JAMAICA PLAIN HEALTH CENTER

by

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Archives

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The design of a comprehensive health care facility is influenced by an understanding of the role of community health in future medical care delivery in our society. After a brief view of the traditional manner of bringing health care to urban areas, a discussion follows showing how different groups, namely, consumers (the community), providers (the health professionals) and government (the overseer) share aspects of this common goal: developing comprehensive community health care programs.

These goals, plus study of the Jamaica Plain area, and the experience of the Allston-Brighton Health Planning Corporation and the Harvard Community Health Plan (two very different approaches to health care) lead to the formulation of specific attitudes which are used in the design of a comprehensive community health center in Jamaica Plain which is presented in this thesis.
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I. HISTORICAL PRECEDENTS

A. Introduction. It was well over 100 years ago that trends in American economics first began to mold the patterns of the medical care system with which we are burdened today. And it is this archaic system which is now under pressure to develop comprehensive community health programs. In general terms, it can be said that the phenomenal American economic growth of the 19th century led to the formation of an industrial working class, usually immigrants, which was obliged to live in congested urban environments. These typical urban environments could be described by a lack of adequate housing, poor nutrition and sanitation, unhealthful working conditions, psychological insecurity for employees, and other denigrating aspects of workers' lives.

Not surprisingly the traditional avenue of approach to health treatment - the private practitioner - was unavailable to the indigent urban dweller, and in its stead there grew a two-faced system of health care delivery.

B. Fee-For-Service. On the one hand there was the fee-for-service doctor, exemplar of our free enterprise
system. His staunch independence had been - even back in the 18th and 19th centuries - part of our American heritage and his image and his service of personal concern and quality care (the family doctor) remain with us today. However, as demands increased on a limited supply of doctors, this system faltered. The large poor populations were the first to find private medical care too expensive.

C. **Clinics.** On the other hand the urban environment fostered the growth of many forms of medical charity, such as dispensaries for the sick supported by philanthropists or religious groups, and expanded out-patient departments of hospitals. Teaching hospitals especially benefited from a curious symbiotic relationship to the indigent sick which is pertinent even today: for providing these medical services, the hospitals and clinics gained a valuable teaching resource for their interns and students: patients. (Even private non-teaching clinics which were established to serve many patients quickly and cheaply were not solely altruistic: they provided a rapid source of income to a young practitioner just starting his livelihood and who would otherwise have to compete in a narrow market against established doctors.) The number of free dispensaries of medical
care rose rapidly in the early 1900's, especially in urban areas along the East coast.

There was no pressure for the hospitals or clinics to upgrade their facilities. The sick poor had no alternative to this service and had no voice in the matter.

The medical profession has consistently been against any change to the individually oriented fee-for-service pattern. In recent years the American Medical Association has vociferously opposed pre-paid health care plans, Blue Cross, union sponsored health centers, group practices, and Medicare and Medicaid.

And yet this same profession has been willing to serve the very poor who cannot afford fee-for-service care, but only through hospital clinics, outpatient departments, and emergency wards at hospitals. Doctors believed that it was very important to draw the fine distinction between the helpless poor (thus eligible for charitable service) and the low-income poor (potential fee-for-service patients). It was the responsibility of the first hospital employed social workers to make this economic distinction for the medical professionals.
D. **Trends.** The same descriptive conditions which led in the past to the development of this Janus-faced health care system are present today in America: namely, increased urbanization, low-income high density populations, lack of proper housing, poor nutrition, inadequate preventive care and an elitist health care system. However, unlike the past, there are contemporary pressures which may turn us away from our traditional (and now inadequate) medical delivery system and towards an efficient and responsive comprehensive community health care program. The next section will outline these pressures.
II. PRESSURES

A. Outline. There are arguments for making drastic changes at many levels of the medical system in the United States, but three of these voices are particularly relevant to suggesting changes in delivery of health care in urban communities. These represent pressures for change in the existing system from 1) The consumers (the community), 2) The providers (the medical profession), and from 3) The government (the overseer). A later section will outline how the planning and design of a community health facility (facilities) should react to these factors.

B. Community Control. There is a growing pressure in society for direct community control of local facilities and services. Dr. John P. Spiegel of the Brandeis Lemberg Center for the Study of Violence calls this a "world-wide shift of values involving the reduction of elitist ("top brass") policy decision-making toward the inclusion of previously excluded groups ("participatory democracy") in policy decision" (Boston Globe "Age of Incoherence", May 8, 1971). This trend has led to confrontations over power in public school administrations, local housing authorities, welfare procedures, police review boards and other areas.
Proponents for change in the traditional power structure in health care argue that the system has been run for the benefit of the professionals, not the patients. Therefore, community control of the system - a health program run by and for the people being served - would reverse these priorities.

This consumer control of the system could be manifest first by locating health care facilities convenient to the community rather than convenient to the professionals, their homes, academic ties or specialty needs. The community and consumers will want to control the operation of the health center. Their control could alter the hours the facility is open to reflect the working patterns of the community, so that a laborer would not have to lose a day’s work in order to have a regular check-up. Often day hours are set only for the convenience of the professionals (doctors, nurses).

The persons in power in the community can decide the medical organization of the center to meet their needs: whether to run clinics on the basis of specialty alone or by a team structure combining different disciplines, or some reasonable combination. And the patients should have a say in what medical services are actually provided and in what manner.
If the residents of the community are recent immigrants they would like to be treated courteously by people who can speak their language or by aides who can translate their questions.

Also, patients want to be welcomed into a hospitable, clean, comfortable building where they can feel their ills are being treated competently.

All in all, consumers want to know that comprehensive medical care will be given in a decent environment that operates at hours that demonstrate caring and that the program is designed by people who are sensitive to the community needs. In an article, "Role for the Consumer" by Peter and Marge Rogatz they say this: "Poor consumers are beginning to come to the point of view that affluent consumers have long held - that optimum health care can be provided only under conditions that protect the dignity and convenience of the patient as well as of the physician and nurse". This article outlines additional reasons other than those above for consumer involvement in the planning and design of health care programs. As communities become more organized to implement change, there will be more pressure for comprehensive health care centers, run by and located in urban communities.
C. **Medical Profession.** There is a trend toward altering the structure of health care delivery from the medical profession itself, especially from those hospitals that provide outpatient clinics, dispensaries or emergency wards for urban communities. Many of these hospitals have developed as specialized treatment centers, a haven for advances in medical care, for serious operations, research, surgery, intensive treatment and so forth. They are not equipped to care for every day minor problems, preventive medicine or comprehensive care for an entire community population.

