NEIGHBORHOOD HEALTH CARE IN CAMBRIDGE

by

DEBORAH CRAMER

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Signature of Author . . . . . .
Department of Urban Studies and Planning,
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Certified by . . . . . .
Thesis Supervisor

Accepted by . . . . . .
Chairperson, Departmental Committee on Graduate Students

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ABSTRACT

The research for this paper consists of an inquiry into the nature and extent of the problems the City of Cambridge faces running its neighborhood health station program and the nature and extent of the problems of citizen participation in that program. The research asks these questions regarding the role of the City actors and the role of citizens who participate. How have they shaped the program? What authority, responsibility and accountability do they have in setting and implementing policy? How do they duplicate, coordinate or undercut each others efforts? What are the problems with the role they play? Why do these problems exist and how can they be resolved?

The research indicates that the City has serious problems setting policy for and administering the program. Administrative leadership is highly fragmented, jobs and responsibilities are ambiguously defined, adequate authority and accountability of the leadership is lacking. Weak leadership results in poor planning, frequent crises, financial instability, inadequate medical backup, uncoordinated care, inadequate responsiveness to community needs. An analysis of the literature on neighborhood health care suggests these problems are not atypical.

Citizens' groups have had serious problems participating in the health station program. Citizens do not agree with each other or with the hospital on goals, health is a difficult issue around which to organize, and citizens' groups lack legitimacy. Citizens' groups and the hospital have no mutually agreed upon definition for the scope and degree of citizen participation and no formal means of communication with each other. Citizens do not know who at the hospital is responsible for the program. An analysis of the literature on citizen participation suggests that these problems are not atypical.

The research also inquired into the positive aspects of the program to determine which qualities should be maintained when other changes were made. The research concluded that despite the difficulties faced by both the City and citizens, neighborhood health stations staffed by nurse practitioners is the most appropriate means to provide geographically, psychologically and financially accessible health care to low income people. A City run program guarantees the program's ultimate accountability to the public.

Based on an analysis of the literature on political decision making, an analysis of the problems, an analysis of the program's benefits, and an analysis of the constraints involved in making any changes in the organizational structure or substance of the program, the research pointed to the following recommended changes: The City needs to combine community health services into one department, hire a medical director who will be Chief of that department and whose authority will be equal to that of any other head of a medical department. The medical director will control services within the health stations and be in a position to negotiate with other department heads over appropriate interface between the hospital and the health stations. The Health Commissioner and the Health and Hospital Board of Trustees need to assume greater responsibility for community health in order to strengthen the accountability of the leadership. Although tension may always exist between citizens and the hospital, citizens will be able to make a more substantial contribution to the program if they are able to establish a mutually agreed upon process for relating to the hospital on a continual basis, if they are able to define the scope and nature of their relationship to the hospital, define specific goals, strategies, and jobs, and recognize that individual citizens groups share enough concerns to work together. Adequate staffing of these groups should facilitate the groups gaining the necessary expertise to participate effectively.

Thesis Supervisor: Robert Hollister

Title: Assistant Professor of Urban Studies

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DISCLAIMER

The opinions and conclusions expressed or implied in this thesis are those of the author. They are not necessarily those of authorities for whom the author did fieldwork, nor of the academic fieldwork sponsors, or reviewers or other contributors.

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I. INTRODUCTION

Neighborhood health centers received special emphasis in the 1960's as aspects of federal antipoverty legislation, particularly in the Economic Opportunity Act and the Demonstration Cities Act. Advocates supported neighborhood health centers for a variety of reasons: to provide health care for low income people in neighborhoods where there were decreasing numbers of physicians, to change the institutional structure of the health care system, to break the "cycle of poverty" and to provide for the participation of citizens in major programs which affect them.[1] Neighborhood health center proponents viewed neighborhood health centers as a place where consumers and providers of health care could work together, where teams of professionals could work together to provide comprehensive care, where new jobs could be created, and where health services and other poverty programs could be linked.[2]

Many of these goals can conflict with each other, and several studies[3,4,5] have concluded that goals of community participation can clash with goals of service delivery. Furthermore, others[6,7,8,] found that existing hospital institutions often resist cooperating with or supporting neighborhood health centers.

Nonetheless, some[9,10,11,12] have concluded that neighborhood health centers and nurse practitioners can deliver accessible, comprehensive health care comparable in quality to health services offered by other providers. For many low income and minority groups, the neighborhood health center provides psychological access to health services which the

hospital, often considered "unknown, unreachable, distant and irrelevant to the way they define their need for assistance", does not.[13]

Neighborhood health centers originally received substantial amounts of funding from the federal government. Federal money is no longer available in large amounts, and the question of who will accept the responsibility of providing health services for low income people naturally arises. For the most part, this responsibility has fallen to public hospitals.

Even before the advent of neighborhood health centers, public hospitals have tended to be responsible for patients who could not pay for private care, and public health departments have tended to be responsible for community health concerns. Private hospitals, which are not accountable to the public, and which have financial incentives to reject nonpaying patients, have tended to provide acute and episodic care rather than primary, preventive community health care.[14,15] Understandably, public hospitals are asked to assume the financial responsibility for neighborhood health centers. Understandably problems occur if the hospital is not fully committed to community medicine in low income neighborhoods.

In the late 1960's and early 1970's, the city hospital in Cambridge, Massachusetts, established community health programs in three areas. In low income elementary schools, school nurses were replaced by pediatric nurse practitioners who, with physician consultation from the Pediatrics Department, provided comprehensive health services to children. In five health stations (indicated on map p. 18) adult nurse practitioners, psychiatric nurses (with physician consultation) and social workers provided comprehensive health services to adults living in low income neighborhoods. Four health stations are licensed as part of the hospital outpatient de-

partment, and one is licensed as a free standing health center.

While the pediatric and psychiatric programs run effectively, the adult program suffers from inefficiency, mismanagement, and controversy. Although health stations tend to be much smaller than health centers (8000 sq. ft. vs. 20,000 sq. ft. for example) the administrative problems tend to be similar. Because the hospital is a public institution and thus accountable to the City Council, the public has the means to insure the continuation of the program. Without this pressure, the program probably would have been phased out.

This paper focuses on the adult neighborhood health station program between 1970 and March 1976, from two perspectives - the role of the city in setting policy for and administering the program, and the role of citizen participation in the program. The general administrative problems of neighborhood health centers are discussed by Zwick and Torrens,[16,17] and this paper presents an examination of these problems in one particular city. The paper does not address issues of program effeciency which would analyze and determine the cost-effectiveness of the program, the most appropriate number of health centers, or the most appropriate allocation of services between the health stations and the hospital. The neighborhood health stations have strong support from the City Council--support which does not come from automatic approval of a line item budget, but rather follows from a careful and thorough review of the program implied by the budget. The neighborhood health station program is one of the few hospital programs whose budget receives careful scrutiny by the Council and by citizens. Despite this support from both the Council and citizens, the program lacks strong direction and administrative leadership, and needs an administrative and decisionmaking structure. Once established, the

structure can be used to resolve the operational issues which inhibit the program, and identify the means to increase program efficiency. Therefore, this paper, by analyzing the experience of the city and the consumers in running the program, attempts to determine the appropriate, feasible roles for city and consumer actors necessary to insure a stable, well run program sensitive to the needs of its users.

The role of the city is discussed with regard to several specific neighborhood health station policy and administrative issues: the relationship between the hospital and the health stations in the areas of medical backup, administrative control, delivery of health care by teams, and responsibility for expansion; and the financing mechanisms for the health stations. Discussion of each issue includes an indication of each actor's authority, responsibility and accountability, her or his roles in shaping and implementing policy, and a description of how each actor duplicates, coordinates with, or contradicts the efforts of other actors, and what problems stem from these particular roles.

The role of citizen participation will be discussed with regard to issues of administrative control over hiring, financing (billing) and expansion. The role of three groups will be reviewed: the Health Care Policy Council, the Neighborhood Family Care Center Board, and the North Cambridge Health and Social Services Committee. Each discussion will include an indication of who participates; how the groups are organized; what are their interests and powers; how they gain (or lose) legitimacy; how they coordinate or do not coordinate with each other; what is the nature and source of the role they play; and finally, how their role has helped bring about institutional change of the health delivery system or the redistribution of power.

The paper includes a review of the relevant literature and analyzes the problems in light of these theoretical perspectives. It also includes a set of recommendations to establish more effective roles for both the city and consumers. It is an opportune time to make such recommendations because the city is in the process of rewriting its health ordinances, reevaluating and reordering the priorities of the Health Department and the Health Commissioner and appointing a new Commissioner.

The resources which form the basis of the analysis and recommendations are my experience doing fieldwork in the Cambridge neighborhood health station program as an advisor to one of the citizen's groups - the Health Care Policy Council - and as staff to the chairperson of the Cambridge City Council Health and Hospital Committee, as well as the literature on neighborhood health centers, citizen participation and social change, and political decisionmaking.

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II. DESCRIPTION OF THE NEIGHBORHOOD HEALTH STATION PROGRAM IN CAMBRIDGE

Five adult neighborhood health stations, located in low-income areas in Cambridge, provide a wide range of medical and social services to approximately 2500 registered patients.[1] The health stations are staffed primarily by nurse practitioners who receive physician consultation services from the hospital. The total budget for the entire neighborhood health station program is approximately $700,000, most of which is money from the City budget, and some of which is money from the federal government.[2] The bulk of the funding originally came from the federal government, but as federal assistance has decreased, the City has assumed the major financial responsibility.

Four of the health stations are under the direction and supervision of the Cambridge Hospital. An advisory group, the Health Care Policy Council, plays a limited role in setting health station policy. The fifth health center, the Neighborhood Family Care Center (NFCC) was run by a board formed by the Model Cities Agency until Model Cities money ran out.

The NFCC opened in 1968 as part of the Model Cities program in Cambridge. Two of the other health stations opened in 1971 and 1972 when the Chief of Community Medicine at the Cambridge Hospital applied for and received a grant from the Office of Economic Opportunity. He initiated the neighborhood health station program in order to insure the availability of primary care in low income neighborhoods with declining numbers of family physicians.[3] In 1973 and 1974, the health station program expanded

into two other low income neighborhoods in Cambridge.

The program developed out of a complex set of goals for improved delivery of health care and other services during the late 1960's. These goals have produced a program which may not be the most cost-effective way to deliver care. However, the program is regarded as an improved means of providing accessible health care in low income neighborhoods and the strong, continued support of the program by the City Manager, several physicians, the City Council, which carefully reviews and analyzes the budget, and the citizens, who actively participate in large numbers in the budgetary process, reflect this view. Since the total cost of the program is less than 1% of the City budget, the City Council and the Manager have generally considered the program an effective way to use City funds to deliver health services at a reasonable price.

Despite considerable public support for the program, it is controversial and has many administrative and other problems. A large number of people, both in a policy making and administrative capacity, play an active role in shaping and directing the program. Serious administrative problems substantially increase the inefficiency of the health stations. Some of these problems are serious enough to have resulted in the closing of the NFCC.

The following sections provide a more detailed description of the size and scope of neighborhood health station services, of the individual health stations and the patients who use them, the financing mechanisms of the program, the policy makers and administrators, and, finally, the available alternative sources of health care.

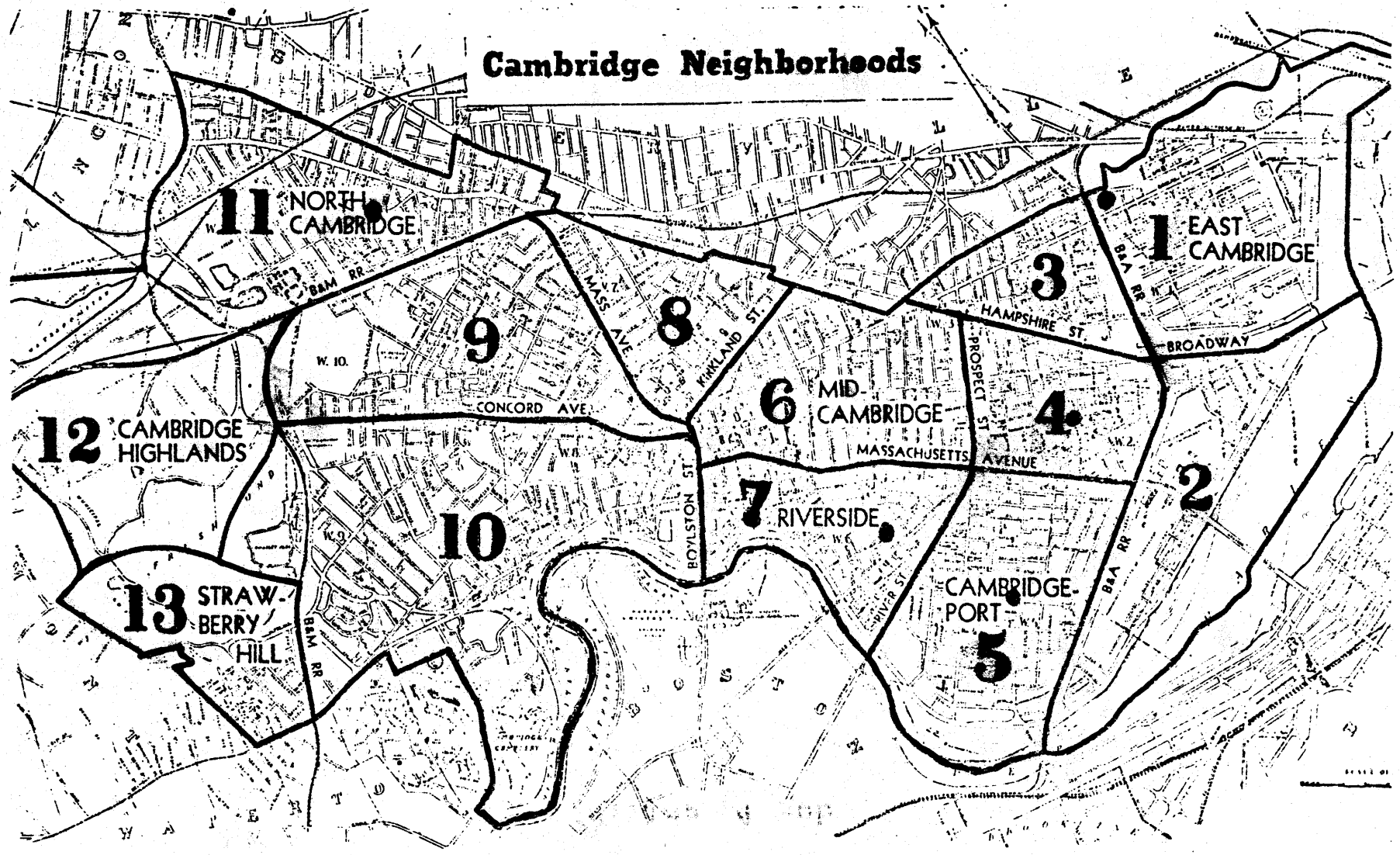
A. Health Station Services: Size and Scope

The locations of five adult neighborhood health stations are marked on the Cambridge map, p. 18. They are: the North Cambridge health station at the M. E. Fitzgerald School in neighborhood 11; the Neighborhood Family Care Center at 105 Windsor Street in neighborhood 4; the Mary Castriata health station (formerly known by the name of Donnelly Field), near the Miller's River housing in neighborhood 1; the Cambridgeport health station, located in the Erie Street housing in neighborhood 5; and the Riverside Health Station located in the Riverside Community Center in neighborhood 7.

Nurse practitioners, nurses who have had additional training in patient evaluation and diagnosis, provide routine primary care in the health stations. Nurse practitioner services include "initial health screening and triage, chronic and acute disease management, health counseling, family planning, routine prenatal care, routine physical examinations, lab and diagnosis tests within the limitations of the clinical setting, and followup of all lab reports."[4] Each health station has at least one nurse practitioner. Two health stations, Mary Castriata and the Neighborhood Family Care Center, have two nurse practitioners.

Most of the adult health stations are also staffed by a receptionist and a health aide, both of whom are, in practice, supervised by the nurse practitioner. At the Neighborhood Family Care Center receptionists and health aides are supervised by the governing board of the health station. Medical receptionists handle the medical record system, make appointments for patients, and register new patients.[5] The job of the health aide varies from ordering supplies to performing basic lab tests and sometimes to doing family planning counseling, depending on the preferences of the

MAP OF NEIGHBORHOOD HEALTH STATIONS



nurse practitioner who supervises the health aide. In some cases the health aides are bilingual and act as translators for Spanish or Portuguese-speaking patients.

