of the population. WELL trains providers, performs outreach services, supports lay health advisors, provides health information, and facilitates access to needed health services. The program also includes a strong research component into needs, so that its efforts can be increasingly effective.

Relatively new is our Latino Health Initiative, built on expansion of primary care for the Latino community, general initiatives in cultural competence, and oriented health promotion and education efforts. In partnership with many Latino community-based organizations, we are engaged in a multifaceted program to expand primary care sites, develop a cross-neighborhood needs-assessment process, and establish a Latino provider group to help the medical center improve its services.

Of considerable interest to us is the patient infected with human immunodeficiency virus (HIV). Beth Israel Deaconess Medical Center is the largest provider in the city of clinical research in providing care to HIV-infected individuals. We are strengthening and diversifying our efforts to work with community-based organizations toward enhancing services available to HIV patients and are working to make clinical trials available to more people in their own communities, with an emphasis on reaching more minorities infected with HIV.

CONCLUSION

This paper has presented only some of the efforts taking place in Boston and at Beth Israel Deaconess Medical Center. Representatives from other hospitals would come up with other specifics. In today's highly competitive economic environment, however, there is a growing common conviction that the health of the community involves all providers, and that all persons are equally deserving of the full consideration that can be offered.