Recently, attitudes are changing. In the article by Peter and Marge Rogatz mentioned above they say: "There is a slowing dawning awareness, for example, that...a neighborhood outreach program may be more worthwhile than a supervoltage radio-therapy unit or a hyperbaric chamber." And Dr. George Baehr has written that there is a great need for a broad program of community medical care based and studied at teaching hospitals. The following examples show the manner that two hospitals became involved with community health facilities. The Gouverneur Hospital in New York's Lower East Side was an example of a hospital with overburdened outpatient services. This area of Manhattan has long been the land place for immigrant peoples, Italians,
Jews, and now Puerto Ricans. In 1961 it was proposed to close the hospital entirely: although the Gouverneur had been active in the neighborhood since 1885, during the 1950's in-patient population had dwindled, beds were underutilized, and outpatient (or Ambulatory) services had become a disproportionate burden to the staff. Well-organized neighborhood groups, however, effectively argued that the neighborhood had special needs which could be treated by this community hospital, that public transportation to alternative services was very poor or lacking, and that - rather than close the hospital - a solution more suited to the community should be found.

The Beth Israel Hospital is located two miles north; 40 years previously it had been located in the Lower East Side but like the Americanized immigrants who left the East Side ghetto, it too had moved north. The two hospitals together established the Gouverneur Ambulatory Care Unit of Beth Israel Hospital, an independent detached unit of a voluntary hospital, financed entirely by city funds operating in a municipally owned building, staffed by competent physicians from a well-established teaching hospital. This staff incidentally included 7 internists, 6 pediatricians, 2 general surgeons full time, plus 40 part-time doctors. Although the medical organization of the center is by specialty clinics,
there is one principal doctor assigned to each patient in order to give the most personal care to each consumer. Much of the staff is bilingual. The "Statement of Purpose" of the original administration included this credo: to provide comprehensive medical care of high quality in a way that will best meet the total needs of the Lower East Side.

Now the Gouverneur Ambulatory Unit has complete back-up or referral privileges at Beth Israel. The Beth Israel has no outpatient clinics but does have staff and population for teaching and research. And the Lower East Side has a comprehensive community medical care facility.

A second example also comes from the area of New York's East Side Community. In "Organizing a Community Around Health", by Ana Dumois, she describes the actions of "the first community group in the country to plan and establish a comprehensive neighborhood health center" (1968), as opposed to outreach centers established and run by existing professional organizations or hospitals.

Two aspects of the plan reflect on trends in consumer control. First, the community board policy conflicted with OEO policy (funds were first to come from the government) because the board wanted complete community
control; OEO wanted separate professional management. Second, the community wanted to make the facility available to all, regardless of income. However, OEO funds could only be used at a center which served only indigent patients. (The center was later funded by the U.S. Public Health Service, Comprehensive Health Planning Act, Section 314 (e), for Community-based health centers).

A third aspect of interest involved Bellevue Hospital, part of the N.Y.U. Medical School. Miss Dumois claims the hospital was initially very uncooperative in offering assistance or staff but when they "realized we might be able to offer patients an alternative to Bellevue, which would be a threat to their flow of in-patients from the Lower East Side, an important source of patients for teaching purposes" they reversed their stance and offered to help.

The trend towards hospital involvement in community health programs may be due to actual concern for the health needs of the hospital's neighbors, an academic bias for community medicine, a desire to reduce costs of outpatient wards, or a vested interest in patients as a medical resource. Regardless of its reasons, this professional interest is a vital contribution toward planning a community health center.
D. Government and Financing. There is a trend within government for developing new ways of financing health centers. As overseer of the public welfare, government must act to reduce costs and to bring comprehensive care to the urban poor who cannot afford the luxury of the traditional free-enterprise fee-for-service system.

One form of innovation is to extend the third-party insurance plans, such as Blue Cross or private health insurance policies which cover the costs of emergencies or special medical services. Medicare, a government insurance system is this type of third-party coverage. These insurance plans all share the feature that a doctor or hospital is still reimbursed on a fee-for-service basis. For the professional this means there is no change in the system. The Nixon Administration Health Care proposal and the AMA proposals would extend health insurance to more consumers by making it either compulsory or government financed but the systems of delivery would not change.

A more radical approach to financing health care - which also directs its focus toward comprehensive and community based programs - is to develop a pre-paid system where premiums or service charges are paid by the consumer (or his employer or the government) to a program which in turn hires medical professionals
(doctors, nurses and hospital facilities) on a salaried basis.

An early program of this nature, first started in 1947, was the Health Insurance Plan (HIP) for Greater New York through which 31 organized group practice units provided care for enrolled families of low and middle income. It has been shown by surveys of the New York City Welfare Department that this population (700,000 enrolled in HIP) unquestionably receive more and better care than those who still depend on the dwindling number of solo practitioners.

Montefiore Hospital in New York in 1949 established a separate staff and facilities for a new Special Department of Social Medicine to provide care for 30,000 insured consumers in 10,000 families in the vicinity of the hospital. Johns Hopkins Medical School is running pre-paid comprehensive health systems to the entire population of the new town, Columbia, Maryland. Both these plans are more comprehensive than the doctor-oriented HIP plan and offer broader benefits to all.

Another pre-paid plan, the Kaiser-Permanente groups on the West Coast have found that not only can they provide more comprehensive care to their consumers but at lower prices. With a pre-paid plan all costs are within the system so there is an impetus to reduce expenses. With insurance or third-party payments doctors and hospitals have no motivation to lower costs.
Government interest in pre-paid comprehensive community health plans is not limited to the Federal level. Massachusetts State Senator Robert L. Cawley plans an investigation by the special joint committee on welfare administration to see if the State could develop a community medical clinic program to offset the present $400 million paid by the Welfare Department for medical care.