The health stations offer other services on a part time basis. A full-time nutritionist divides her time among the health stations and sees patients who are referred by the nurse practitioner. She generally discusses an appropriate diet with prenatal, overweight or undernourished patients.

Social workers, psychiatric nurses, physician residents and alcohol counselors are assigned to the health stations on a part time basis, so that patients who need or want to be referred to one of these people can be seen in the neighborhood health station. A part time family planning counselor divides her time among the clinics. She provides family planning information to patients who are interested but may not yet want or need to see the nurse practitioner.

The Cambridge Hospital also provides consulting physician services. A gynecologist and a general practitioner or internist visit each adult health station at least one afternoon per week, and see patients who have been referred to them by the nurse practitioner.

The neighborhood health stations are open during the day, but not during the evening. Each nurse practitioner sees from 50 to 75 patients per week, depending on her experience (newer nurse practitioners seem to have less confidence and thus spend more time with patients initially,) and on the other demands on her time (such as meetings with other staff and with hospital administrators, and following up patients who are seen at other hospital departments).[6]

As will be noted below, the health stations serve only a fraction of the population in their respective areas. At most of the health stations there is a six to eight week wait for people who wish to register as new patients and for well patients who wish to receive an annual physical examination.[7] At some clinics, no new patients are enrolled because the nurse practitioner feels there is no time to see new patients.

Waiting lists and closed registration result partly from a lack of physical space. Health centers tend to be larger than health stations because they provide a wider range of services. While neighborhood health centers nationally average 20,000 square feet,[8] the Cambridge adult health stations are much smaller, each having about 8,000 square feet, comparable in size to health stations in other cities. In such a small space, expansion of services is almost impossible. The North Cambridge health station, for example, has one examining room and a waiting room. The nurse practitioner cannot see patients when the physician, psychiatric nurse, social worker or nutritionist is present unless somebody sees patients in the waiting room or the bathroom.

B. Patients

The kinds of patients seen at the adult health stations tend to vary with each health station, but the patient population is representative of the neighborhood where it is located, with one exception. Very few patients are male.

Mary Castriata Health Center. The neighborhood surrounding this clinic is one of Cambridge's designated Model Cities areas. The largest concentration of Spanish and Portuguese speaking people live in this area, as well as large numbers of general relief and welfare recipients.[9] The

health station opened in August, 1972 and serves an area (East Cambridge and Donnelly Field) with a population of approximately 13,000. In 1972, there were only one or two doctors who had private practices in the neighborhood. These doctors were about 70 years old at that time, and since then no new physicians have set up practices in the neighborhood.[10]

The regular nurse practitioner sees between 60 and 75 patients per week, and a new nurse practitioner sees about 50 patients per week.[11] The projected number of visits at the clinic in 1975-76 is 3,800.[12] Many of the patients who use the health station speak only Portuguese. The health station, which has bilingual staff, is more responsive to their needs than the hospital, where interpreters are frequently unavailable.

The neighborhood setting allows the nurse practitioner to become familiar with the cultural characteristics of the Portuguese patients and makes it easier for her to understand what role she can play in addressing their social, medical and psychological needs. Many patients who have psychiatric problems are much more willing to be seen in the neighborhood setting than at the psychiatric outpatient department because they needn't label themselves publicly as in need of psychiatric help.[13]

Neighborhood Family Care Center. The Neighborhood Family Care Center, on Windsor Street, was the first comprehensive neighborhood health center in the City. When it opened in 1968, the clinic offered pediatric, psychiatric and social services. In 1970, a physician from MIT volunteered to provide family planning services, and an adult nurse practitioner came with him. The health center is in a Model Cities Neighborhood, which contains very high numbers of Spanish speaking people and two public housing programs, Washington Elms and Newtown Court.

Many of the patients at the center are Spanish speaking and/or live in the housing projects. When the health center was fully staffed, the nurse practitioners saw between 60 and 80 patients per week.[14] In 1973, 2,000 adult patients were registered in the health center and 8,700 visits were estimated.[15] In 1974, however, there were only 4,000 visits,[16] a decrease primarily due to severe personnel and staffing problems. There is no alternative source of care within the neighborhood. One elderly physician practices in the neighborhood.[17]

The nurse practitioners at the NFCC, like those at the Mary Castriata health station, feel that the neighborhood setting provides the occasion for them to learn about the needs of the people living in the neighborhood. The health center is not open at night, because there are no adequate security measures, and the nurses try to meet the needs of working people by scheduling their appointments early in the day.

The health center has been closed since the summer, during a controversy over control of the health center between the city of Cambridge and two neighborhood groups--the Neighborhood Family Care Center Board of Directors and the Spanish Council. When the controversy is settled, the health center will reopen in a new and more spacious location in the building next door.

North Cambridge Health Center. The North Cambridge health station is located in the M. E. Fitzgerald elementary school in North Cambridge, a community north of the B & M railroad tracks with a population of approximately 12,000. The population is fairly stable, with most people living in owner occupied two or three family houses. A large number of

French Canadians live in the area. A large number of elderly people live near Massachusetts Avenue in the Clarendon Hill housing project for the elderly. One housing project, Jefferson Park, is in the neighborhood.[18] In 1972, there were two family physicians whose average age was 55. Now there is only one.[19]

The health station projected it would have 3,000 visits during the 1975-76 year. In 1974, there were 2,000 patient visits.[20] One nurse-practitioner sees about 65-70 patients a week.[21] Enrolled patients must wait approximately six weeks for an appointment, and no new patients are accepted because the wait is so long. Money has been budgeted for an additional nurse practitioner, but in the present health station, the space is not sufficient for two nurse practitioners. Most of the health station patients live within a ten or fifteen minute walk of the health station (68%) and some (17%) come from the housing project.[22]

As in the other clinics, the neighborhood setting allows the nurse practitioner to meet the needs of the community. The health station opens at 8:00 a.m. to accomodate working patients. Patients with psychiatric and alcoholism problems are willing to see the nurse practitioner because she is receptive to their problems, while they are often not willing to go to the hospital. The disproportionately low use of hospital based mental health services, relative to the population, indicates people's reluctance to use the hospital.[23]

Cambridgeport. Cambridgeport is a residential neighborhood with an increasingly large transient population and a very large number of elderly people.[24] The health station is located in a housing project for the elderly in the middle of the neighborhood. There are now no family

physicians operating in the area. The last one closed his practice in December, 1975.

The health station has ample room for two nurse practitioners but only one had been hired and her position is empty now. The highest percentage of elderly patients, 21%, are seen in this health station.[25] Many of the remaining registrants are young women who come for family planning services.[26] The two nurse practitioners from the Neighborhood Family Care Center see both Neighborhood Family Care Center and Cambridgeport patients at the Cambridgeport health station. When the Neighborhood Family Care Center reopens, there will be no nurse practitioner coverage in Cambridgeport.

Neighborhood residents and the people living in the elderly housing have disagreed bitterly over whether neighborhood residents could use the health station. Many residents of the Erie street housing felt that the health station should only be for elderly people.

Riverside. The Riverside health station, in the Cambridge Community Center, which opened in 1974, is the newest health station. The population base of the health station is 6,000, and there are no physicians practicing in the neighborhood. A low income housing project, most of whose residents are black, is one block away. Harvard married student housing is nearby.

During the first year, there were 950 patient visits.[27] Most of the patients were white, middle class women who wanted family planning services.[28] Very few patients came from the nearby housing projects, because they did not know much about the health station and tended not to seek anything other than emergency medical care.

The five neighborhood health stations provide accessible primary medical care as well as psychiatric and social services to low income people in neighborhoods where there are few practicing physicians. Patients feel more comfortable using neighborhood health centers than using the hospital because of the bilingual staff and the sensitivity of the nurse practitioners, who not only provide primary care, but who also teach patients about disease management so that they understand their problems, can take care of themselves, and can prevent problems in the future.

C. Financial Sponsors. The City of Cambridge and the federal government, through the Cambridge Economic Opportunity Council (CEOC) fund the neighborhood health program. The approximate budget is:[29]

Year	Federal	City
1972	110,000	35,000
1973-74 (18 mo.)	115,000	213,000
1974-75	115,000	526,000
1975-76	70,000	618,000

The federal money, an HEW family planning grant, pays for a program coordinator, nutritionist, family life educator, ob-gyn physician consultation, some rent, and some supplies.[30] Another HEW grant underwrites some services for pregnant mothers and young children. Model Cities has provided substantial amounts of money to the NFCC, about $118,000 in 1973.[31] In that same year, the NFCC also received $72,800 from private sources.[32]

While the financial support for the program originally came from the federal government, the program has grown substantially, federal money has decreased, and the City has assumed increasing financial responsibility. The Ob-Gyn Department at the hospital has applied for an HEW maternal and infant care grant that would fund part of the neighborhood health program. This grant has not yet received approval.

None of the various monies for the health stations are administered from the same place. The City Manager, through the Hospital Director, is ultimately responsible for the City money, CEOC administers one HEW grant, the Department of Pediatrics administers another, the Model Cities board controlled Model Cities money, and the Ob-Gyn Department is applying for the maternal and infant care grant. The City Council, ultimately responsible for making the decision to compensate for losses due to decreased federal funding, has not, until recently, been aware of the extent of federal financial support. Despite rising costs, the City Council has been willing to appropriate money needed, not only to keep the program at present levels, but also to expand it.

D. Policy Makers and Administrators

Identification of the actual policy makers and administrators is difficult because nobody really agrees who they are. Table I is the hospital's organization chart, and Table II is a composite of the perceptions of the different personnel involved in the program of the program's place within the Health Department organization.

Leadership of the program is obviously fragmented and decentralized. Distinctions between policy makers and administrators are fuzzy because

TABLE I

Organization Chart, Cambridge Hospital

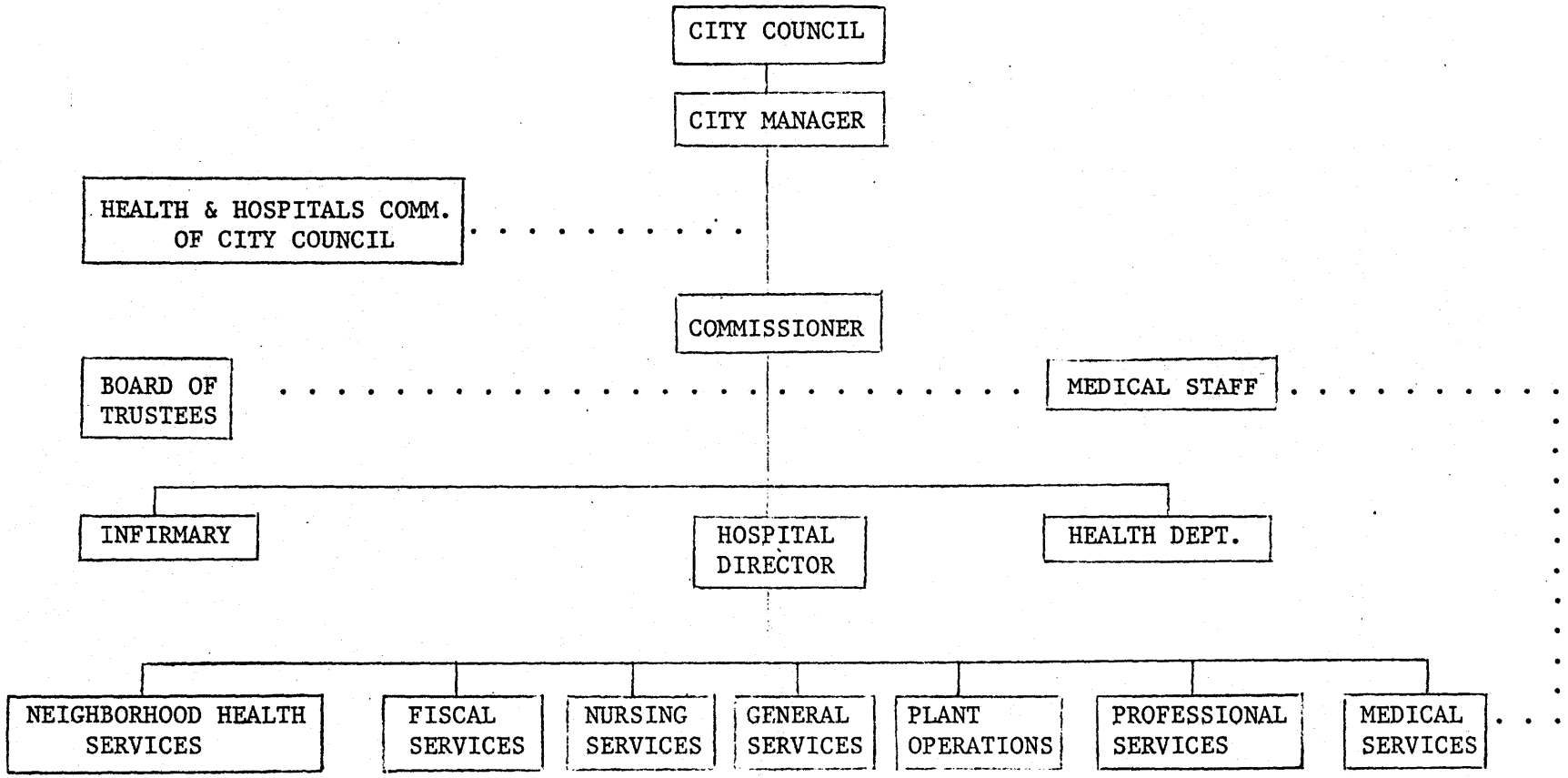
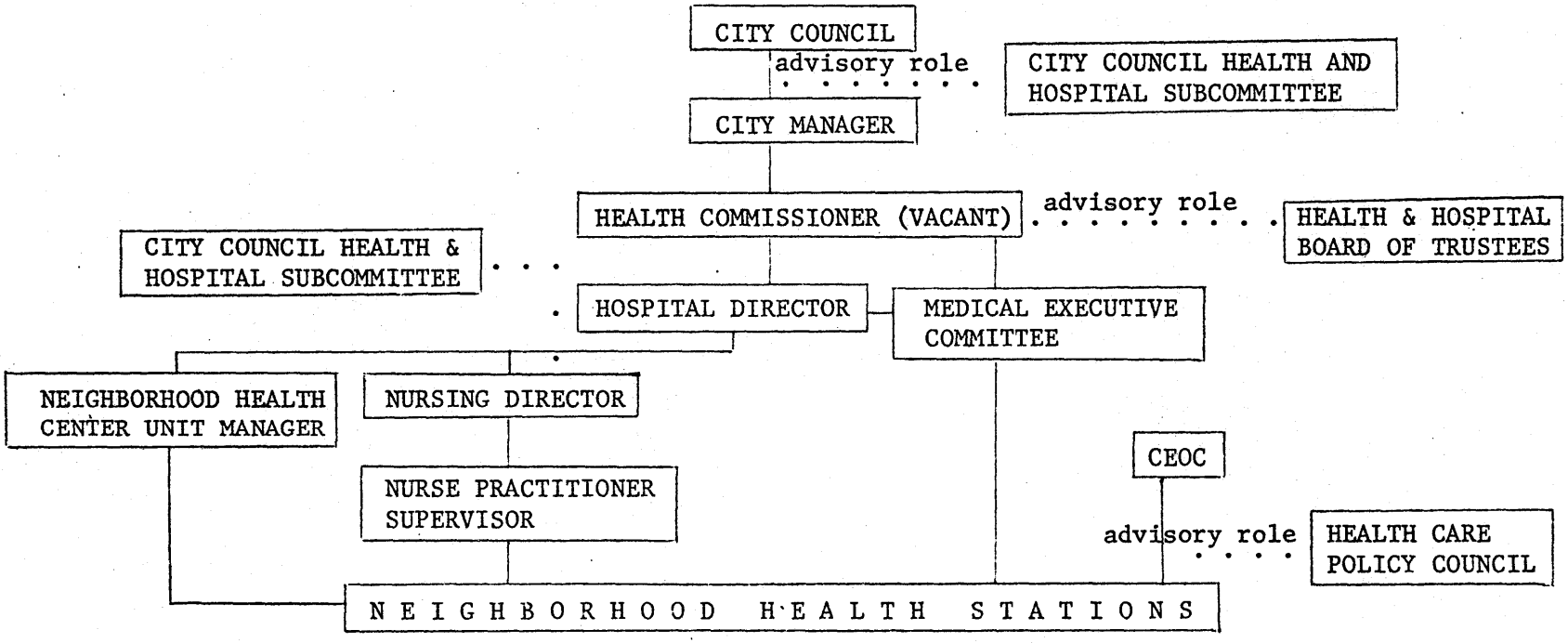
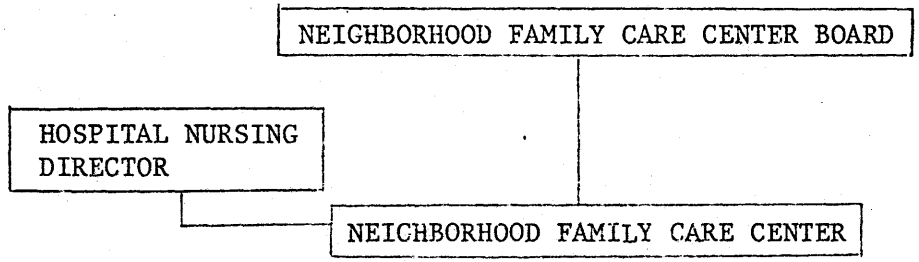


TABLE II

Organization of the Health Station Program as Perceived by Program Personnel





the weak Health and Hospital Board and the absence of a Health Commissioner (the former Commissioner resigned on December 31, 1974,) has resulted in a diffusion of policy making responsibilities among the different administrators, whose responsibilities already overlap or conflict.