This excerpt is from a recent article in the Boston Globe about Senator Cawley's goal:

The senator envisions a program available to welfare patients and to paying patients, just above the economic bracket of welfare recipients. The clinics would cut the high cost of private physicians and hospital care for the poor, Cawley said....

Having surveyed the 28 public and private health clinics operating in the Boston area, Cawley thinks a program of state-supported medical clinics across the commonwealth could help save the high cost of state payments for medical aid....

Cawley said ideally he would like a program in which the state covered costs for persons now eligible for medical assistance and also allowed low-income families to contract for prepaid medical care at reasonable rates....

"We want to hear from the American Medical Assn. on this," he said. "They are not providing the health care necessary. They admit it. We need new methods. A lot of people are not getting the health care they need. Often when they do they pay for hospital care when they need only clinic care."

(Boston Globe, May 8, 1971).
These conflicts will remain; pressures for changes by the community (the consumers), the providers (health professionals) and by the government will have to be resolved in order to bring comprehensive health care to urban communities. Appendix A, "Allston-Brighton Health Center" and Appendix B, "Harvard Community Health Plan" show by real examples how these pressures can interact in planning and running health care programs in two Boston areas.
III. DESIGN GUIDES

A. Introduction. If comprehensive health care programs for urban communities are to be developed from the pressures outlined above, then the architectural design and programming of a building facility must be sensitive to this particular development. This section describes certain guides for the way a design should respond to this concept. (This is a most awkward step to justify: the assumption that a health program could be best served by one building rather than some entirely different physical form. However, in the broader field of community health and community involvement, and for a study of relationships of different participants in a health care program, I have framed these guides in the context of one health center building.)

B. Medical Structure. One of the first questions to be answered by the design of the building is the organization of medical personnel. One approach is to structure a group of doctors of different disciplines around one physical clinic work area to which all patients from one sector of the population - regardless of age or ailment - are directed, and the patient always returns to the same team regardless
of his illness. This "team" concept is meant to provide the most personal type of care because the doctors in theory function as a multi-headed family doctor: everyone in one family visits the same team. A further goal is to group together the different specialties that would in effect treat the same family, so that the doctors can more readily learn about the health of all members of this family jointly and also expand preventive care. Many community boards have favored this type of approach. A new Roxbury Comprehensive Community Medical Center designed by PARD Team of Boston puts this concept into a physical format.

The more traditional medical organization is to keep doctors of one specialty together. Then there are separate clinics for pediatrics, adult medicine, gynecology, or what have you. Doctors, the professionals, feel they have a better environment for assuring competent care: they are working with similar specialists and gain from exchanging knowledge and seeing unique cases; specialty nurses and supplies can be more efficiently utilized. One unit such as gynecology or geriatrics could be expanded to meet community needs independent of other services. And waiting
areas by specialty means that a working man would not be in the same area as the adolescents.

Whichever system of medical organization is chosen by the community, the design of the health center should encourage liaison and exchange and sharing of equipment and ideas between the clinics or teams, as the case may be (see Figure 1).

C. Intake and Lab. As better comprehensive health care becomes more available, there will be more frequent monitoring and checking on apparently well populations. At the same time there must also be an efficient filtering system for patient intake and diagnosis in order to best use the time of specialists. The system proposed by Sidney Garfield for future use in the Kaiser Permanente Plan is for an expanded laboratory and diagnostic center where most of the patient's routine history and lab work can be concentrated as part of the intake system to the health care process. Computers are being used already at the Harvard Community Health Plan to expedite taking patients' records and history. Their use assures a thorough background and a clear print-out for the doctor to study.
This expanded diagnostic, lab and intake area will develop an identity of its own. It should be accessible to the public directly upon entry, for this may be their only place to visit at the center. This area will also include the specialty equipment shared by different clinics (lab, X-ray, operating rooms, emergency care), and so the design must make the area easy to reach directly from the clinics (see Figure 2).

D. Ancillary Services. For a community health program care system to be comprehensive in scope and thus provide better care than the present emergency wards or out-patient clinics of hospitals the system should include a wide range of secondary services, all of which, in one way or another, touch on a person's health, but often in ways not obvious to the patient. These services include social workers, legal aid offices, welfare consultants, nursing care for the aged and senile, nutritionists, birth control advisors, family planning, and the gamut of public health programs (e.g., epidemiology, pollution, rat control).

Also, the health center should coordinate and work with school health education classes, and inoculations. These are programs and personnel who must
function in two capacities: first, as aides to the primary medical treatment and second, as public servants directly responsible to the community. The offices and facilities for these programs should not be separated from the purely medical clinics because their identity (and location) should be of a medical nature. They should be available to the doctor for referrals and yet the public should be able to utilize the same services independent from the doctors. Their design must allow for this double relationship (see Figure 3).

E. Community Center. A community health center can be beneficial to an urban population as an identifiable focus for community activities, both formalized and casual. Public places where groups of citizens can meet, relax, do crafts or projects and develop interests are often unsuccessful when established independently; but similar activities have flourished when they are associated with other public areas for community focus. For example, branch libraries are places where all ages and groups can come to read or relax. Schools and churches also support associated activities (sports, scouts, parents meetings, study groups, sports leagues, craft shops).
These types of activities are important to the fiber of a community and by extension its health. And it seems reasonable and, in fact, necessary to design a health center to be able to support these types of happenings as its contribution to the community.

There should be space in the center for auxiliary groups to meet and organize. The public spaces of the center should be able to hold sales or bazaars or exhibits. Lounging space should invite the community to relax and gather, or to play light games or cards. A day care program could be staffed. More extensive recreation (a gym or locker room or ball field) might be added later, but the important concern is that the broader definition of "community health center" provide in the design for some of these activities.

Although direct comprehensive medical care is still the initial function in community health, the center will be more readily accepted by the neighborhood and used by the population if it can encourage a broader range of activities. And acceptance and use are really the reasons for the facility in the first case.
DISTINCT TEAMS

w/ similar medical specialties in each separate team.

SEPARATE CLINICS

w/ teams as administrative units only.

MEDICAL ORGANIZATION
LAB - INTAKE - DIAGNOSIS CENTER

PUBLIC ENTRY

RELATION OF LAB AREA

FIG. 2

ANCILLARY SERVICES

BY MEDICAL REFERRAL
OR FROM PUBLIC ENTRANCE

RELATION OF ANCILLARY SERVICES

FIG. 3
F. **Site.** It goes without saying, and must therefore be said, that a community health center should be located so that it is readily accessible to the health consumers. Public transportation should be available. Pedestrian routes should be nearby. Parking for cars should be provided. A study of usage of Massachusetts General Hospital in a City Planning Thesis showed that "physical accessibility to the hospital appears to have greater significance in determining use by patients of low socio-economic status than by patients of high economic status" (Clausen, L.).

In addition, planners should consider the character of the locale. Herman Field, at the New England Medical Center, Office for Long-range Community Health Planning, has pointed out that community health care has traditionally meant "Public Health" or welfare programs, often located in space provided by Public Housing Projects.

This image is a stigma to acceptance by the broader population of a community, since most people want to move away from the Project. (There are a few exceptions to this attitude where tenant control of government housing projects has led to pride in
management, e.g., a few buildings at Bromley Health, Jamaica Plain). Mr. Field further says that there can be no one answer to where a center should be located. Rather a planner or architect should look at the entire fabric of a target population and recommend a site suitable to public acceptance and growth and development and identity within the community. This acceptable locale could, in some cases, be in a housing project; it could be in a commercial area, a shopping center or mall. Churches and schools provide other possible places for associated identity. Even the blanket of governmental administration or proximity to existing health facilities may be appropriate.

Herman Field also feels that architects too willingly abandon the idea of renovation. People can accept and feel comfortable in old buildings, he says. Mr. Field's main point is that each community will have its own fabric, history and pattern which would influence the best site and locale for its health center.
IV. JAMAICA PLAIN HEALTH CENTER PROGRAM

A. Demography and Community. The Jamaica Plain section of Boston has a population of 45,000 persons. This is a predominantly white lower-income community; thirty percent (30%) are receiving some form of public assistance. The ethnic origin is mainly Irish Catholic; however, the Puerto Rican segment is increasing, and around ten to fifteen percent of the community is black. There is a large elderly population.

Until recently the community had been relatively stable in terms of population movement and development. However, the location of Jamaica Plain near to Boston's central core and also on the path to outlying suburbs has brought strains to this stability. The community and commercial relationships in Jamaica Plain are bound to change drastically in the next few years because of the impending construction of an eight-lane highway, I-95, which would slice through the community. A new high speed transit system is planned to run down the median strip of the highway. Governor Sargent's year-old moratorium on highway construction within Route 128 has not allayed the fears of the community that this gash through Jamaica Plain might still materialize.

There are compensating schemes for depressing the highway and for encouraging ameliorating commercial investment along the few remaining cross streets but
JAMAICA PLAIN HEALTH CENTER
for comprehensive community health care
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undoubtedly if the highway is built, community patterns in Jamaica Plain will change (see Figure 4).

Even if the highway were not to be built, a new sense of cohesiveness was developed among the populace during the fight against the highway, and this spirit - in its own way - will influence future growth in the area.

With regard to health care, the Jamaica Plain Wide Health Coordinating Committee (JPWHCC), an ad hoc group of residents and professionals, was organized to attain these general goals of its own: to develop a completely integrated community wide primary health care program for all Jamaica Plain with a prepayment system.

The problems facing this community effort are enormous and endemic to any community health care planning. On the one hand, the consumers have high expectations for both the development of comprehensive health services and for having community control over the program. On the other hand the services and resources to fulfill these expectations are vested almost entirely with the hospitals. A paper written by students at the Harvard School of Public Health (for Health Services Administration Seminar), "Southern Jamaica Plain Health Center (Curtis Hall)," by M. Aeschlimann-Herrera, et. al.) identifies this conflict and relationship in more detail.
B. Existing Health Care Facilities. A study of health care in Jamaica Plain in 1969 showed that there were nineteen (19) practicing physicians, thirteen of whom were over 65 years old. In spite of the proximity of some of Boston's most renowned and prestigious hospitals and extended care facilities, health care which can serve the low-income community comes from three centers: Model Cities Family Planning No. 1, The Martha Eliot Health Center and the Southern Jamaica Plain Health Center at Curtis Hall. Figure 4 shows their locations.

The Model Cities Family Life Center No. 1, on Brookside Avenue is a small clinic which deals mainly with family planning and mental health problems. It has a target population of 10,000 in the Model Cities Area nearest Roxbury. This facility was only opened in December 1970 with funds from the Model Cities Program.

The Martha Eliot Health Center occupies renovated apartments in the Bromley Heath Housing Project. It was established four years ago as an arm of the outpatient departments of the Peter Bent Brigham Hospital, the Childrens Hospital Medical Center and the Boston Hospital for Women. This facility provides the most comprehensive health care in the community; its target population is 17,000 persons in northern Jamaica Plain. The center has developed a great deal of autonomy and
community involvement through a Health Advisory Corporation.

The Southern Jamaica Plain Health Center was opened late last year as an outreach center of the Martha Eliot. This center is operating five half-day sessions per week of pediatric and gynecological services. They use 3 examining rooms plus a waiting-reception area on the third floor of the Curtis Hall Municipal Building. The Southern Jamaica Plain Health Committee which helped launch the operation of the Center estimates the target population at 5,000 persons.

C. Program. This program in descriptive terms is an outline of ideals and goals for a comprehensive community health program for Jamaica Plain. As such it assumes the best of possible relationships among consumers, providers and government financers and draws from the trends outlined above. These goals also try to reflect the experience and planning of other health plans in Boston, as shown in Appendices A, B and C. The program incorporates the rough estimates of services made by Dr. Robert G. Rosenberg, Director of the Martha Eliot Health Center in Jamaica Plain. It also tries to account for attitudes in the community, and to assimilate other research into the planning and design of community health facilities.
This program can then be used as a basis for a building design and as a test for that design.

The community health program should be the primary entrance for patients into all types of health care. This means that hospitals which provide specialty back-up care or intensive treatment are really out-reach adjuncts to the community program rather than the reverse. A community health center should have its own clinical license, maintained by a governing board or corporation composed of residents and health consumers in the community. This is the controlling body that would decide programs for the center, its organization, hours of operation, staffing, functions and such.