The following section identifies and introduces the different actors who have played policy making or administrative roles in the neighborhood health station program. Their different formal and informal program responsibilities, their different interests in specific issues, and their problems dealing with issues will be discussed briefly.

City Council. The City Council votes on the budget, although most of the budget decisions are made by the time the Council meets to vote. City councillors tend to view the budgetary process not always as a way of assuring the implementation of well thought out policies, but sometimes as a way of responding to a constituency and assuring that money is in the budget for politically popular programs. For example, money is voted for the neighborhood health station program when City councillors look at the audience and see the seats full of health station patients and supporters. This bias toward politically popular programs works in two ways. If the City Manager promotes substantial policy, the Council may substitute policies which are more politically expedient. At the same time, if the executive offices are not responsive to people's needs, the City Council is the mechanism whereby the executive offices are made accountable to the general public. Like any legislative body, the Council cannot perform executive functions such as implementing policy. However, the City Council can make policy, and it does so when it votes a budget.

The City Council supports the health stations because City councillors who have taken the time to learn about the program support it, because the program is highly visible and because it has a vocal constituency. Since both the high level executive branch (the City Manager,) and the City Council support the program, there is no problem obtaining the necessary appropriations.

City Council Health and Hospital Subcommittee. This Subcommittee has played an increasingly large role in setting neighborhood health center policy in Cambridge in the past two years. In monthly or bimonthly meetings with physicians and hospital administrators, the Subcommittee: 1) has increased its understanding of what the program implications are of a $618,000 line item budget so it knows what services the City is buying; 2) has provided a forum for the resolution of policy problems and implementation problems so that difficulties need not go before the City Manager or the City Council. Some personnel are threatened by these meetings. They fear the City Manager will intervene if they don't act, so they make and implement some policy decisions. The Subcommittee does not determine how policy is implemented, although some hospital people feel the Subcommittee is overstepping its boundaries in making any kind of policy decision.

The Subcommittee spends much of its time pressuring the hospital to implement the policy of neighborhood health stations. While the City is ready to institutionalize the program by accepting financial responsibility, the executive offices have not been able to administer it.

City Manager. The City Manager is ultimately responsible for preparing the budget and submitting it to the City Council for approval. He

also hires City personnel. Usually, he delegates policy and budgetary authority to the Health Commissioner. In the absence of a Commissioner, the Hospital director has responsibility, but running the health stations and the Hospital is too time consuming, even for the most able hospital director.

Planning Department and Community Development Office. Occasionally, personnel in these offices have been asked to prepare studies on appropriate neighborhood health center location for the Commissioner or City Manager. The staff person responsible for coordinating health and social services within the city, has been unable to spend much time on this project because she has been acting as the City's representative in negotiations with the NFCC over its certificate-of-need application.

Commissioner of Health and Hospitals. The Commissioner makes and assures the implementation of health policy in Cambridge. The position has been vacant since January, 1975. The previous Commissioner was an occasional advocate of neighborhood health stations, in that he sometimes made policy, but only sometimes saw that it was carried out.

Health and Hospital Board of Trustees. This weak advisory board has contributed little, in the form of policy direction, to the health station program, but when its powers are increased under the new health ordinances, its contribution should be greater.

Hospital Director. In the absence of a Commissioner, the ospital director is responsible for the neighborhood health station program because he supervises both the program administrator and the head of the nursing service. He must sign off on any administrative personnel hired for the health stations, and on any policy made for the health stations by his

administrative staff. He tends to feel that running the health stations and the Hospital is too big a job.[34] According to his job description, he is to provide liason among policy makers, and to implement established policies[35] but since there is no Commissioner, his role as policy maker has increased. A major difference in authority between the Hospital director and the Commissioner is that the Chiefs of service are directly accountable for their actions to the Commissioner. The Hospital director's authority is budgetary.

Neighborhood Health Services Committee. Composed of all the Chiefs and department heads, this group, created by the Commissioner, was supposed to coordinate neighborhood health services. However, few people understood how much policy or management power the group had, or what the relationship was between this group and the medical executive committee. In January 1974, the committee requested to become a standing committee of the medical executive committee, and to be responsible for "coordination and direction" of the health stations.[36] The Commissioner did not act on the request.

In December, 1975, the Hospital director assigned the committee a new role. The committee had an "objective: the planning, organization, control, and evaluation" of the health stations, and, a "purpose: to insure the delivery of needed community health services in an efficient and effective manner."[37] Although the job description would appear to include policy making capability, the Hospital director feels that this committee is a management committee which implements, rather than makes, policy.[38] The committee has not played an effective role in either area.

Project Coordinator. The HEW family planning grant, administered by CEOC, calls for a project coordinator who supervises all nonmedical

personnel, coordinates training programs, and orders supplies.[39] The project coordinator functions as a community organizer who is the staff to the Health Care Policy Council, a neighborhood health station citizen advisory group. She also runs the family planning education programs in the health stations and orders some of the contraceptive supplies.

Program Administrator. The project coordinator position, as originally described in the HEW grant, has been shifted to the City payroll under the name of program administrator. The Neighborhood Community Care Committee had requested this position, and had wanted the person to coordinate health station programs by doing the budget, taking care of supplies, keeping statistics, and working with community groups.[40]

The administrator called himself director of neighborhood health services in his job description, and said he was responsible for the supervision and direction of the health stations, and for setting policy and management plans with the Neighborhood Health Services Committee.[41]

In January, 1976, the administrator was replaced by a unit manager, whose responsibilities included ordering supplies, and dealing with licensing and billing issues.

Nurse Practitioner Supervisor. This administrator in the nursing department is responsible for coordinating continuing education programs for the nurse practitioners, assisting in the establishment of protocols (decisions about what kinds of medical problems nurse practitioners take care of by themselves, and which they refer to physicians), representing the nurse practitioners at professional or community meetings, and establishing liasons between the hospital and the health stations. The position was vacant for two years before it was refilled in the fall of 1975.

Director of Nursing. This person hires and supervises all nursing personnel, including nurse practitioners. When the nurse practitioner supervisor position was vacant, the Nursing Director did not delegate the responsibilities to anyone, nor did she assume them herself.

Nurse practitioner. Nurse practitioners run all the health stations except the NFCC. They are service providers, as well as administrators who end up assuming many responsibilities hospital personnel do not meet. Their job description states that they are "accountable and responsible to the recipient and the institution for the quality of care rendered."[42] The individual to whom they are responsible is not explicitly stated, although it has been assumed that they are responsible immediately to the Nursing Director and ultimately to the Hospital Director.

Chiefs of Service. Each Chief of Service is responsible for the provision of physician services from her or his department in the health stations, and for medical backup at the hospital. These services include psychiatry, internal medicine, pediatrics and obstetrics-gynecology. Chiefs are accountable to the Commissioner, but not the Hospital director.

Health Care Policy Council. The Health Care Policy Council is a citizen's advisory board concerned with the health stations. The group was organized by CEOC and the Medicine Department in 1973, when the health station budget was threatened. Residents of each neighborhood where there is a health station sit on the Council, and the group as a whole is interested in issues of billing, hiring and service mix, but has a great deal of trouble participating in any decisions made by other actors. The group is unsure what role it desires to play, and unsure of an appropriate

structure and organization. The group and the hospital disagree sharply over an appropriate role for citizen participation.

Neighborhood Family Care Center Board. This board controls the NFCC, having both administrative and policy setting responsibilities. The City and the NFCC board are involved in a bitter controversy over control of the NFCC.

E. Alternative Sources of Care

Whether neighborhood health stations staffed by nurse practitioners is the best way to provide medical and health services has been the subject of a great deal of debate. A brief examination of the existing alternatives suggests that although neighborhood health stations may not be the most cost-effective or efficient means to deliver medical and health care, alternative ways of delivering services might not provide comprehensive health services which are geographically, financially, and psychologically accessible to low income people.

Going to private physicians is not a real alternative. The population base of the neighborhood health stations is 50,000, and there are four physicians practicing in the areas served by the health stations, all of whom are old, and none of whom is a pediatrician. The Chief of Medicine initiated the health station program in the first place because the supply of medical care providers in these neighborhoods was so limited. It is questionable whether Brattle Street physicians (physicians in a wealthy neighborhood) would accpet low income people as patients and provide high quality, continuing care for them, and whether low-income Cambridge residents would use them. The assumption of those physicians

who initiated the neighborhood health station program was that care from private family physicians was not available to low income people, and, the availability of this alternative has continued to decline over the years. While there is talk of opening group practices in some of the low income neighborhoods, serious consideration should be given to whether group practices oriented toward the delivery of acute medical care, are preferable substitutes for nurse practitioners, who provide a wider range of health and social services.

A second alternative, the outpatient department at the Cambridge Hospital, does not provide convenient, continuous care for patients in its present form.[43] Patients rarely see a doctor on a regular basis because the scheduling of physicians does not allow this kind of continuity. Follow up is often inadequate, because the medical records are too scanty to allow for continuous care, and scheduling problems mean long waits for the patients at the hospital. Bilingual staff is limited. The physicians do not keep complete medical records, and thus providing continuous care is made more difficult. Distance and travel times to the outpatient department are problems for some patients, particularly those from North Cambridge.[44] Although the City could provide transportation, most patients walk (within 10 minutes) to neighborhood health stations and the percentage of those who drive, take taxis, or public transit is much smaller.[45] Therefore, there is some question about how many people would use a transportation program even it if were provided. Furthermore, outpatient department personnel are not familiar with the special needs of individual neighborhoods, and tend to respond primarily to medical problems, rather

than to a wider range of health and social issues. Changing the orientation of OPD personnel has been extremely difficult in other areas.[46] That OPD usage is decreasing[47] and waiting times for appointments at the neighborhood health stations is increasing, illustrates people's preferences.

The Emergency Room is not an adequate substitute for neighborhood health stations, either. The Emergency Room staff provides emergency care, so people who want complete physicals or more comprehensive care are referred to the OPD. The care provided is continuous with care patients receive elsewhere only when a physician or a nurse practitioner goes to the ER to find the discharge summary.[48]

The Harvard Community Health Plan, a prepaid group practice, has a branch near the Cambridge Hospital. HCHP offers comprehensive care on a prepaid basis, either individually, or in groups through employers. Although the care is considered to be quite good by supporters of the program, the program is financially, psychologically, and in some cases, geographically inaccessible to many low-income Cambridge residents. While the City could pay the HCHP enrollment fees for patients, it would still be questionable whether people would use the plan. After HCHP's unsuccessful experience enrolling low-income people in its Boston branch, it would be unclear whether the HCHP leadership would want to undertake a similar effort in Cambridge. The HCHP expressed a goal of enrolling low income people in its plan and opened a satellite in Mission Hill--a low income neighborhood in Boston. Since many people enrolled did not use the HCHP exclusively, HCHP lost interest because it had to pay for all the OPD and ER visits made by members in the plan. Since the Cambridge HCHP branch is near the Cambridge Hospital, patients would have to bear the same time and travel costs as going to the hospital--costs which are prohibitive to

some people. Furthermore, many low income residents in Cambridge are antagonistic toward Harvard, and since the Harvard Health Plan is associated with Harvard, even if only by name, many people might refuse enrollment. The Hospital director himself feels that HCHP is designed primarily for young, transient, middle class people.

The review of available alternative sources of health care illustrates the four basic problems with these alternatives.

1. Financial inaccessibility: People who are considered "medically indigent," that is, who are not on some form of public assistance, do not have the money themselves and do not have employers who provide medical coverage, cannot afford to join the Harvard Health Plan or use a private physician.

2. Psychological inaccessibility: The Cambridge Hospital and the Harvard Health Plan both have characteristics which make them psychologically inaccessible. These institutions can be distant, imposing and impersonal, and their employees tend to be insensitive to neighborhood needs and values. Furthermore, both are affiliated with Harvard, an institution perceived as being insensitive to low income Cambridge residents and as being a direct threat to them. (Harvard's students who force rent raises, making it harder for people who have lived in Cambridge all their lives to keep living in their neighborhoods, Harvard's attempts to expand the boundaries of its campus and rebuild parts of neighborhoods for dorms, and Harvard's tax free status are examples.)

3. Geographic inaccessibility. Lack of a car, difficulties providing for child care (lack of facilities at the institution or inability to pay for a baby-sitter, unwillingness to leave work for long periods of

time, or inability to travel very far (elderly patients), make the time and travel costs of using the Cambridge Hospital too high for many people. Studies indicate that people's use of hospital outpatient services declines when the distance from the hospital increases and when they have to use public transportation. OPD use further declines when patients have to use two or more public transports.[49]

4. Lack of continuous quality care. While the Harvard Health Plan emphasizes continuous care, the Emergency Room and outpatient department at the hospital tend to provide acute care rather than preventive care or health maintenance, and the structure and organization of these departments does not allow for the provision of continuous care.

Given the alternatives to neighborhood health care described above, and given the disadvantages to these alternatives, it is understandable why the program was initiated and why the demand for it is so high:

Care at the neighborhood health stations is financially accessible to everyone, and will continue to be accessible, even when billing begins.

Care is continuous because each nurse practitioner follows a group of patients on a regular basis.

Care is comprehensive because the nurse practitioners are sensitive to health related issues, including environmental, social, and psychological issues. The nurse practitioners do not limit themselves only to medical care. However, the medical care they do provide is considered to be as adequate as that provided by any physician. (See further discussion in Chapter V.)

Patient education is a substantial part of service delivery, so patients have the opportunity to understand the treatment program and to participate more fully in it.

The neighborhood location of the health stations allows greater geographic, and psychological accessibility for the patients, as well as allows the nurse practitioner a greater understanding of the cultural norms in the community where she works.

The next two chapters present and discuss issues which illustrate the controversy and the problems of the program, paying particular attention to the role the City and citizens' groups have played making and implementing policy for the health stations. From a discussion and analysis of these issues will emerge a set of policy and implementation recommendations which should address the most serious difficulties and establish a process for improving the services.

II. FOOTNOTES

1. An exact number of registered active patients is hard to determine because data at the individual health stations is often incomplete. The program administrator determined that the number of registered patients was 2,500. The number corresponds with the nurse practitioners' estimates, but is considerably lower than the estimate of the Cambridge Economic Opportunity Committee, which administers the family planning program. CEOC's estimate is 3900.

2. Exact budget figures for the program are not available, because the adult health station budget has not been separated from the pediatric budget. According to City statistics, the City share of the entire neighborhood health station program (both adult and pediatrics) is $618,000. (Cambridge annual budget, 1975-76, p. iv-79). An HEW family planning grant, administered by CEOC, contributes $70,000. Another federal grant, administered by the Pediatrics Department at the hospital, contributes money toward care for pregnant or new mothers and their babies. The exact amount is not known. Model Cities has contributed substantial amounts to one health center--the Neighborhood Family Care Center, and the School Department pays the overhead for health stations located in the schools.

3. Neighborhood Health Station Crisis Coalition. "A Neighborhood Health Station Program for Cambridge," January 1973, p. 2.

4. Adult nurse practitioner job description for Cambridge Neighborhood Health Stations, March 4, 1975.

5. Chief of Community Medicine's HEW family planning grant budget proposal for the neighborhood health stations, 1973-74.