The work sheets which follow place these goals plus the design guides of Part III into a structured format.
JAMAICA PLAIN

Model Cities

Martha Eliot

Curtis Hall

\{ 49,000 \ldots Population \\

- 15,000 \quad \text{served at existing centers -- to become outreach centers} \\

\underline{34,000 \ldots \text{Target Population}}

Projected percentage enrollment: 40\%

\quad \frac{x \cdot 4}{x} \quad \sim 15,000 \ldots \text{Patients served annually}

Expected Patient Visits per patient

\quad \frac{x \cdot 5}{75,000 \ldots \text{Patient Visits per year -- (300 per day)}}

Use 1 MD for 5000 patient visits

\quad \frac{\div 5,000}{= 15 \ldots \text{Doctors supporting 40 \ldots staff}}

\text{see Appendix C for source of values used here}

Jamaica Plain Health Center

Worksheet 1
Doctors

4 Pediatricians
4 Internists
3 Dentists
4 Assorted (part-time)
  e.g. ENT
  ophthalmologist
  podiatrist
  psychiatrist
  psychologist

Staff

8 Nurses - Aides
6 Public Health Nurses
3 Dental Hygienists
2 Lab Technicians
1 Psych Aide
1 Nutritionist
2 Social Workers

6 Secretaries
1 Administrator
1 Medical Director
3 Assistants
2 Records Clerks
1 Accountant
1 Receptionist

"TEAM"

pediatrician - Administrative
internist
nurse
secretary
social worker

34

W.9.2
<table>
<thead>
<tr>
<th>CATEGORY of SPACE</th>
<th>TYPES of USE - AREA</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEDIATRIC CLINIC</td>
<td>reception, waiting, examining rooms, offices, nurses areas, utility</td>
</tr>
<tr>
<td>ADULT MEDICINE</td>
<td>reception, waiting, examining, rooms, offices, nurses areas, utility</td>
</tr>
<tr>
<td>DENTAL</td>
<td>reception, waiting, operatory rooms, prep area, dark room, minor surgery (recovery), Lab, hygienists</td>
</tr>
<tr>
<td>MEDICAL (assorted)</td>
<td>Maternal, Family Planning, Mental Health, Podiatry, geriatrics, ENT, ophthalmologists, pre-natal clinic, nutritionists</td>
</tr>
<tr>
<td>INTAKE - DIAGNOSIS - LAB</td>
<td>Interview area, X-ray, ECG, spirometry blood tests, urine samples, LAB (hematology, bacteriology, constant temp), Physicals, pap smears, conference, computer terminals</td>
</tr>
<tr>
<td>EMERGENCY</td>
<td>Triage, casts, access outside, operatory rooms, recovery, prep.</td>
</tr>
<tr>
<td>CATEGORY OF SPACE</td>
<td>TYPES OF USE, AREA</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>ANCILLARY OFFICES</td>
<td>Social workers, nutritionist, legal aid, job interview, training, dispensary, school health program, speech therapy.</td>
</tr>
<tr>
<td>ADMINISTRATION</td>
<td>Program Director, two aides, records, billing, accountant, Medical Director, aide, research ass't, telephone switchboard, supplies, computer terminals, receptionists, conference area.</td>
</tr>
<tr>
<td>PUBLIC (COMMUNITY) USE</td>
<td>Day care, nursery (baby sit), toilets, lounge, telephone, snack area, exhibits, games, shows, conference, meetings, telephone, classes, community, breakfast.</td>
</tr>
</tbody>
</table>
D. Site Location. The Cardinal O'Connell Minor Seminary, is located on 9 acres of land in central Jamaica Plain, bordered by South Huntington Avenue, Brynner Street, Day Street and Perkins Street (see Figure 4). There is an undeveloped corner at Hyde Square (Perkins Street, Day Street and Centre Street); shops and transportation are nearby (see Figure 5). This is the site chosen for a new Jamaica Plain Health Center.

While more study of Jamaica Plain, its development, other land available, old buildings for renovation, or cost comparisons might have changed this choice, a different site would not effect the general purpose of this thesis.
V. BUILDING DESIGN
PUBLIC ENTRIES -- INTERNAL CIRCULATION

CLINIC

SERVICE

CLINIC

MEDICAL AREA

SCHEMATIC

FIG. 7
JAMAICA PLAIN HEALTH CENTER
- for comprehensive community health care -
CARL J. ROSENBERG - MIT B. ARCH. Thesis - May 1971
JAMAICA PLAIN HEALTH CENTER
- for comprehensive community health care -
CARL J. ROSENBERG - MIT B. ARCH. Thesis - May 1971

FIG. 12
SECOND LEVEL
SCALE:
FEET 0 5 10 20
Figure 13

Security and Sound

Shaded areas can each be locked separately for security when the rest of the center is open. Shaded and hatched areas also sound-isolated from lobby.

Jamaica Plain Health Center - for comprehensive community health care -
Carl J. Rosenberg - MIT B. Arch. Thesis - May 1971
JAMAICA PLAIN HEALTH CENTER
- for comprehensive community health care -
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DETAIL: SERVICE AREA

TO CLINICS

WAITING
OFFICE
X-RAY
OPERATING
RECOVERY

RECPT
DRK RM
DRSNG
PREP
ENTRY

EXAM
EXAM

ECG
URING
LAB
OFFICE

BLOOD

TO CLINICS

UP

SCALE

FIG. 16

1/8" = 1'-0"
JAMAICA PLAIN HEALTH CENTER
- for comprehensive community health care -
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LONGITUDINAL

TRANSVERSE

JAMAICA PLAIN HEALTH CENTER

- FOR COMPREHENSIVE COMMUNITY HEALTH CARE -

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JAMAICA PLAIN HEALTH CENTER
- for comprehensive community health care-
CARL J. ROSENBERG - MIT B.Arch. Thesis - May 1971
The City of Boston (and Jamaica Plain) maps were available from the Boston Redevelopment Authority. The proposed route for I-95 was obtained from Mr. Tony Disarcina of the Boston Department of Road and Transportation. A lengthy report "The Southeast Corridor Study" by the Architects Collaborative, Perry Neubauer coordinator, indicated the future development to accompany the highway. Frank Lupo, architecture student, did part of the working model and the interior perspective drawings.
APPENDIX A: PLANNING A COMMUNITY HEALTH FACILITY IN ALLSTON-BRIGHTON

A. The Community. Allston-Brighton is a community of about 60,000 residents near the urban core of Boston yet distinct in its community identity. It is bordered by other "communities" such as Newton, Brookline, Cambridge, Watertown. The population is largely low- and middle-income families, plus a high proportion of elderly, and transient students. The cultural origin of permanent residents is predominantly Canadian, Irish, Cuban and Puerto Rican; there are few Negros. Median family income in 1969 was $5,700, compared to $6,800 for the City of Boston as a whole. Fifty-three percent (53%) of the area's families reported incomes in 1969 below $6,000, compared with forty-three percent (43%) city-wide.

Although Allston and Brighton are here linked together it might be mentioned that the 1960 U.S. Census showed Allston, as compared to neighboring Brighton, having more unemployment, lower level of educational achievement and a higher percentage of dilapidated housing. The 1970 census showed Allston population at 12,175. This area is the main "target population" for the proposed Health Center.
B. Existing Health Facilities. In all of Allston-Brighton, there are no comprehensive health centers. Service is provided by the overburdened emergency rooms and outpatient clinics of St. Elizabeth's Hospital and Kennedy Memorial Hospital for Children, but, as might be expected, these emergency rooms and clinics tend to be used for the medical crises rather than for on-going preventive care. St. Elizabeth's runs a federally-funded Child and Youth (C and Y) Program and a Maternal and Infant Care (MIC) Program through a satellite facility located at the Storrow School in North Brighton. Two thousand children are registered.

The City of Boston Dental Department supports a dental program for elementary school children; this is housed in the Court House basement. The Health and Hospitals Department runs a weekly well-baby clinic at St. Elizabeth's.

C. Initial Planning. Given this problem of diverse services which were geographically scattered and disconnected, community planners began action to coordinate and upgrade their health care; they wanted to find a way to provide under one roof high quality medical care for all members of a family at hours and in a style acceptable to the community.
Initial investigation was undertaken by the Allston-Brighton APAC (Area Planning Action Council). This local group was financed by an OEO Model Cities grant and had proven itself to be competent and useful. They hired a part-time coordinator and formed a committee, namely, the APAC Health Planning Committee.

The next step was to separate this planning committee from the APAC. This was important for the group's integrity as well as to allow for separate funding procedures. An Allston-Brighton Community Health Corporation was incorporated, a non-profit group composed of resident consumers in Allston-Brighton and representatives of health provider institutions in the community. This Corporation stated this goal: "The establishment of a neighborhood community Health Center to provide comprehensive primary health care on a personalized and preventive basis to the families and individuals in Brighton and Allston. Health services now scattered throughout the community would be brought together and supplemented by additional services to form a comprehensive program backed up by local hospitals." An expanded Planning Committee was established under the aegis of this Corporation; there were four working subcommittees: Needs, Program, Funding and Site. Although all the hard working members of the Planning Committee and Health Corporation Board - both consumers and
providers - were sure of the need for providing a comprehensive health care facility and system for Allston-Brighton, they also knew they had to determine more thoroughly the extent to which residents of the community shared this concern, and also to assess in more detail the range of health services needed by this population. Therefore, the Needs Committee distributed a health questionnaire to nearly 5,000 families, a third of whom responded. Eighty-seven percent (87%) of the respondents in the target Allston area felt there was a need for a Health Center in this area. In general, the Health Corporation's belief in the need for a comprehensive Health Center was supported by the response to the questionnaire.

In addition, the committee found that alarmingly few of the newer Spanish and Chinese speaking families who have moved into Allston are seeking preventive health care or even curative care for themselves or their children; a new health center could be an important aid to helping their health and social integration.

The Program Committee had the task of combining existing health programs and arranging new ones so that the proposed center could actually provide the comprehensive, family-oriented continuous health service it was proposing to the community. Their goals were tempered by the
results of the health questionnaire and now plan to include pediatrics, adult medicine, obstetrics and gynecology, child and adult dentistry, family planning, mental health, some lab work, and social work service.

This committee arranged for the transfer of existing programs by their supporting agencies from their present locations, plus the outline of additional staff requirements and the coordination of the needs of the consumers to the resources of the providers.

D. Pressures and Conflicts. From this background of planning and growth of the small Allston-Brighton Neighborhood Health Center, we can see all the pressures of much larger community planning.

The issue of control of the facility is not yet resolved; at present it rests entirely with the Health Corporation which is comprised mainly of health provider professionals, service administrators or professional health planners. This is the same body which has instigated the development from the beginning. They have vested in themselves the right to formulate all policy matters other than those of a medical nature which require medical training and experience. Such matters include the planning, development and operation of the Center, and encompasses fiscal review, selection of personnel, and
types of services provided.

At the same time, the Health Corporation is trying to encourage and enlarge community involvement. They (through the efforts of the Needs Committee and a social work student assistant) are having meetings in the community, drumming up support and interest for the project. The Corporation believes (so they claim) that community participation is the sole means for insuring the Center's responsiveness to community needs. Whether or not this is true and whether the Health Corporation (now very ably and aptly run by professionals, not potential consumers) will allow a change in authority, remains to be seen.

A second issue is the functioning of the medical planning: to organize as specialty clinics or as teams. Because of limited funds and the separate auspices of the different programs which will be brought under one roof at the proposed center, it was realized that each program will be functioning apart. And yet the Health Corporation wants to take a "family" or "comprehensive" approach to health care. To resolve this conflict, they propose that the staff of each program should coordinate their efforts through weekly staff meetings and case review, thus trying to simulate a team approach. During this planning stage the Health Corporation has
kept doctors and directors of the supporting programs constantly informed regarding the future of the program they are with and how it is envisioned that this program will function with the new Center. In fact, these staff members are often on the committees.

This same relationship has been true for the back-up hospitals involved. Although these parties were at first skeptical of the health center idea, as the entrenched their role in the planning and as they saw further benefits from removing costly programs from their facilities and reducing the burden on their outpatient clinics, they have been increasingly helpful to the support of the Center. Both St. Elizabeth's and Kennedy Memorial Hospitals are committed to accept referrals from Health Center physicians to their inpatient care.