6. Interviews with neighborhood health station nurse practitioners in April 1975.

7. Ibid.

8. Hollister, R. "Neighborhood Health Politics in Denver." Symposium on Decision Making and Control in Medical Care, New York Academy of Medicine, 1970, p. 2.

9. Planning and Development Department of City of Cambridge. Social Characteristics of Cambridge, vol. 1, 1971, p. 100, 104, 108. Planning and Development Department of City of Cambridge. Social Characteristics of Cambridge, vol. 2, p. 25, 27, 29.

10. Cambridge CEOC, "A Brief Review of the History and Status of the Neighborhood Health Center Program," Dec. 6, 1972, p. 1.

11. Interviews with Donnelly Field nurse practitioners, April 1975.

12. Cambridge City Budget, 1975-76, op. cit., p. iv-79.

13. Interviews with Donnelly Field nurse practitioners, April 1975, and Macht, L., "Neighborhood Psychiatry." Psychiatric Annals, vol. 4, no. 9, September 1974, p. 53.

14. Interviews with NFCC nurse practitioners, April, 1975.

15. Memo from Dwight Conrad, James Hartgering, M.D., and Daniel Greenbaum to the Health and Hospital Subcommittee of the Cambridge City Council, March 12, 1974.

16. Cambridge City Budget, 1975-76, op. cit., p. iv-79.

17. Buckley, D., "Staff Summary--Determination of Need by the Public Health Council," project number 3-4252, February 10, 1976.

18. Social Characteristics of Cambridge, op. cit., pp. 9, 44, 56.

19. "A Brief Review of the History and Status of the Neighborhood Health Center Program," op. cit., p. 1.

20. Cambridge City Budget, 1975-76, op. cit., p. iv-79.

21. Interview with North Cambridge health station nurse practitioner, April 1975.

22. Ibid.

23. Ibid., and, discussion with Chief of the Outpatient Psychiatry Department, April, 1975.

24. Social Characteristics of Cambridge, op. cit., pp. 44, 52.

25. Willemain. T., "Neighborhood Health Centers in Cambridge: A Review of Registration and Cost Data," p. 7.

26. Interview with Cambridgeport nurse practitioner, April 1975.

27. Cambridge City Budget, 1975-76, op. cit., p. iv-79.

28. Interview with Riverside nurse practitioner, April 1975.

29. These numbers, taken from "A Neighborhood Health Station Program for Cambridge," op. cit., the CEOC budgets for 73-74 and 75-76, and the City of Cambridge Budget, 75-76, are only approximations because the hospital has just begun to separate the health station budget from the hospital budget. The substantial increase between 72 and 73 is due to expansion of the program.

30. The CEOC budget proposal to HEW entitled "CEOC Neighborhood Health Stations Program," November 1974, pp. 16-18.

31. Cambridge Model Cities Agency, Planning and Evaluation Department, Impact Study: An Analysis of Impact of Reordering Federal Budgeting Priorities in Cambridge, May 7, 1973.

32. Ibid.

33. The Cambridge Task Force on Health and Hospitals, a group chosen by the City Manager, is rewriting the Cambridge health ordinances in order to restructure the Cambridge Health Department. One of the changes in the health ordinance will provide for a Health Policy Board (now called the Board of Trustees) with policy making power.

34. Discussion with the Hospital Director, October 1975 and January 1976.

35. The Hospital Director job description, written by the Hospital Director and presented to the Cambridge Task Force on Health and Hospitals, Fall 1975.

36. Memo from the Neighborhood Community Care Committee to the Health Commissioner entitled "Report on Policy and Administrative Structures," January 31, 1974.

37. "Cambridge Hospital Neighborhood Health Services Committee" distributed by the Hospital Director in December 1975.

38. Statement by the Hospital Director at a public meeting in North Cambridge, December 75.

39. "A Neighborhood Health Station Program for Cambridge," op. cit., p. 5.

40. Memo from Neighborhood Community Care Committee, op. cit.

41. Director of Neighborhood Health Services job description.

42. Adult nurse practitioner job description, op. cit.

43. Cambridge City Budget, 1975-76, op. cit., p. iv-76, states that the "factors of cost, convenience, and continuity of care are major concerns to the patients" and problems in the OPD.

44. Barron, Cohen and Yim. "Site Alternatives for a Prepaid Group Practice in Cambridge." Prepared for Al Martin, M.D., Cambridge City Hospital.

45. Willemain, op. cit., p. 15.

46. Gordon, J. "The Politics of Community Medicine Projects: A Conflict Analysis," in Hollister, Kramer, Bellin (ed.) Neighborhood Health Centers. Lexington: Lexington Books, 1974, p. 116.

47. Cambridge City Budget 75-76, p. iv-76.

48. These criticisms of the ER are based on discussions at City Council Subcommittee meetings about what kind of coverage is available there, talking to the adult nurse practitioners about the nature of their communication with ER personnel concerning the exchange of patient information, and talking to the Chief of Pediatrics about how he coordinates with the ER. These discussions were held in April, 1975.

49. Acton, J. "Demand for Health Care Among the Urban Poor, with Special Emphasis on the Role of Time," prepared for the U. S. Office of Economic Opportunity and the New York City Health Services Administration. Rand - 1151 OEO/NYC April, 1973.
Action, J. "Nonmonetary Factors in the Demand for Medical Services: Some Empirical Evidence." Rand #P5021. New York 1973.

III. THE ROLE OF THE CITY IN SETTING POLICY FOR AND ADMINISTERING THE NEIGHBORHOOD HEALTH STATION PROGRAM

This chapter contains a discussion of the evolution of several policy and administrative issues regarding the neighborhood health station program. These issues are: 1) the relationship between the hospital and the health stations in the areas of medical backup from the hospital, administrative control of the health stations, delivery of coordinated team care, responsibility for expansion of the health stations, and 2) financing mechanisms for the health stations.

Discussion of each issue will include an indication of what authority, responsibility, and accountability each actor has had, what roles she or he has played in determining or implementing policy, how each actor duplicates, coordinates with, or contradicts the efforts of other actors, and what the problems are with the program as it presently operates.

A. Relationship of Health Stations to the Hospital

1. Medical Backup. This section describes the relationship between the health stations and the hospital regarding medical backup including the responsibilities of those individuals involved in medical backup, the problems the health stations experience in obtaining adequate medical backup, and the ways in which the problems have been resolved.

The hospital is supposed to provide medical backup for the health stations, in the form of consultation services, both in the health stations, outpatient specialty clinics and inpatient service. Physicians are expected to provide on-site medical coverage several hours per week and to provide

continuous telephone consultation. A complex set of relationships among the nurse practitioners, the consulting physicians, the department chiefs and the Director of Nursing sometimes results in inefficient and inadequate medical backup.

The following description of the administrative structure of the health station program will indicate the difficulties of addressing these issues before they reach crisis proportions.

Each Chief of Service (Ob-gyn, Internal Medicine, Psychiatry, Pediatrics) is responsible for the delivery of services in her or his department, both in the hospital and in the health stations. Each Chief is responsible for providing direct physician coverage in the health stations at least one session per week in order that a physician can see patients referred by the nurse practitioner. Each Chief is also responsible for providing a schedule of doctors who will be available on a regular basis to be called at the hospital for a telephone consultation with the nurse practitioners. Chiefs are responsible for scheduling and supervising interns and residents who work in the health stations. Any coordination among the various services takes place in the Neighborhood Health Services Committee (the Committee of Chiefs).

Chiefs are accountable for their actions to the Health Commissioner. At the moment, the Health Commissioner's position is vacant, the Hospital Director does not have the power to direct the Chiefs, and the City Manager has the power, but not the time. Consequently, the Chiefs function independently.

Both the Chiefs and the Nursing Department are responsible for developing the protocols, the standards which determine the nature of the telephone consultation between the nurse practitioner and the physician. The

protocols indicate which kinds of symptoms a nurse practitioner may treat without consulting the physician and which indicate the need for a consultation. The protocols also suggest how the physician should respond to the nurse practitioner - whether and when the physician should question the evaluation of the nurse practitioner or accept it as she reports it.

The head of the nursing service is responsible for supervising, hiring and training nurse practitioners. Usually she hires a person to supervise nurse practitioners. The nurse practitioner supervisor works on the protocols, provides for the continuing medical education of the nurse practitioners, is responsible for hiring nurse practitioners and hiring nurses and enrolling them in the nurse practitioner training programs.

In terms of medical backup, leadership for the neighborhood health stations program is terribly fragmented. When problems occur, determining who is responsible for providing a solution is difficult. Encouraging the person to do something constructive is even more difficult. Most of the crises concerning medical backup occur in the Department of Medicine. The pediatric program is controlled by the Chief of Pediatrics, whose hospital department is small enough that he can run both the department and the pediatric health station program.

In December 1974, the problem of inadequate medical backup in the Internal Medicine Department, both in terms of on-site coverage and consults, became acute. The way the hospital dealt with the problem indicated either an inability to run the health station program effectively or a lack of adequate commitment to the program. The development of the issue and its resolution took place in the following way.[1]

Throughout the fall of 1974, the nurse practitioner who attended meetings of the Neighborhood Health Services Committee (Committee of

Chiefs) suggested that medical backup from the Internal Medicine Department was inadequate. In a memo, the nurse practitioners described the problems as little on-site physician medical coverage, little supervision of interns, poor telephone coverage, unfamiliarity of physicians with the protocols, poor communication between the physicians and the rest of the staff, and lack of a director.[2] The nurse practitioner who attended the meetings asked that the committee take steps to improve the telephone coverage and to replace two physicians who had been responsible for medical backup and who had resigned. Telephone coverage was so poor that nurse practitioners often spent 45 minutes to an hour trying to reach a physician. The physician who ended up taking the call was often unfamiliar with the protocols (and thus the conversation took more time) and sometimes was unfamiliar with the health station program and the expanded role of the nurse practitioner (as opposed to the more limited role of a nurse). Resignation of the two physicians severly reduced the on-site physician coverage in several health stations.

The Neighborhood Health Services Committee did not act on any of the nurse practitioners' comments. The chairman recognized the problem, but felt there was little the committee could do. Although he did not attend regularly, the Chief of Medicine came to several meetings, so he was aware of the problems. He did not take any actions to ameliorate the difficulties because the health station program was a low priority. The nurse practitioner also informed the project administrator of the inadequate medical backup. He could not do anything himself, nor could he persuade the Chief of Medicine to do anything. The Hospital Director was not really aware of the dimensions of the problem.[3]

In November, one of the doctors who resigned sent a letter to the project administrator and the entire Neighborhood Health Services Committee stating his reasons for resigning. They were: "there is no person clearly in charge." Nobody knows to whom to go for support or direction. "On call physicians seem forgetful or disinterested in the matters of their appointed rotations and the routine protocols." They change their schedules without arranging for substitutes. Interns are not supervised. Coordination with the Outpatient Department is so poor that "requests for consultations come back unanswered and patients referred in for consultation are often started on medication before the nurse practitioner and her internist are notified."[4]

No action was taken by anybody during the fall to address these grievances or to fill the vacant physician's position.

The City Council Subcommittee on Health and Hospitals usually holds meetings at the hospital once a month. These open meetings, attended by all the Chiefs, a nurse practitioner, the Director of Nursing, the Director of Social Services, the Hospital Director and consumers, became the forum for discussion of problems pertaining to neighborhood health stations which could not be resolved within the hospital. There is little incentive within the hospital structure to resolve issues since there is no Commissioner and little accountability. The Subcommittee provides some incentive in the form of an unstated, implied assumption that if problems were not resolved, they would be taken either to the City Council or to the City Manager. Because the City Manager controlled the budget decisions, the hospital staff generally preferred not to have an antagonistic relationship with him.

When it became apparent that neither the project administrator, Neighborhood Health Services Committee, Hospital Director, or Chief of Medicine had taken any effective measures to improve the situation, the City Council Subcommittee intervened.

The Subcommittee was aware that the nurse practitioners threatened to resign unless the difficulties were resolved. In their statement of the problems, they offered several solutions: hiring a director for the health stations, providing an orientation for all physicians which described the health station program and the protocols, revising the telephone schedule to allow for better coverage and to provide for physician alternates, assigning a regular meeting time for all professional staff who are involved with the health stations.[5]

The City Council Subcommittee intervention is an example of how the City Council can bring about policy decisions and problem resolutions. Subcommittee intervention occured in the following way: at a Subcommittee meeting, responsibility for revising the telephone schedule and for providing adequate on-site coverage was assigned explicitly to the Chief of Medicine who previously had responsiblity but had not given the issue any priority. He was asked to provide a schedule within two weeks and he did so, although several staff members complained that the City Council was bringing "politics" into the hospital and was meddling in hospital business. At that time the City Council Subcommittee saw its role as setting health policy in a very general sense. When the City Council votes on the budget, it sets a policy of continuing the existence of neighborhood health stations. How that policy was implemented was not considered by the hospital or the City Council to be within the Subcommittee's jurisdiction.

Since the nurse practitioners threatened to resign, and therefore force the health stations to close, the City Council felt justified to intervene. However, the Council did feel that pursuing the nurse practitioners' recommendations any further - hiring a program director or providing mechanisms for better communication between physician and staff - constituted overstepping the line between setting policy and making administrative decisions. While the Council meeting provided the impetus for a solution to the most pressing problems, there still remained no process to deal effectively with future problems.

2. Administrative Control. The fragmented administrative structure of the neighborhood health station program, in which everybody controls a piece of the program but nobody has responsibility for overall direction, and where individual Chiefs appear to be accountable to no one, results in many complications and difficulties.

While the Director of Nursing supposedly supervises, trains and hires nurse practitioners, she has not fulfilled this responsibility, nor did she delegate any authority to anyone until the fall of 1975. She has not been available to assist the nurse practitioners in their efforts to obtain greater physician coverage and she has done little recruiting for additional nurse practitioners. Consequently, when a nurse practitioner is ill, there is often no one to cover the health station. The low enrollment of nurses in the adult nurse practitioner training course illustrates the conclusion that no one is taking responsibility for hiring and training. Since nurse practitioners are in great demand, training nurses to become nurse practitioners by enrolling them in local programs (MGH for example) is a way to insure adequate staffing. The Chief of Pediatrics makes sure

that a nurse is enrolled in the pediatric nurse practitioner program almost every time the course is given. Neither the Chief of Medicine nor the Director of Nursing takes this step to provide for an adequate number of adult nurse practitioners. Consequently, when the Neighborhood Family Care Center reopens, there will be no nurse practitioner at the Cambridgeport Health Station.

The Director of Nursing's efforts to hire nurse practitioners who are already trained have not been successful either. The nurse practitioner at the Cambridgeport health station resigned in early fall 1975, and she has not been replaced. The nurse practitioner at the M.E. Fitzgerald School announced in July 1975 that she would be taking a leave of absence at the end of January 1976. On January 20, 1976, a new nurse practitioner had not been hired.

As in the crisis concerning medical backup, the City Council Subcommittee in its usual reactive position, intervened when it became readily apparent that no one at the hospital was assuming responsibility for either hiring a new nurse practitioner or providing increased on-site physician coverage. This time, the Subcommittee intervened when the Health Care Policy Council (a citizen's advisory board) threatened to bring the issue before the City Council. The Subcommittee persuaded the City Manager to meet with the Hospital Director and acting Chief of Medicine and to tell them to hire a medical director for the health stations and to hire a nurse practitioner. A trained nurse practitioner was found and hired within the week. As a result of pressure from the Manager and the City Council, the Hospital Director assumed the Nursing Director's responsibility for hiring a nurse practitioner, but the process itself did not

provide a clear pattern or direction for the future. For example, when the nurse practitioner who took the job heard it was available, her contact with the hospital was made for her by another nurse practitioner, because the Nursing Department did not return any of her calls when she wanted to apply for the job. While the Director of Nursing claimed that no one answered her advertisements, when the Hospital Director took responsibility for advertising, he received calls from qualified people within two days.

Although a nurse practitioner was hired, there is still no one who has accepted responsibility for finding a nurse practitioner in Cambridgeport, or for running the program. During meetings when the issue of who was in charge came up, responsibility was passed off on whoever was not present. Potentially responsible people include the Hospital Director, the Chief of Medicine and the Director of Nursing, but each one denies having responsibility.

The lack of leadership results in a number of other administrative problems which do not reach crisis proportions and which the City Council Subcommittee does not deal with, but which greatly increase the inefficiency of the health station program. Nobody knows who is responsible for hiring and supervising nonmedical professional staff in the health stations.