E. Site. The Site Committee was particularly eager to locate the new center in a new low-moderate income housing development located on North Harvard Street in North Allston, the Charlesview Housing Development, just being completed. There will be 212 new apartments in Charlesview (30% of these to be leased by the Boston Housing Authority) with an estimated increase in Allston population of nearly 1,000 people. With an interest in this site for a long time (the history of this particular
housing development is a rich and florid story in itself), the Allston-Brighton APAC Health Planning Committee, and subsequently the Allston-Brighton Community Health Corporation negotiated with the Charlesview Housing Development for space in the new apartment complex for a small health facility. Due in part to community representation on the Governing Board of the Development, a working relationship has been maintained and up to 3600 square feet of the housing area has been allocated, albeit on a rented basis, for a health care facility.

The APAC Health Planning Committee originally eyed this location because there was new construction here and also because this area of the community includes a potential service population of over 20,000 people of relatively lower income than the remainder of Allston-Brighton. This is a residential neighborhood of two- and three-family dwellings of primarily working class families and some students. It is this part of the Allston-Brighton community that is farthest removed from the few health facilities described above. Also, three bus lines serve this site, on Western Avenue and North Harvard Street, and it would, therefore, be accessible to most Allston-Brighton residents.
F. Facility. The chosen location for the Center, the Charlesview Development should be very suitable. It will enjoy the image of a new building. The apartments will also support a Nursery, small shops and other functions of community focus. In spite of these benefits, it must be admitted that a thorough study of alternate locations was not made, and expansion may be difficult.

The area staked out by the Health Corporation is the lower two stories of a four-story, pre-cast and poured-in-place concrete structure. There are 1,150 square feet at ground level and 2,540 square feet on the second floor; total, 3,700 square feet. As is, the space is an enclosed shall, with hot water perimeter heating, availability of electrical and plumbing lines. The Center will have to pay for major rehabilitation.

The Planning Committee's basic commitment to an integrated approach to family health care, together with the practical realities of making the best use of the prescribed space and meeting the needs of each program led to the following preliminary plan, designed by this author and John James, a Cambridge architect.

The 1,150 square feet, ground floor: This area could house the reception and waiting room area, two examining rooms, one interview room (for intake registration)
and an office—all focused on adult medicine, i.e. Obs.-Gyn. and internal medicine. (see Figure 24).

We sought to eliminate the necessity of climbing stairs for older patients and prenatal patients. Circulation on this ground level could move so that a patient could enter the vestibule, check in at reception, reach the waiting room, be called to his appointment and then leave the clinic passing by the reception area (to make a follow up appointment) and out the vestibule. The patient would not have to pass through the waiting room again, sparing him any awkwardness and limiting other patients' annoyance.

Also, the area directly adjacent to the waiting area outside—reached through sliding glass doors—would be well suited for a patio or waiting room extension, accessible only through the Clinic. It could be easily controlled and monitored.

Public parking is available in front of the Clinic, facing Western Avenue, adjacent to bus stops. Entrance to the Center is off a public passageway which goes under the building into the interior courtyards and to other apartments.

The 1,150 square feet immediately above, second floor:
This area is designated primarily for pediatric examining
rooms and work areas and for office-consulting rooms for those staff who work directly with children and their families; this might include the social worker, nutritionist, psychiatrist, psychologist and public health nurse. The laboratory is also located in this area. (see Figure 25).

Again the circulation flow could be: patients come upstairs from the far end of the waiting room (a secretary or nurse area at the head of the stairs would offer orientation) and, after their visit, leave by the stairs nearest the exit, again past the receptionist and through the vestibule, without necessarily disturbing the other visitors.

At the same time, patients or visitors who had business directly with the associated staff (social workers, nutritionist, etc.) might be able to go directly to the second floor by these first stairs, thus avoiding passing through the waiting room entirely.

The adjacent 700 square foot "wedge", second floor:
This area will concentrate the non-medical work areas (administrative offices, records, billings), and also the public activity/function space (conference room and classroom). For the staff of the Center, this is an area where they could hold meetings, have coffee breaks, and learn what is happening in other programs. For the
community, this space could be used for health classes, First-Aid courses, training sessions or consumer-community meetings regarding the running of the center.

The second 700 square foot "wedge": This space would be allocated to the dental program with its three operatory rooms, small lab, dark room, and waiting reception area. Both of these wedge sectors are accessible from the stairs nearest the entrance and neither would require persons to use the main waiting room.
ALLSTON - BRIGHTON
NEIGHBORHOOD HEALTH CENTER
Proposed layout of spaces at Charlestown Apts.
24 March 71
CJR
FIG. 24
Utility core includes hot and cold water, sewage/waste and ventilation ducts.
APPENDIX B: THE HARVARD COMMUNITY HEALTH PLAN

The Harvard Community Health Plan (HCHP) is a recently established pre-paid comprehensive health program in Boston. It was designed as a model of what health care could be like in America, and a study of its organization and facility, its successes and problems, will reveal trends and pressures which must be resolved by the health delivery system today.

The plan was first instigated by Harvard Medical School and has been generously funded by Blue Cross, ten commercial insurance companies, Harvard Medical School and private foundation grants. It has been in operation since October 1969. The Harvard Plan is similar in many ways to existing pre-paid group practices, such as Kaiser-Permanente in California and the Health Insurance Plan (HIP) of New York. To join, subscribers must first be members of groups, most often unions. For a fixed monthly premium ($51.00 per month for a family of any size), HCHP subscribers are insured of obtaining office visits, periodic check-ups, laboratory services, unlimited semi-private hospitalization including doctors'
in-hospital visits, up to 100 days extended care in a convalescent or nursing home, and limited psychiatric services. This care is offered by a closed salaried panel of doctors, six full-time and eighteen part-time.

The Harvard Plan leases its own health center facility (three floors of a modern apartment building in Kenmore Square) and has contracts for inpatient care at four Harvard affiliated Boston hospitals.