While job descriptions do not necessarily mean that the person holding the job actually will do his or her job according to the description, clear job descriptions provide a way for people to be held accountable for what they do. However, job descriptions for neighborhood health station personnel are either ambiguous or conflicting. The job of nurse practitioner includes supervision of aides and receptionists, but so does the

job of the project administrator. The project administrator's job also includes hiring responsibility in coordination with other professional staff, but neither the Nursing Department nor the Internal Medicine staff has actively participated in nonprofessional hiring. In the Neighborhood Family Care Center, nonprofessional staff is supervised by and accountable to the Board of Directors. Often, they refuse to cooperate with the nurse practitioners, who have no recourse since there is no communication between the board and the nurse practitioners. Understaffing on all levels - physicians, nurse practitioners, health aides and receptionists - makes it very difficult for the nurse practitioners to do their work efficiently. The lack, for over a year, of a nurse practitioner supervisor resulted in the nurse practitioners' having to spend more time dealing with administrative issues (hiring, medical backup, coordination with hospital - discussed below -) and less time seeing patients.[6]

Lack of administrative leadership is also suggested by the fact that over a year ago, the City Council passed a motion requesting the addition of a health station with evening hours. No one has taken any steps to implement that policy.

The project administrator's job has been the subject of a great deal of confusion ever since an individual was hired for this position. Originally, the job was called "project coordinator" and was part of an HEW family planning grant. A community organizer for health issues was paid out of the Cambridge Economic Opportunity Committee (CEOC) budget. The project coordinator job was advertised in the Boston Globe as being a job offered by CEOC. As mentioned earlier, the job was basically administrative. Recruiting and interviewing were done by CEOC. During the interview process, the Director of CEOC and the Health Commissioner made an arrangement whereby

the CEOC community organizer became the project coordinator, although the job would still involve organizing the community and providing staff to the citizens' advisory group, and the project coordinator became the project administrator. Although the job was essentially the same, the location was different. The person moved from CEOC to the hospital and from the HEW payroll to the City payroll. This exchange had advantages for CEOC and the hospital. CEOC was able to put one organizer, formerly on the CEOC payroll, onto the family planning grant payroll and thus was able to use the salary for other purposes. The hospital, by paying for the administrator and moving his office to the hospital, obtained much more control over the program.

The administrator's job was never clearly defined by the Health Commissioner. After the administrator had been on the job a few months, he wrote his job description, in which he called himself Director of Neighborhood Health Services and in which he mentioned that he was to supervise and direct health station activities, and establish policies with the Chiefs and the Hospital Director. Nobody, however, seemed to see him in this light. He had no authority to exercise his powers. The Chief of Pediatrics did not communicate with him, the Chief of Medicine did not respond to his requests to improve physician coverage, the Welfare department did not respond to his attempts to negotiate for third party payments, and the Hospital Director did not sign the personnel papers of several people he had hired.

The project administrator held this frustrating job for about a year before it was phased out. Responsibilities for licensing the health stations, ordering supplies, taking care of housekeeping and heat were given to a

hospital "unit manager," who has no responsibility for policy setting. The responsibilities of setting policy and program direction have not been assigned to anybody.

One responsibility the project administrator did not have was the administration of the Neighborhood Family Care Center, the Model Cities health center. The administrator for that health center was hired by the NFCC board. When the Model Cities money ran out, the administrator had to resign. The NFCC does not have another administrator and the City has not assumed responsibility for providing any administrative services there.

3. Coordinated Team Care. Both a national and a local goal of neighborhood health center proponents was the provision of comprehensive, accessible care to low-income people. Health care delivery was to be provided by a team consisting of a nurse practitioner, psychiatric nurse, social worker, and physician. The fragmented leadership of the Cambridge health station program, however, makes such coordination extremely difficult, even within individual health stations. Despite the many directors who control pieces of the program, there is enough flexibility so that with one exception, coordination does take place within the health stations to the satisfaction of all the staff. The one exception is that pediatric and adult nurse practitioners do not meet to discuss cases where both a parent and a child are being treated. Since there are no family records, and since the Chief of Pediatrics does not encourage joint consultation, communication between the adult and pediatric nurse practitioners is on an informal basis.

In terms of coordination with other hospital departments, the problems are much more serious. When a patient is referred to the outpatient de-

partment from the neighborhood health stations, a copy of the patient's medical record is sent too. Usually, the attending physician does not put the statement of the diagnosis and treatment in the medical record. The nurse practitioner often has to retrieve the medical record and the physician's statement herself.[7]

Patients who use the Emergency Room may tell the adult nurse practitioner that they went to the ER. If they do not tell her, she has no way of knowing, since the discharge summaries are rarely returned to the health stations for inclusion in the patient's medical record.[8] The Chief of Pediatrics makes sure that the parents of all children who use the ER are contacted by the pediatric nurse practitioner and encouraged by her to use the health stations instead of the ER for routine care. The Chief of Pediatrics makes sure the pediatric nurse practitioners know who from their neighborhood uses the ER each day. As a result, inappropriate ER usage by children living near neighborhood health stations has decreased considerably in the past few years.[9] Inappropriate use of the ER, use of both the ER and the neighborhood health station for routine care, and the difficulties of encouraging patients to use neighborhood health centers instead of emergency rooms have been documented in other neighborhood health center systems.[10,11,12] While the Chief of Pediatrics has taken steps to address this problem, the Department of Medicine has not made this problem a priority. The Medicine Department is bigger than the Pediatric Department, and the effort needed to address the problem would be much larger. The nurse practitioners do not have time to check through the ER discharge summaries every day to look for patients, and the ER staff does not send the summaries to the health stations.

Coordination of patient care between the inpatient service and the neighborhood health stations has been poor for the past two years. If neighborhood health station patients are admitted through the Emergency Room, neither the ER nor the inpatient service has sent a report to the nurse practitioner. The nurse practitioners have spent a considerable amount of time trying to find physicians to inform them of what is happening to the patients so that they could provide follow up care. Often patients have been discharged to the Outpatient Department for care, even though they are regular health station patients. Coordination with the lab also has been poor. Lab reports have often not been sent back to the health stations, thus making it necessary for the nurse practitioner to spend time at the hospital tracking down records and reports.

The Neighborhood Health Services Committee has not found an effective way to provide for coordination or communication among the different departments on these issues. The Chief of Pediatrics did not attend committee meetings until the fall of 1975 when he was made chairman. No minutes have been kept and few decisions have been made.

4. Expansion. Several of the health stations have long waiting lists for appointments, several are not taking any new patients and one is terribly overcrowded. Money has been included in the budget for additional staffing and for expansion. However, nobody is clearly responsible and accountable for making and implementing expansion plans.

The Chief of Medicine and members of the citizen's advisory board decided in 1973 that the Riverside neighborhood needed a health station. Little planning took place beyond the decision that the neighborhood community center would be a good location. Nobody remembers who decided to

put the health station on the second floor, but neither the State Public Health or Public Safety Department will license the health station because it does not have an elevator. When the health station was built, the director of the community center and the nurse practitioner supervised the building of the health station. No assistance came from the Cambridge Hospital.

The Cambridgeport health station is in an elderly housing project and shortly after it opened, the residents of the building demanded that no neighborhood people from outside the building be allowed to use the health station. The dispute about who should use the health station was finally resolved by the Cambridge Housing Authority so that the entire neighborhood could use the health station. However, demands by residents of the building for priority over other neighborhood residents did not cease, and eventually the nurse practitioner resigned. Discussion of opening another health station in elderly housing in North Cambridge does not consider the problems of Cambridgeport.

The adult health station at the M.E. Fitzgerald School is severely overcrowded. Money has been in the budget to move this health station to a bigger area for two years, yet no relocation has taken place. The North Cambridge residents prepared a plan indicating where they would want the health station to move. The plan was approved by the planning department and by the Health Commissioner. Neighborhood residents identified possible locations. The Hospital Director prevented the project administrator from acting to secure any of these places, stating that either a group practice or a small health station in an elderly housing project (not at all centrally located, but considerably more inexpensive) would probably

replace the health station in the M.E. Fitzgerald School. Eventually, the City Council asked the City Manager to intervene, and he requested the hospital to begin negotiations with the landlords of the buildings suggested by the residents of North Cambridge. Nobody implemented this directive.

Summary of Issue #1 Relationship of Neighborhood Health Stations with the Cambridge Hospital.

Each of the areas discussed regarding the relationship of the neighborhood health stations with the Cambridge Hospital - medical backup, administrative control, coordinated team care, expansion - share certain common characteristics. In all areas, the support from the hospital in the adult health stations has been inadequate. Lack of hospital support is not unusual in neighborhood health station programs.[13] The leadership is highly fragmented, responsibilities and jurisdictions are ambiguously delineated, and hospital personnel deny responsibility themselves as well as deny it to other staff. There is no one to whom the Chiefs are accountable. While such conflict is not unusual,[14] the result is an increased inefficiency of the program and a severe strain on the nurse practitioners who have to deal with the consequences of diffused leadership, but can not do anything about it. Several factors contribute to the behavior of various hospital doctors. Some do not want to give up any of their perogatives to cooperate with other departments in an effort to provide coordinated, comprehensive care. Others regard the neighborhood health station program as a threat to the business of other departments (i.e. the Outpatient Department) and are thus reluctant to refer patients. Some simply do not know about the program. Some personnel feel that cost is a critical issue and are reluctant to spend money on a program which does not pay for

itself. While those who may have the time to run the program do not have the authority, department heads who do not have the time to run an inpatient service and a neighborhood health station program have decided to put their priorities on inpatient service. Although there does not seem to be time for the Chief of Medicine to run both an inpatient and outpatient service, other Chiefs have no trouble. The program, which serves about 2500 patients, is too small to have full time physicians.

The current administrative structure produces a program which is poorly run. Whenever a crisis occurs, the City Council Subcommittee on Health and Hospitals intervenes to force somebody to deal with the immediate problems. Usually, this intervention results in a solution to the immediate problem, but rarely produces or initiates a process within the Health Department or hospital which will deal with problems on an ongoing basis or which will provide leadership. The one exception to this pattern occurred at the end of January, 1976, when the City Manager, at the request of the Council Subcommittee, authorized the appointment of a health station director. However, by March 1976, hospital personnel had not begun the process of searching for a director.

B. Neighborhood Health Station Financing Mechanisms.

1. Federal. OEO, through the Cambridge Economic Opportunity Committee, funded most of the neighborhood health station program through the first year (OEO provided $115,000, the City $35,000). This money went to the Neighborhood Family Care Center, the North Cambridge Health Station, and the Donnelly Field Health Station. In the following years, OEO, and then HEW, through a family planning grant, funded the neighborhood health stations at $115,000 for one year (73-74) and then at a level of $70,000 per year.

The regional HEW office considers the Cambridge neighborhood health station program a model program, and gives Cambridge top priority. The decrease in the size of the grant was not due to regional disinterest, but rather due to decreasing appropriations from Congress. The regional office has always informed CEOC of impending budget cuts early - considerably before the City Council votes on its budget - and occasionally has been able to fund the program above the expected budget. Nonetheless, federal funding under the family planning grant is decreasing. At this point the HEW regional office feels that Cambridge can receive no more than $57,000 for 1976-77, and that the $13,000 difference will not be made up later on in the year. The Ob-gyn and Pediatrics departments have applied for a large HEW maternal and infant care grant for the health stations, but no funding has been guaranteed.

The Neighborhood Family Care Center has received a great deal of Model Cities money, approximately $117,000 in 1973, for example. Model Cities board members, who are also NFCC board members, have guaranteed the NFCC money every year. However, when Congressional appropriations ceased, Model Cities had no money to give the NFCC board. The cutoff in federal funding forced the NFCC board to fire most of its staff. The board has not secured funding from any other federal source, and the City would prefer that the board divest itself of policymaking and executive responsibility, and become an advisory board.

2. State. Neither the adult health stations nor the Neighborhood Family Care Center recover any payments from third party reimbursements, primarily because third party payers do not generally cover services delivered by nurse practitioners without direct physician supervision. Direct

physician supervision means that a physician is on-site at all times the nurse practitioner sees patients.[15] Other health centers recover Medicaid payments without having complete on-site physician coverage, but the Medicaid office has refused to issue Cambridge a vendor number. Discussions with the Medicaid office on this issue began several years ago and no agreements have been reached, partially because the issues have become polarized and both sides are unyielding, and partially because the neighborhood health station program is so disorganized.

Lack of physician coverage in the health stations was not the only obstacle to third party payments. Until 1975, most of the health stations had been operating without licenses or certificates of need because no one at the hospital had assumed responsibility for procuring the Department of Public Health and Department of Public Safety licenses. The health stations still do not meet several Medicaid requirements. The Dept. of Public Welfare does not consider a health station system where each Chief of Service controls a piece of the program adequate leaderhip. The lack of leadership was emphasized to the Medicaid office, not only by the organization charts Cambridge presented, but by the fact that several hospital employees separately went to the Medicaid office to apply for vendor numbers. Each claimed he was in charge, and each described the health station program differently. Given these circumstances, the reluctance of the Medicaid office to issue a vendor number is not surprising. Furthermore, the Medicaid office assessed the Cambridge program structure for citizen participation as being inadequate.

3. City. As federal funding for the health stations decreased, the City has been asked to make up the difference and to provide additional

money for expansion. During the first year of the neighborhood health station program, the Department of Medicine provided the City's share - $35,000 dollars. In working out the 73-74 budget, the Health Commissioner received a commitment from the City Manager to provide three additional staff positions (for nurse practitioners) above the first year's $35,000. Taking into consideration an expected decrease in the OEO grant, increases in the number of patients using the health stations, and the need to provide two additional health stations in Cambridgeport and Riverside, the Department of Medicine estimated it would need about $200,000 from the City for 18 months, or about $130,000 for twelve months.[16] The City Manager at first did not budget this increase, but CEOC, with help from the hospital, organized a group of people who went to a City Council meeting and demanded the increase. The City Council supported the people and the City Manager appropriated the money.[17]

If CEOC and the Department of Medicine had not informed the City Council, the Council would not have been aware that by approving the City Manager's budget, the program would have been cut. Under the City Manager form of government, the power to make program decisions by choosing a budget tends to reside with the City Manager, even though the City Council can disapprove the budget proposal or request additional appropriations or deletions prior to approval. The budget, however, has been presented to the Council in line-item form, so the Council can not recognize what programs are being added, maintained, or deleted, by analyzing the budget.

In recent years, the City Council has paid much more attention to the neighborhood health station budget. The City Council Health and Hospital Subcommittee has held meetings at the hospital where the budget has

been reviewed and its contents discussed. City councilors have been able to determine how many nurse practitioners they are voting to support. In the past two years, hospital personnel have begun to separate the health station budget from the hospital budget so that it becomes easier to see exactly what services the City Council is buying. As a result of the effort on the part of the hospital to define line-items and to provide a program budget, and on the part of the City Council to participate more actively in budget decisions the health station program always has a budget. The City Council has always approved budget requests, even though they have increased, and the City Manager has approved requests, because the program constitutes less than 1% of the total budget, is highly visible, and experiences high demand.

The City Manager has also approved line-item requests by the Neighborhood Family Care Center for additional funding to tide them over until they could secure more federal funds or until they could initiate a billing system to recover some payments. These approved requests have amounted to $50,000. Unfortunately, the NFCC has not recovered any third party payments. Medicaid has refused to issue a vendor number for internal medicine services because the NFCC has no full time physician director. The NFCC had a vendor number for family planning services which elapsed without the NFCC collecting any money. The primary reason for this was that the hospital wanted to bill and collect from third party payers for all services rendered at the health stations. The NFCC was asked not to bill Medicaid itself, but to wait until the hospital was ready, and to bill through the hospital. The hospital was not ready by the time the vendor number elapsed.

Billing by the hospital was delayed for many reasons. There was a

great deal of controversy and confusion over how much patients would be billed for services, whether there would be a sliding scale, whether the patient would receive a bill for the full amount, or the scaled down amount, whether a patient could pay in cash, whether the hospital would take steps to verify a patient's declared income, and whether billing would begin in all health stations at once or one at a time. When the hospital was ready to do billing, the City Council Subcommittee intervened and requested that no billing begin until the citizen's advisory group, the Health Care Policy Council, agreed to the system and until it could be implemented at all health stations at the same time. No mutually agreed upon resolution has been reached.

Summary of Issue #2 Financing Mechanisms.

Many neighborhood health center programs--not only Cambridge--have experienced problems procuring third party payments, uncertainties of year-by-year budget allocations, ambiguities of line-item budgets, and difficulties stemming from the discretionary power of the City Manager over the budget.[18,19] In Cambridge, decreasing federal allocations have put pressure on the City to assume a greater share of the cost of the neighborhood health station program and the City Council has appropriated increasing amounts of money, primarily due to the City Council Subcommittee's belief that the program is worthwhile. This conclusion of the Subcommittee stems from their efforts to understand what kinds of programs are implied by the budget request, and the political popularity of the program. Because the neighborhood health station budget has been separated from the hospital budget, there is less incentive for the Hospital Director to cut the budget, even though the money allocated to the program, especially personnel money,

is not spent. Although the City Council and the City Manager are ready to accept and to be responsible for this program which was financially initiated by the federal government, the hospital has not acted to institutionalize the program. Many neighborhood health centers suffer for lack of funding because cities are reluctant to assume financial responsibility when federal money disappears. Cambridge is willing to make up for the decreasing OEO/HEW money and to make up for decreasing Model Cities money to the degree that all the health stations receive equal support. The City could expand the program without additional appropriations, because some money could be recovered through billing third party payers and those patients who could pay something. Setting up the system to recover monies requires a concerted effort on the part of the hospital, an effort which has yet to be made.

C. Findings and Analysis.

The problems emerging from the discussion of neighborhood health station issues in the last section are: the lack of a strong commitment to neighborhood health stations in some hospital departments, the lack of any clear authority responsible for making and implementing policy, and the lack of accountability of the existing leadership which is highly fragmented and autonomous. Absence of a strong commitment, either because of disinterest or lack of time, results in inadequate hospital support. Highly fragmented leadership means that there is no clear allocation of responsibilities. Lack of accountability means that it is difficult to alter anyone's behavior.

This section analyzes these problems for the City in administering and setting policy for the health stations. The section is divided into three

parts: 1) a discussion of those problems existing within the health stations themselves which can be changed and which the recommendations will address, 2) a discussion of those problems existing in the relationship between the health stations and other groups or institutions which can be changed and which the recommendations will address, and 3) a discussion of those characteristics of the situation in Cambridge which may contribute to problems, but which are givens, cannot be altered, and must be kept in mind when making recommendations.

1. Problems within individual health stations.

Leadership is highly fragmented: no one individual is in charge of the staff at each health station. Often, several people with conflicting or competing interests claim the responsibility for staff supervision. This problem is particularly acute at the NFCC, but exists at other health stations too, because hospital supervisors control pieces of the program and no one knows who actually supervises and hires health aides. There is no uniform hiring policy. Services are poorly coordinated. Some hospital personnel discourage consultation between adult and pediatric medicine, there is no central system of medical record keeping, referral mechanisms between the health stations and other hospital departments are poor. Adequate referral mechanisms could decrease the unnecessary Emergency Room usage by health station patients. In the pediatric program, the Chief of Pediatrics has been able to reduce unnecessary ER usage. The existence of neighborhood health centers in other cities have resulted in decreased ER usage.[20] The pattern of health service delivery is not always reponsive to community needs. The daytime hours, for example, make it very difficult for employed patients to use the health stations. The

long waiting lists make it difficult for new patients to enroll at the health stations. Some studies indicate that travel times and waiting lines are still significant barriers to health care for poor people.[21] Accessibility in terms of travel time has been shown to be extremely important in bringing people into a health care system in other studies,[22] and the neighborhood health stations in Cambridge are certainly accessible to patients in terms of travel time. Administrative improvements and expansion could increase efficiency and bring more patients into the health stations. For patients who are reluctant to use any kind of medical services at all except in emergencies, an extensive outreach program at the Martha Eliot Health Center in Boston has been very successful in bringing patients into the health center.[23] Similar outreach efforts cannot happen in Cambridge so long as outreach worker positions are left unfilled.

The health station program is financially unstable because no billing system exists, no one is actively and consistently searching for additional funding, efforts to structure the program to be compatible with existing requirements for reimbursement have not yet met with success, no one is lobbying for change in the reimbursement requirements, and no one is working actively to increase the efficiency of the program. Financial instability is a characteristic of many neighborhood health station programs and some observers feel that comprehensive national health insurance is the only solution to these financial problems.[24]

2. Problems in the relationship between the neighborhood health stations and other groups and institutions

The most basic and serious problem in the relationship between the health stations and other groups and institutions, especially the hospital,

is that there is no clear assignment of responsibilities, and no mutually agreed upon neighborhood health station program director. Hospital leadership is fragmented and uncommitted. The problem of lack of leadership is exacerbated by the lack of established communications channels among all the groups.

Cambridge Hospital. Nobody is responsible for negotiating and implementing policy agreements between the health stations and the hospital regarding medical backup, referral patterns, administration, or expansion. Hospital personnel do no take responsibility for the adult program themselves, but at the same time deny the necessary authority to others. There is weak, ineffective communication between the health stations and the hospital. Some hospital personnel could not cooperate in a better referral system because they do not even know the health stations exist. Others resent the health stations because they feel money from their programs is being siphoned off into the health stations, that the health stations are diverting patients from the Outpatient Department, and that nurse practitioners should not be practicing medicine.[25]

These kinds of problems are not atypical. In his studies of neighborhood health centers, Daniel Zwick found that "the development of linkages and institutional relations that provide desirable support without imposing unacceptable bonds remains one of the most difficult challenges . . . Established institutions have not provided the necessary management."[26]

Community Groups. There is no mechanism for consumer participation in decision making which affects the health stations. Citizens groups exist--the NFCC Board, the Health Care Policy Council--but there is no agreed-upon definition of the roles citizens' groups should play and what kinds of issues they should address.

The State. Different people representing different aspects of the health station program represent the City in the negotiation process with the Department of Public Welfare, and the Department of Public Health. Such diversity lowers considerably the status of Cambridge in the eyes of these agencies whose decisions clearly shape City programs. Furthermore, these diverse and often conflicting views force the state agencies to settle Cambridge's problems, and increase the chance of a solution or determination which is not necessarily in Cambridge's best interests. Nobody represents the City's interest in the legislature, and occasionally bills come up which could have substantial effects on the program.

The Region. The health stations have no way of relating to, in a city-wide context, regional planning agencies. Different competing groups present themselves at HEW with grant applications, making Cambridge look disorganized in the eyes of regional administrators.

The Health and Hospital Board. The health station program does not relate at all to this Board, which is supposed to advise the Commissioner on health policy. Since the Board is inactive in this role and there is no Commissioner, the City Council Health and Hospital Committee has taken the place of the Board in dealing with the health stations. Such an arrangement will be problematic when a Commissioner is hired, and when the Board assumes responsibility.

The City Council Health and Hospital Subcommittee. This committee cannot make definitive, binding policy, because it has no powers of implementation, except indirectly through the City Manager. These powers tend to be used only in crises. The City Council, however, can insure City funding of health stations, and has done so. The City Council, though,

should not be the main advocate of the program, which needs a strong voice from within the Health and Hospital Department. (See further discussion in Chapter IV of this group.)

The City Manager/Commissioner. The City Manager delegates the responsibility for the Health Department and its budget to the Health Commissioner, who has in the past delegated most of the responsibility for the hospital and the health stations to the Hospital Director. The Commissioner has, in the past, served as a stronger health station advocate than the Hospital Director, but did not become involved in the direct administrative problems which cause so much trouble today. The health stations need an advocate within the Health Department.

Community Development Office, Planning Department. These offices have technical and planning skills that could be of assistance to those who run the health station program, but since there is no formal communication and no program leadership, this possible connection does not exist, and the skills are used in other areas and departments.

3. Givens

Highly fragmented leadership, ambiguous division of responsibilities, lack of accountable leadership, lack of program support (either because of disinterest or insufficient time to handle both inpatient and outpatient services), and lack of coordination among the hospital departments, are problems which can be addressed. The difficulty lies in finding a mechanism which not only addresses the problems, but which will be effective. Therefore, as a first step to making realistic recommendations, this section examines those characteristics of decision making which are present in Cambridge and which cannot be changed.

The nature of the health station program is highly political and medical professionals resist entering the political arena. Other neighborhood health center programs share this characteristic. According to one researcher of neighborhood health centers nationally: "Since the community health center was a strategy for restructuring the medical care system within the broader purpose of reintegrating an alienated population into the political and social fabric of society, the task of establishing and legitimizing this institution has been especially difficult."[27]

Another reason why the health center program is political, is that the program is run by a city hospital, and ultimate policy control over the institution belongs to the City Council, a political body.

Gordon has found however, that "members of the medical professions, among others have tended to deny the political dimensions of health care."[28] In his study of the neighborhood health center program in Denver, Hollister found that program administrators attempted to keep the program away from political pressures.[29]

The same can be said of Cambridge. Many hospital personnel resent what they consider interference in hospital business from the City Council and from citizen's groups. Whether Council involvement in hospital operations is justified depends on one's perspective. Physicians may believe that they know best how to deliver medical care and how to define the public need for medical care and that the City Council does not have that expertise. On the other hand, the City Council can also represent the public interest, because the City Council is accountable to the public while physicians are not.

Why medical professionals would resist entering into the political arena is suggested by Norton Long, who, from his studies of power in local

communities, (particularly Boston), infers that the activities of any community are undirected, and determined by the way in which groups cooperate to protect their self interests.[30] The self-interest which many medical professionals wish to protect is of the kind Eliot Friedson describes, a desire to maintain their status as knowledgeable experts, who by virtue of their medical skills, have been able to dominate decision making in the medical area.[31] To enter the political process in the neighborhood health station program poses a direct threat to this self-interest. Whether physicians' self-interest is based on their confidence in their expertise, their desire to preserve their autonomy, or some mixture of both is difficult to determine. Certainly, a physician may be justified in telling a consumer that he or she does not have the expertise to discuss certain medical issues. However, the fact that department Chiefs do not consult with each other on the establishment of a health service which ideally would need coordinated services[32] indicates that the autonomy of individual services is an issue. Furthermore, while consumers may not have the expertise to make medical decisions, they do know what kinds of services they would like, whether providers are sensitive to cultural norms and what hours are convenient for them to use the services. Some physicians are reluctant to acknowledge community expertise in these nonmedical areas.

Regardless of the preferences of medical professionals, however, the nature of the neighborhood health station program and the structure of Cambridge City government inevitably place the program in a political context. The City Council, accountable to the public, ultimately controls policy at the City hospital. Since the health station program has a fairly sizable and vocal constituency, and since the City Council Health and

Hospital Subcommittee Chairperson is favorable toward the idea of neighborhood health stations staffed by nurse practitioners, the Council will inevitably respond to its constituency and intervene when the program is not running well. Since the Council's crisis intervention has not resulted in a process which will provide for a more responsibly run program, the Council is attempting to build a process which will deal with the program on a continual basis by authorizing the City Manager to hire a program director and by choosing a new Health Commissioner and hospital board who will be concerned with community health.

A second given in this particular situation lies in the nature of decision making. In the Cambridge Health Department there is no unilateral decision making process with regard to neighborhood health stations where executive orders are handed down to administrators. The one who could issue orders would be the Commissioner, and that position is vacant. While the City Manager can issue executive orders, he has too many responsibilities to see that they are carried out. Thus, the Chiefs are accountable to no one. As a result, the implementation of any decision requires voluntary cooperation from them.

Research on the politics of public programs in fields other than health may help to explain the political dynamics at play with regard to the Cambridge neighborhood health program. This research literature should be illuminating to the extent that the programs studied are similar in significant ways to the Cambridge neighborhood health program.

Analysts of poverty programs and of health administration have tended to find the decision making process taking on these characteristics: The process was competitive, where groups openly vied for power, or cooperative,

where groups used bargaining, cooptation, or coalition building as a way to gain control over resources, or exclusion, where any kind of interaction or transaction was avoided by those who wanted to maintain power.[33] Bachrach and Baratz have tended to emphasize the nondecision, or exclusionary aspect of exercising power whereby powered groups prevent decisions from being made which might adversely affect them.[34]

All of these characteristics of political decision making have been evident in the decision making process of the neighborhood health station program. An example of cooptation was the Commissioner's decision to move the project administrator from CEOC and into the hospital. Exclusionary tactics characterize the behavior of hospital personnel toward the community. In the fall, 1975, no members of community groups were included in meetings of the Neighborhood Community Care Committee (the committee of Chiefs). When the City Manager requested (as á result of citizen and City Council pressure) that a neighborhood health station program director be hired, this Committee met to discuss the request. The representative of the Health Care Policy Council who attended the meeting with permission of the City Manager, was not allowed to speak, let alone vote. The decision at this meeting was not to hire a director. Thus, policy statements coming out of the City Manager's office are sometimes completely undermined by those who must implement them, a characteristic not uncommon in other implementation processes.[35]

Because decisions can so easily be undermined, the major means of decision making is bargaining, a process in which neighborhood health station advocates have a weak role. An illustration of their weakness is the discussion of billing policy. After having met with members of the

Health Care Policy Council, and hearing their opinions about what would constitute a desirable billing system, the hospital personnel proceeded as they had originally intended until they were stopped by the City Council.

The kind of bargaining process which assumes the need for consensus decision making and assumes the need for parties with different values to reach a common ground by giving up some values and compromising, has been called the process of "partisan mutual adjustment" by Charles Lindbloom.[36] The process of partisan mutual adjustment has not always been used successfully. Frieden and Kaplan, in their study of the politics of Model Cities legislation, found that this process watered down the legislation so much as to make it ineffective.[37] Consensus decision making diluted and undermined a distinct, coherent program drawn up by rational academics and planners.[38] Frieden and Kaplan suggest that Model Cities failed because Model Cities advocates within the national bureaucracy were not in powerful enough positions or did not have powerful enough allies to hold onto the major pieces of the program during the negotiation process.[39]

Consensus decision making is not necessarily an evil which can or should be eliminated. A more authoritarian system could be totally unresponsive to the public interest, and substituting authoritarian neighborhood health station advocates for inpatient service advocates may be replacing one imbalance with another imbalance. Furthermore, the chances of someone undermining a decision would seem to be less in a consensus, rather than an authoritarian model.

The necessity of accepting a partisan framework with consensus decision making as a given is eloquently expressed by Marris and Rein in their analysis of community action programs.

> Any interested party has the right to propose reform--the mayor, a social welfare agency . . . the poor themselves. None of these is obliged to concern himself primarily with the needs of society as a whole; he is partisan. Disinterested reformers, whose concern is not constricted by any jurisdiction, can only influence this "partisan mutual adjustment," if they too, become in a sense, partisan,--even though their stake in the outcome is different. Since their right to ally their resources to any interested party is questionable, they may represent their purpose rather as seeking a new form of fairer accomodation. But there is a crucial distinction between innovations which try to give a particular issue more constructive expression, and those which try to create a means to arbitrate between all manner of needs. . . . They (Community action projects) tried to establish means, not only to give expression to a variety of needs, but to determine the way in which those needs should be reconciled. And this, we suggest, no one in American society has the power to do. . . . A disinterested reformer, just because he is disinterested is easily misled into searching for such a non partisan framework within which all conflicts cannot be resolved. But the attempt to create a non partisan framework collapses for lack of any secure and truly representative basis within the community power structure from which to promote it.[40]

Consensus decision making is a given in Cambridge. According to the new City health ordinance, to be in effect in spring or summer of 1976, the Commissioner of Health must reach consensus with the Health and Hospital Board of Trustees (to be renamed Health Policy Board) concerning matters of health policy. Until the ordinance is passed and goes into effect and a new Health Commissioner is hired, things will continue as they are now, with the Hospital Director in the awkward position of having to find common ground between the Chiefs and the City Council.

Consequently, consensus decision making is a given and acknowledgment of this process must be implicit in any set of rational planning recommendations.

The difficulty with consensus decision making in matters concerning the neighborhood health station program is that neighborhood health station advocates have a weak role in the bargaining process.

Keeping in mind Frieden and Kaplan's and Marris and Rein's interpretations of the failures of the OEO and Model Cities poverty programs, recommendations of this report will take as givens the partisan political nature of the community and of the decision making process and will try to give one issue, neighborhood health, more constructive expression by strengthening its advocates within the system. Polsby has suggested that power is in the hands of those who are the leaders in the decision making process.[41] At the moment, those leaders are the Chiefs. Recommendations of this report will give neighborhood health center advocates some power so that they will have a stronger role in the bargaining process. While a strong neighborhood health station advocate may be able to take a leadership role in deciding what happens in the individual health stations, the nature of the coordination between the hospital and the health stations will depend on how well the different departments coordinate and cooperate with each other. Taking into consideration the possibility that the adult neighborhood health station program has been a low priority because the leaders have had insufficient time to run both an inpatient and outpatient service, the recommendations will suggest full-time leadership responsibilities for the health stations. Taking into consideration the additional possibility that lack of service coordination and department cooperation in the neighborhood health station program has resulted from the desire of medical professionals for autonomy, the recommendations will suggest a mechanism whereby department Chiefs become accountable for their actions and whereby Health Department policy decisions must take into account the public interest.