Because the Harvard Plan is essentially competing in the public market to provide health services, there is the need for the Plan to provide high quality care at reasonable prices in pleasant inviting surroundings. As with other pre-paid group practice plans, HCHP anticipates controlling its costs through the provision of preventive care and decreased length of hospitalization.

The issue of who runs the HCHP has been neatly sidestepped by a unique governing board structure: it is comprised of one-third providers and one-third independent public interest members. This structure was designed to appease the fears of
consumers or providers that one group or the other would have sole control.

The name "Community" Health Plan is really a misnomer. There is no focus on one geographic or political community, not even the Harvard University community. Nevertheless, the Harvard Plan draws 20% of its subscribers from the economically and medically indigent population of Mission Hill - Parker Hill, an urban, predominantly black community on the edge of Roxbury. This enrollment may be due to the concern by the Harvard Plan Board to extend comprehensive health care into the low-income areas of the city. It may also be due to a recent policy of HEW which is to make grants to pre-paid group practices that agree to include one-fifth of the membership from indigent groups.

This extension of the consumer population, from predominantly white middle class subscribers to include a lower class or poverty community has brought signs of strain to the Plan. HCHP originally intended to keep all professional medical services at one location and to establish an outreach center in Mission Hill merely for
administrative processing, registration, consulting and so forth. However, there was strong reaction by consumers to this plan: they wanted to feel that medical services could be part of the community, and they resented having to travel all the way in to Kenmore Square. Also, the community wanted to be able to control the operation of the outreach center, its hours, its staffing, its services and its programs. These conflicts are not yet resolved. The layout of facilities at the Kenmore Square building shows the structure of the Plan. First, there is no area for any community functions or public open space because there is no single identifiable population segment, or community being served. Second, there is complete separation of services on the basis of clinics or medical specialty. There is no formal, informal or administrative team coordination of different disciplines which may be serving the same family. Third, the first floor laboratory and diagnostic area - while it has the advantage of being easy to reach from the entry - has the disadvantage of being separated from the clinics. A patient who has visited a doctor must dress and undress to reach the X-ray area and must dress and undress
again to have other lab work done. All circulation between separate service areas goes solely through a central public channel (elevator and corridors). (see Figure 26).

The Harvard Community Health Plan is by no means a resounding success. Enrollment is far below early projections: it is still at around 13,000 instead of a planned size of 30,000. Costs are far in excess of early projections. This may be due to poor marketing of the plan, higher cost of HCHP compared to other health insurance, costs of the facility, and what has been labeled a basic lack of innovation in the actual system of delivery of health care (see Health-PAC article). In any case, the Harvard Community Health Plan is a significant attempt to provide pre-paid comprehensive health care, one which will offer valuable experience for the future.
APPENDIX C: HEALTH CARE FACILITY PROGRAM ESTIMATES

A. Introduction. Data from twenty-five (25) existing Boston Neighborhood Health Centers was used to evaluate and substantiate the program requirements arrived at in Part IV. This data on services, hours, patients, patient visits, doctors, funding and populations was gathered and compiled by the Peter Bent Brigham Office of Community Medicine ("A Directory of Boston Neighborhood Health Centers"), and by the Staff of the Community Health Service, Department of HEW ("Summary of Free Standing Ambulatory Care Services in Greater Boston"). Both compilations are dated 1971.

B. Identity of Community. A "target" population may or may not fall within a political boundary. One must look at neighborhood environments, history, tradition, ethnic backgrounds, shopping patterns - all of which are strong bases for community identity. (see Figure 27).

C. Percentage Enrollment. To consider what percentage of a "target population" might enroll in a health care program (either directly through a pre-paid or assigned relationship, or indirectly through acknowledged usage), I used numbers from the surveys mentioned above. Twenty-five free standing ambulatory service centers in the greater Boston area claimed "target populations" ranging in size from 6,000 persons, to 100,000, to the rather presumptuous claim of "All of Boston". These same facilities
also had data - or were able to make estimates - regarding the number of individual patients served during a year. A thorough interpretation of these visits would look at type of service, methods of enrollment, type of community, etc. However, a certain range of percentages did reoccur. This range, Figure 28, shows that most of the surveyed centers served about 10% to 40% of their target population.

This range of percentages could be due to the cost-competitiveness of the health program, its accessibility, how well it has established its rapport with the community, type of community, income of the residents, availability of other services, neighborhood private physicians, social stigma, and other reasons.

D. Frequency of Use by Patients. Number of individual patients served does not show the frequency of use that these patients give to a center. The same twenty-five greater Boston neighborhood health centers had estimates of their number of annual patient visits. This number divided by the number of patients equals the average number of visits annually per patient. Figure 28 shows a wide disparity around a rough average of two to three visits per year per patient.

The factors that determine utilization are myriad: ease of transport, operating hours, waiting time, services
provided, method of payment, public image, etc. but with certain confidence the above range could be predicted.

E. Number of Doctors. From data again from these surveys, it is interesting to find that as a rough estimate each full-time doctor will handle about 5000 to 6000 patient visits per year, See Figure 29. A finer study might show these statistics to be weighted largely by pediatric care which has a different pace than other treatments. Nevertheless, for the facilities around Boston there is striking mathematical agreement on this range. A similar consistency follows with a comparison of the number of individual patients per doctor, Figure 29.

F. Existing Pre-paid Health Care Plan. One of the largest pre-paid health insurance plans is HIP (Health Insurance Plan), which serves roughly 700,000 middle-income residents of New York City. The HIP Plan, in serving area populations of 20,000 persons with comprehensive care, averages 5,121 physician visits per 1000 enrollees; around 5 visits per patient per year. For this nexus of 20,000 persons they utilize 19.0 full time physicians averaging 5,400 patient visits per year or one doctor per about 1,000 enrolled patients (HIP Research and Statistics, April 1, 1970).
NEIGHBORHOOD HEALTH CENTERS

JAMAICA PLAIN HEALTH CENTER - for comprehensive community health care -
CARL J. ROSENBERG - MIT B. ARCH. Thesis - May 1971

- BOSTON

FIG. 27
**Fig. 29**

The images depict bar charts showing the number of centers for different ranges of patient visits and the number of doctors for different ranges of patients served. The charts highlight the relationship between the number of centers and the corresponding patient visits and doctors served. The specific details of the data are not provided in the image.
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