No recommendations will be suggested which expect to resolve conflicts between patients and providers, between research-oriented physicians and service-oriented physicians, between male physicians and female nurse practitioners, and between those who would contain the budget and those who would expand the scope of care. These conflicts are characteristic of the health delivery system and cannot be easily reconciled. Rather the recommendations accept these conflicts and try to strengthen the position of neighborhood health station advocates by giving them a stronger role in the bargaining and compromise process.

III. FOOTNOTES

1. I attended the meetings where these issues were discussed and resolved. No minutes were kept.

2. Memo from adult nurse practitioners to hospital administrators entitled "Urgent Problems in the Neighborhood Health Clinics" Fall 1974.

3. Letter from the Director of the hospital to the Director of nursing. October 74.

4. Letter from the adult nurse practitioners to the hospital administrators. Fall 1974.

5. Memo from the adult nurse practitioners, op. cit.

6. Interviews with the adult nurse practitioners, April 1975.

7. Ibid.

8. Ibid.

9. Discussion with the Chief of Pediatrics, April 1975.

10. Kluge, Wegrhy, and Lemeg, "The Expanding ER Department." Journal of the American Medical Association vol. 191. #10 (1965) p. 97.

11. Hillman, and Charney. "A Neighborhood Health Center" Medical Care 10:336-334. July-August 72.

12. Beale, and Schroeder, "Marketing for an Urban Health Center." Health Services Reports, vol. 88. #1 January 73.

13. Morenead, and Donaldson, "Quality of Clinical Management of Disease in Comprehensive Neighborhood Health Centers" Medical Care vol. 12 #4, April 74. Also discussion with people in the Boston Department of Health and Hospitals concerned with neighborhood health centers.

14. Torrens, P. "Administrative Problems of Neighborhood Health Centers," in Hollister, Kramer, Bellin (ed.) Neighborhood Health Centers Lexington: Lexington Books, 1974, p. 164.

15. Definition given by Charles Schwager, Commissioner of Massachusetts State Department of Public Welfare.

16. The Chief of Community Medicine's HEW family planning grant budget proposal 1973-74.

17. Letter from the City Manager to the City Council concerning the additional City budget appropriation. March 24, 1973.

18. Torrens, op. cit., p. 165.

19. Stanley, D. "Effect on Budget Finance" in Managing Local Government Under Union Pressure. Washington: Brookings Institution, 1972.

20. Hillman and Charney. "A Neighborhood Health Center. What Patients Know and Think of its Operation." in Hollister, Kramer, Bellin, op. cit., p. 244.

21. Aday, L. "Noneconomic Barriers to the Use of Needed Medical Services." Medical Care vol. 13, no. 6, June 75.

22. Hillman and Charney, op. cit. p. 245.

23. Salber, Feldman, Rosenberry and Williams. "Utilization of Services at a Neighborhood Health Center." Pediatrics vol. 47 no. 2 February 71 p. 415-423.

24. Torrens, op. cit., p. 165, 166.

25. The expanded role of the nurse practitioner includes patient evaluation and diagnosis. Physicians unfamiliar with the differences in training and education between nurses and nurse practitioners do not feel nurse practitioners are qualified to do patient evaluations.

26. Zwick, D. "Some Accomplishments and Findings of Neighborhood Health Centers" in Hollister, Kramer, Bellin op. cit., p. 82.

27. Gordon, J. "The Politics of Community Medicine Projects: A Conflict Analysis," in Hollister, Kramer, Bellin, op. cit., p. 117.

28. Ibid.

29. Hollister, R. "Neighborhood Health Politics in Denver." Symposium on Decision Making and Control in Medical Care. New York Academy of Medicine, 1970, p. 51.

30. Long, N. "The Local Community as an Ecology of Games." American Journal of Sociology vol. 64, #3 November 58 251-261.

31. Freidson, E. Professional Dominance. The Social Structure of Medical Care, New York: Atherton, 1970.

32. An adolescent clinic in one of the high schools was established by the Department of Pediatrics with no consultation with the Psychiatry Department or the Ob-gyn physician in charge of family planning.

33. Arnold and Welsh. "Community Politics and Health Planning" in Arnold, Blakenship, Hess (ed.) Administering Health Systems. Chicago: Atherton, 1971, p. 154-176.

34. Bachrach and Baratz. "Two Faces of Power" American Political Science Review, December 1962, p. 947-952.

35. Pressman and Wildavsky. Implementation. Berkeley: University of California Press, 1973.

36. Lindbloom, C. The Intelligence of Democracy. New York: Free Press, 1965, p. 25-26.

37. Frieden and Kaplan. Politics of Neglect. Cambridge: M.I.T. Press, 1975.

38. Ibid., p. 130. Lindbloom's discussion is also found in "The Science of Muddling Through" Public Administration Review vol. 19. Spring 1959, p. 80.

39. Frieden and Kaplan, op. cit., chapter 10.

40. Marris and Rein, Dilemmas of Social Reform New York: Atherton, 1969. p. 227-228.

41. Polsby, N. "How to Study Community Power: The Pluralist Alternative" Journal of Politics, vol. 12, August 1960, p. 474-484.

IV. THE ROLE OF CITIZEN PARTICIPATION IN THE NEIGHBORHOOD HEALTH STATION PROGRAM

This chapter discusses the role of citizen participation in the neighborhood health station program, specifically with regard to issues of administrative control over hiring, financing (billing) and expansion. The role of three citizen's groups will be reviewed: the Health Care Policy Council, the Neighborhood Family Care Center Board, and the North Cambridge Health and Social Services Committee.

Each discussion will include an indication of who participates; how the groups became organized; what are their interests and powers; how they gain (or do not gain) legitimacy; how they coordinate or do not coordinate with each other; what are the nature and sources of the role they currently play; and finally, how their role has helped bring about institutional change of the health delivery system or the redistribution of power.

A. Health Care Policy Council. Late in 1972, when the previous City Manager would not grant the $135,000 budget request for the health station program, CEOC organized a large group of people who demanded that the City Council not approve the budget until the neighborhood health station program had been reinstated. Out of this group, called the Neighborhood Health Stations Crisis Coalition, evolved the Health Care Policy Council. The group was organized in April 1973 by CEOC and the Department of Medicine to act as an advocacy group for the health stations.

The Department of Medicine played a big role in forming the group and determining its structure, in a manner similar to the departments of Medicine in other areas who organized community groups, not because they necessarily believed in citizen participation, but because they saw citizens as potential allies in the budget process.[1] The advantage to the Department of Medicine in having such a group is that the nieghborhood health station budget would be protected from potential cuts by the Hospital Director, Commissioner and City Manager, and the group could help pressure the hospital to accept the program. While the intentions of the Department of Medicine may have been to provide the best possible structure for citizen participation, the proposal endorsed was that the group agree to assume advisory status, rather than incorporate and request shared control of the funds and policy making power with the hospital. Reasons given for the original proposal were: that it was unwise to ask the City for the funds to pay for four corporations--one for each health station--because the population base was not big enough to justify it; that the group could not be within the structure of the Health Department and have actual policy making power, because that power rested with the Board of Trustees; and finally, that there was nothing unsatisfactory about advisory status, because the Department of Medicine had a firm commitment to citizen participation.[2]

Several considerations counter this position. Incorporation is not very expensive and would not be a financial burden on the City, although clearly, the City could not and should not be expected to pay a group to share its power. There are financial sources other than the City. One group raised its incorporation money from a bake sale. The size of the

population base necessary to justify a neighborhood corporation is difficult to determine, and the population base of the Neighborhood Family Care Center Corporation is not necessarily the best standard against which to gauge the appropriateness of incorporated boards in other neighborhoods. Theoretically, a neighborhood which is big enough to have a health center should be big enough to have an incorporated board. The more relevant question is how many, if any, health centers the population base justifies The Department of Medicine assumed (and many have questioned this assumption) that Cambridge needed a total of five neighborhood health stations. While five boards might well be unwieldy, the idea of one incorporated board for all five did not receive consideration.

In addition to the considerations just mentioned, the power to set policy did not reside with the Health and Hospital Board of Trustees, but rather with the Commissioner, who could have been asked to delegate some of his authority. In Boston, the Board of Trustees does delegate some of its authority with respect to neighborhood health programs. Lastly, a personal commitment on the part of one physician does not commit the rest of the institution, and certainly does not commit his department after he leaves.

The actions on the part of the Department of Medicine are cooptive--whether consciously or unconsciously--in that a group was given a place in the institutional setting, but given no power or authority. How much of a voice the group had in decisions depended upon the good faith of those in power, and while the physician in the Department of Medicine responsible for the neighborhood health stations remained in his job he negotiated in good faith with the Health Care Policy Council.

In June 1973, the Health Care Policy Council adopted a structure and a set of bylaws. The Council was to have three elected representatives from each health station neighborhood and was to assume the following responsibilities in cooperation with the Department of Medicine: review of the budget, review and approval of all funding applications, determining priorities of need, i.e. new programs, types of service, hours of service, developing personnel guidelines, interviewing the top three candidates for nonprofessional positions, approving the hiring of professionals.[3]

The Health Care Policy Council participated effectively in none of the areas mentioned in the bylaws. Large numbers of citizens do not seem interested in participating in the group on an on-going basis, while a smaller number (approximately 8) consistently attend meetings. This small group is not interested in amassing power or completely controlling the health station program. Rather, the members seem to prefer that the hospital take the responsibility for running the program. They are interested in having a say in only a few decisions, and basically would prefer to stay out of hospital affairs unless there is a crisis or a major decision to be made. Attendance at Health Care Policy Council meetings has, until early 1976, been quite low. As a crisis over leadership and staffing came to a head, more people attended meetings. When the Council and its staff were able to choose strategies to reach their goals, attendance became consistently high (approximately 15). Before this event, however, three representatives from each neighborhood were rarely present. The Council has not had any elections in several years. Many patients do not know about the Health Care Policy Council, and most do not care, unless the health

station program is directly threatened. This kind of group, fairly passive, isolated from the rest of the community it represents and without any authority, is not uncommon.[4] The following examples, in the areas of control over hiring, expansion, and financing, illustrate how the role of the Health Care Policy Council has evolved.

1. Hiring. According to the bylaws, the Health Care Policy Council is to interview the top three candidates for any nonprofessional position. It is the intent of the HEW family planning grant that non-professional personnel be hired from the community which houses the health station.[5] Hiring became the subject of a great deal of controversy, resulting in tremendous antagonism between the hospital staff and the Health Care Policy Council (HCPC). Often, when a vacancy occurred, somebody would be hired, and the HCPC would not be informed. When the physician from the Department of Medicine who worked with the HCPC resigned, nobody from the hospital regularly attended HCPC meetings and few hospital people communicated with the group. The HCPC directed its anger and resentment at hospital personnel without any constructive result. The group remained consistently unaware of vacant positions, so it could not always request to be included in hospital decisions. The group voiced an opinion after the individual was hired, but by then it was really too late for them to do anything but antagonize the staff people responsible for the hiring. The staff to the HCPC did not suggest a change of tactic. Rather than suggest alternative strategies, he supported the group's actions. As a result, resentment grew each time somebody was hired, but there was no process for change. Citizens and professionals yelled at each other at meetings and walked out on each other. Eventually, because of this

situation and some other equally antagonistic circumstances (discussed below) the nurse practitioner supervisor resigned. Several HCPC members stopped attending meetings because the frustrations were too many and the accomplishments too little. Other members simply lost interest in interviewing personnel.

Present members of the HCPC want to participate in planning and hiring decisions which directly affect the health station program. They want to help hire a director and they want to work out a way of obtaining information about impending program decisions from the hospital. They seem unconcerned about who the new Health Commissioner will be, although she or he will have a significant influence on the program. While they are concerned that nonprofessional personnel be hired to fill vacant positions, they are not strongly interested in participating in that process.

People lack interest for several reasons. This particular group of people is not concerned with the neighborhood health station program as a way of providing jobs for low income people, or as a way to acquire power by controlling services which are for their use. Rather, they see the neighborhood health station program as a way to gain access to quality medical are. Consequently, their goals are more service oriented than power oriented, contrary to the experience of the Neighborhood Family Care Center, discussed later. Since the nurse practitioner provides the bulk of the health services, it makes sense that the HCPC is concerned that there be adequate numbers of nurse practitioners.

The HCPC did become involved in hiring a nurse practitioner in North Cambridge. The nurse practitioner had announced her resignation in

July 1975, and announced that it would be effective on February 1, 1976. When, by the end of January, 1975, nobody had been hired to replace her, citizens stepped in. The HCPC arranged several meetings in North Cambridge to inform patients that services would be sharply curtailed in February, and to find out from the Hospital Director, the acting Chief of Medicine and the Director of Nursing exactly what they intended to do about the problem. All three never attended a meeting together, and at each meeting, responsibility for finding a solution was delegated to whoever was absent. A North Cambridge subcommittee of the HCPC informed the Chairperson of the City Council Health and Hospital Subcommittee, who submitted two motions to the City Council, one asking the City Manager to find a solution to the problem, and the other asking the City Manager to determine who was in charge of the health stations. The City Manager was to meet with hospital personnel and citizens to address these two issues. The City Manager determined, at the request of the North Cambridge and City Council subcommittees, that a nurse practitioner should be hired at a salary competitive with other local (Boston) nurse practitioner salaries and that a health station medical director, a physician, should be hired. Both determinations were made at the request of the North Cambridge subcommittee and the City Council Subcommittee. When the North Cambridge subcommittee became aware that a nurse practitioner wanted the job, they informed the City Manager so he could make sure that somebody in the hospital hired her. This crisis has made the HCPC acutely aware that the Nursing Department was not actively supervising and hiring nurse practitioners. Consequently, the group is monitoring the hospital's progress in carrying out the City Manager's directive to appoint a medical director, and taking steps to insure representation on any screening committee.

HCPC members who play the greatest role in this effort are those from North Cambridge. The rest of the HCPC members have begun to realize that what goes on in North Cambridge has implications for the rest of the City program, and they have attempted, so far unsuccessfully, to prevent similar crises elsewhere by demanding that the hospital begin training other nurse practitioners. No nurse practitioner is assigned to the Cambridgeport health station, but since the Neighborhood Family Care Center is closed, their nurses are in Cambridgeport, and the absence of a regular nurse practitioner will not result in a substantial reduction of services until the NFCC reopens and the nurse practitioners return there.

2. Expansion. Issues of expansion have also created a great deal of resentment and antagonism between hospital personnel and the HCPC. The roles of the HCPC in decisions relating to program expansion have varied.

The HCPC's role during the expansion of the program into Cambridgeport had destructive results. In 1973, residents of the elderly housing project which housed the health station claimed that only they were entitled use of it, and other neighborhood residents disagreed. Members on the HCPC who were supposed to be representing the entire Cambridgeport neighborhood happened to be residents of the elderly housing and took the side of the elderly residents. Because the HCPC itself was divided, it contributed to the conflict, rather than to a resolution. The conflict between the elderly housing residents and the other neighborhood residents still continues. Each nurse practitioner who has been hired for this health station has resigned because she felt she could not work without another nurse practitioner in a situation where there were so many demands on her

time. The conflict over the use of the Cambridgeport health station has not been incorporated in planning for other health stations, for there is discussion, both at the hospital, and among elderly residents of North Cambridge, of a health station in an elderly housing project in North Cambridge.

The HCPC has tried to play a more effective role in more recent decisions relating to the expansion of the health station at the M. E. Fitzgerald School in North Cambridge. In 1974, members of the HCPC prepared a plan indicating the need for expansion and a central neighborhood location. Both the Health Commissioner and the Planning Department approved the plan. HCPC members worked to make sure expansion money would be in the budget. They talked to landlords and identified several possible locations. As of March, 1976, no expansion had taken place. Relocation of the health station is a necessity, since conflict with the School Department has thwarted the possibility of extending health station hours in the present location, even as a temporary expansion measure.

When the hospital had not hired a nurse practitioner to replace one who had resigned, North Cambridge HCPC members turned their attention to that issue. Since hospital personnel did not take the initiative in hiring the nurse practitioner, and did not implement the expansion policy, HCPC members are now focusing their attention on securing a neighborhood health station director, who will be the health station advocate responsible for implementing policy and dealing with problems of hiring and expansion.

3. Financing. The HCPC has been very interested in the subject of billing. While members agreed that most patients could probably afford to pay something for services, they wanted to be certain that any billing

system did not deny patients financial access to care. They wanted to participate in decisions the hospital made concerning the nature of a billing system--specifically the structure of a sliding fee schedule, the provision for patients to negotiate and pay the fee in the health stations rather than the hospital, the provision that patients be billed an adjusted fee rather than the full fee if they were on the sliding schedule, and the provision that patients be able to pay cash for services in the health stations rather than at the hospital. Hospital personnel guaranteed that these preferences would be taken into consideration, but never presented the HCPC with any plans or decisions. Rumors from the hospital that certain fee schedules had been set would trickle down to the HCPC, causing resentment toward the hospital personnel for not including or informing them. Hospital personnel were often unavailable to meet with the community to answer questions or make joint decisions, unless the City Council Subcommittee suggested a meeting.

At these meetings, the Subcommittee requested the hospital not to begin a billing system until the HCPC had agreed to it. As of March, 1976, a billing system had not been initiated. The primary reason for the delay is that while hospital personnel have designed a billing system, they have not explained the system to the HCPC and they have not demonstrated that the system is responsive to the needs of the community (i.e., allowing for cash payments at the health stations). The City Council Subcommittee has requested that billing not begin until the hospital and the community have come to an understanding of what a billing policy should entail. Furthermore, the hospital would like to begin billing at one health station at a time, and the HCPC and the City Council Subcommittee would prefer the hospital to wait until it can begin billing all health stations at the same time.

Summary of Role of Health Care Policy Council

The Health Care Policy Council is a small advisory group, mainly concerned with adequate delivery of services rather than acquisition of power. While the Council is supposed to represent city-wide health interests as a whole, most of the members have tended to be concerned primarily with their individual neighborhoods. Many health station patients are not aware of the HCPC or interested in it except when there is a crisis. Crises tend to produce citizen participation on the HCPC, and the form that this participation takes is open conflict with the hospital which antagonizes hospital personnel and contributes to their opposition to citizen participation. Conflict generally results because the group has no formal, continuing relationship with the hospital. Resistance of hospital personnel to the idea of citizen participation has discouraged some citizens from participating in the program. Poor communication and misinformation contribute a great deal to the conflicts and antagonism. Hospital personnel meet with the HCPC, not always of their own volition, but on the urging of the City Council Subcommittee and the City Manager, a situation which indicates the hospital's disinterest in dealing with this particular group. The increasing number of crises and hence the increasing concern of the HCPC and the City Council Subcommittee, has resulted in both groups pushing, not only for solutions to immediate problems, but also for the establishment of a process within the institutional setting to deal with neighborhood health stations. The HCPC at this point, is pushing for an institutional process in which they have an advisory, or maybe a partnership, but not a controlling role. They are not demanding a substantial change in the distribution of power, that is,

they are not asking that power be transferred to them. The group has not generally worked to bring about other kinds of changes, i.e. expanding the program, or demanding new kinds of services, but rather has worked to maintain the change (the initiation of the program) brought about by CEOC and the Department of Medicine in the early 1970's and mandated by the City Council. The hospital has not responded positively to this mandate, and, in order to maintain the program, the group is insisting that a medical director, who will act as an advocate for the program, be appointed. This change has not yet come about. However, in determining the goal of obtaining a medical director, and of precluding future crises of staff shortages, and in defining a strategy to meet these goals, HCPC members have begun to see how they can accomplish something. Consequently, attendance at meetings is much higher.

B. Neighborhood Family Care Center, Inc.

The Neighborhood Family Care Center is a health center in the Model Cities neighborhood. Opened in 1968, it was the first neighborhood health center in Cambridge. Unlike the other health stations, it is run and controlled by the 18-member Neighborhood Family Care Center Board, a corporation established and funded by the Model Cities Board. Control over this health station has been a troublesome and controversial problem for all who are involved. The issue is not how much say the Board can have in policy set by the hospital, but rather whether the hospital or the Board will make policy and control the health center. The City and the hospital both feel that the NFCC Board is unqualified to run the health center, a situation which makes it difficult for the hospital to provide services there. The City wants to assume operating control and is asking the Board

to accept an advisory status. An analysis of the role of this citizen group will include a discussion of those issues which resulted in the City's attempt to assume complete responsibility for the health center and an analysis of the nature of the present controversy.

1. NFCC, 1968-75. Citizen Control. Although the Model Cities legislation called for an advisory role for citizen's groups, ("widespread citizen participation")[6] and the Economic Opportunity Act called for a greater role for citizens, ("maximum feasible participation")[7] in social service programs, the reverse occurred in Cambridge. While CEOC, the local Community Action Agency, was willing to accept advisory status for the Health Care Policy Council, the Model Cities Board and the Neighborhood Family Care Center Board found advisory status unacceptable. The differences are perhaps accounted for by the professional leadership at the time. The Department of Medicine strongly urged that the citizen's group take advisory status, while the Assistant City Manager supported Model Cities neighborhood residents in their desire for control of the Model Cities Board and supported them until they received control.[8] Consequently, control by the citizen's group was a given when the NFCC board was formed.

Many NFCC board members had been or were Model Cities Board members. Some of the characteristics ascribed to the Model Cities Board in another study[9] also hold true for the NFCC Board. The most striking of these are that the Board has no real base of support in the neighborhood, or accountability to neighborhood residents. There has been no new leadership on the Board, because members tend to reelect themselves continuously without electing anybody new. Furthermore, until 1975, nobody representing the Spanish-speaking community, which is very large in this neighborhood, has attended board meetings. The City and the Model Cities Board did not

provide enough administrative help to put the health center in a financially stable position. One professional who helped organize the Model Cities Board felt that lack of administrative support made it extremely difficult for people who did not know much about how to run a health center to run one well.[10] Consequently, their power to provide health care was limited.

Whether or not initial lack of administrative support caused problems later, the administrative support in the health center has always been inadequate. The person the Board hired did not deal with several crucial problems. At the NFCC, the nonprofessional staff are accountable, not to the nurse practitioners, but to the Board. The nurse practitioners are accountable to the Nursing Department at the hospital, not to the Board. As a result, health aides refused to take the family planning counseling training course run by CEOC and offered to other health aides, on the grounds that they were not required to take orders from the nurse practitioner, who asked that they take the course. The administrator did not ease the tensions between the nurse practitioners and the staff, and the Board did not interact with the nurse practitioners unless absolutely necessary. Board members were very suspicious of any kind of professional, and tended not to deal with them. The administrator wielded little power, since all decisions were made by the Board, usually without any staff consultation. Since the Board did not communicate regularly with the staff, the Board was not always aware of problems existing in the health center. The Board was neither aware of personnel problems or of the state of the health center's finances. One reason they did not worry was that the Model Cities Board, some of whose board members were on the NFCC Board,

would always guarantee funds. Model Cities money was discontinued in 1975, and the administrator did not look for other sources of money, nor did he pay the outstanding debts. For example, although he deducted federal income tax from employee's salaries, he neglected to send the deductions to the federal government.

In addition, he did not take care of the physical repairs of the building and often it was so cold that patients had to be examined with their coats on. The housekeeping service was not running smoothly either, and if the nurse practitioners did not empty the garbage and clean the health center themselves, no one did.

The City had a paradoxical attitude toward the NFCC. When it became clear that the NFCC needed more money, the City Manager was willing to add a line item to the budget for the NFCC, and the Commissioner supported that decision.[11] Although no contract was written and signed, the agreement was that the NFCC would receive an additional appropriation provided that it institute a billing process as soon as possible. The NFCC applied for and received a vendor number for reimbursement of family planning services, but was asked by the City and the hospital to wait until the rest of the health station program had a billing service. Although the NFCC is licensed as a free standing health center, and the other health stations are licensed as part of the Hospital Outpatient Department, the hospital personnel wanted all bills sent from the City, all payments sent to the City, and some reimbursement sent back to the NFCC. NFCC Board members preferred the money to come to the NFCC with a reimbursement sent to the City. This disagreement never came to a head because the NFCC did not develop the capability to proceed without the hospital, and, as of

March, 1976 the hospital was not ready to bill. Consequently, the NFCC never collected any money.

Late in 1974, the NFCC fired its administrative director because he did not address the financial problems and because the nurse practitioners had been taken out of the health center when the head of the Nursing Department decided the health center was too filthy to work in. The nurse practitioners returned after the Board spent a weekend painting and cleaning. The Board did apply to Medicaid for a vendor number to receive reimbursements for all services, but the vendor number was denied because there was no full time medical director.

During the spring of 1975, the Board tried to find another administrator, but they were unable to hire their first choices because Model Cities only had enough money to support a director for six months. The person whom they eventually hired proved unable to get the health center back on its feet in the amount of time she had. In the late spring, most of the NFCC staff were released because there was no money to pay them. The nurse practitioners stayed at the health center, without interpreters and health aides until the summer when they felt they could no longer work without any staff support.[12] The health center closed and the nurse practitioners were moved to other health stations.

2. <u>NFCC. Fall 1975--the present time</u>. During the period described above, the building next door to the NFCC was being renovated to become a health center. The new health center was to have been an expanded and relocated version of the NFCC, controlled by the NFCC Board. The renovations were being paid for by a Neighborhood Facilities Grant given by the Department of Housing and Urban Development to the City.

The grant contained a contract which stated that although this development would be undertaken by the City, the health center was to be leased at no cost for 21 years to the NFCC. The operational funds and services of the health center were to be the responsibility of the NFCC. If it failed to carry out its responsibilities, the City could intervene and take over the lease.[13,14]

In August 1975, the City Manager requested that the HUD regional office change the sponsorship of the new center from the NFCC to the City on the grounds that the NFCC had been unable to discharge its responsibilities. He requested that the Cambridge Department of Health and Hospitals be named the sponsor, and that an advisory board be established with the help of the Human Services Coordinator in the City Manager's office.[15] On October 1, 1975, the City sent a letter to HUD confirming the change in sponsorship.[16] HUD had taken the position that the decision to change a sponsor was up to the City, not up to HUD, because no change in service was involved. Subsequently, the Cambridge City Solicitor gave the opinion that the City was acting legally in terminating its contract with the NFCC board.[17]

Meanwhile, the City acted upon its intent to sponsor the new facility and on September 2, 1975, filed a certificate-of-need application with the Department of Public Health. The NFCC Board also filed a certificate of need application for the new facility, feeling that the City had no right to assume sponsorship. The Department of Public Health staff refused to hear the NFCC application because it did not meet departmental requirements.[18] Although the Public Health Council staff did not consider the NFCC application, it also felt that the "Cambridge Hospital lacks an effective organization through which to facilitate community input for its

neighborhood health services program."[19] The Human Resources Coordinator in the City Manager's office tried to work out an arrangement for an advisory board with the two groups who were involved. In addition to the NFCC Board, the Concilio Hispano de Cambridge had expressed an interest in the NFCC. The Concilio represents Spanish speaking people in Cambridge and has an interest in the NFCC because of the high number of Spanish speaking patients. The Concilio has demanded bilingual personnel at the NFCC and has negotiated an affirmative action policy with the hospital. Provided that there was an affirmative action agreement, the Concilio was willing to support the hospital's application.

The area 311 committee of the Health Planning Council of Greater Boston (a group entitled to review and comment on certificate-of-need applications) felt that adequate consumer input meant that the City appoint an advisory board, the majority of whose members were consumers, including at least one representative from the NFCC Board, the Concilio, Health Care Policy Council, and the Health Planning Council of Greater Boston.[20] The City Manager intended to appoint board members from lists submitted by community groups.[21] Because the City Manager had agreed to this mechanism of establishing an advisory board, the Public Health Council staff recommended to the Public Health Council that the certificate-of-need be awarded to the Cambridge Hospital with the condition that all agreements be implemented by March 10, 1976.[22]

At the meeting of the Public Health Council, the NFCC Board opposed this recommendation claiming that one of their board members on an advisory board was not enough, and the City of Cambridge had no legal right to reduce the board to an advisory status.

The Public Health Council agreed and delayed issuing the certificate-of-need to the Cambridge Hospital for another 60 days, or until such time as the City and the NFCC Board came to an agreement. Members of the Public Health Council wanted to know why the Cambridge Hospital was a more suitable applicant, and voted not to hear the NFCC's application only when the State Health Commissioner broke a tie vote. Members of the Council expressed strong feelings in favor of the NFCC. They suggested that the City had not demonstrated an ability to develop a substantial citizen participation component at the other neighborhood health stations, and that the NFCC's ability to run the health center for eight years demonstrated its competence.

Summary of Role of NFCC, Inc.

The Neighborhood Family Care Center, Inc. is an 18-member board of a Model Cities health center in one of the Cambridge Model Cities neighborhoods. The Board is more concerned with the concept of community control than with adequate delivery of services, and will fight for control, even if the result is a long delay in the opening of the new facility and a closing of the old one. The Board is not necessarily responsive to or even aware of neighborhood needs, continually reelecting itself without bringing on new members. The Board is highly suspicious of professionals and consequently, has a difficult relationship, not only with the hospital, but with its own administrator. The Board is unwilling to delegate authority but also unaware of health center problems. Lack of the necessary administrative skills resulted in the Board's inability to take steps to make the health center financially stable before the Model Cities money ran out.

One source of the Board's difficulties may be, that although they had the power to run the health center, they do not have the skills, and support did not come from the hospital, even in the areas where the hospital had responsibility (i.e., activities of nurse practitioners). Threat of a lawsuit over affirmative action, and threat of opposing the City's certificate-of-need application are the only tools the Concilio has to pressure the Department of Health and Hospitals into hiring bilingual personnel who belong to minority groups. Although the City Council Subcommittee raised the issue over a year ago, and requested that the hospital take steps to address the problem, little was done. Allowing a state body, such as the Public Health Council, to make a decision about community control in Cambridge indicates Cambrdge's inability to resolve these issues. Furthermore, a decision made by a group lacking a great deal of information, such as the Public Health Council, may not necessarily be a decision which meets Cambridge's needs.

C. North Cambridge Health and Social Services Committee, Inc.

The North Cambridge Health and Social Services Committee, Inc. consists of a group of residents from Jefferson Park, a housing project in North Cambridge. The group was formed about seven years ago for the purpose of obtaining a health center and social service center in Jefferson Park. The group was staffed by and received strong support from the Department of Psychiatry at the Cambridge Hospital. The group has no money. A doctor from the hospital Psychiatry Department, Harvard law students, and architects have all donated their time. After several years of ineffective negotiations with the hospital, the Health Commissioner agreed to sign a certificate-of-need application for a health station in

Jefferson Park. The Public Health Council refused to approve it unless the Cambridge Hospital agreed to provide medical support. The Health Commissioner signed the application just before he resigned, so there was no one at the hospital to carry out plans for the health station, since the Hospital Director was opposed to putting a health station in Jefferson Park. The residents are committed to the idea of a health station and have negotiated an agreement with the Cambridge Housing Authority, whereby the Housing Authority will do the renovations necessary for the health station.

For several years, members of the North Cambridge Health and Social Services Committee have refused to join the Health Care Policy Council, because they felt that to belong to both groups constituted a conflict of interest. Recently, however, they have come to realize that they share many concerns with the Health Care Policy Council, especially the conern that if the M. E. Fitzgerald adult health station has fewer than two nurse practitioners, no nurse practitioner will be in Jefferson Park.

Like the Health Care Policy Council, and unlike the NFCC Board, this committee is not conerned with control, but rather with adequate delivery of health services. However, they do feel they need some clout in order to make sure the hospital does not neglect the health station. They feel the Health Care Policy Council is in a very weak position, and at the same time, that the NFCC Board is exercising too much control.

After a long period of little response from the hospital in their requests for equipment and a nurse practitioner (requests which had to have a positive response before the Housing Authority would begin renovations), a local politician from North Cambridge intervened and set up several hospital meetings for the Jefferson Park group. The group wants

to set policy for the health station, and then lease it entirely to the hospital. The hospital will have the Department of Public Health license, the certificate-of-need, and the responsibility for supervision of staff and provision of medical services. If at any time, the hospital does not deliver services according to the terms of the lease, the Committee can terminate the contract and ask the hospital to leave. The hospital is also entitled to pull out if the terms are not met. The group thinks its ability to terminate a contract gives it power and policy control, but an immediate problem is that if a contract is terminated, there will be no health station unless the Committee finds another hospital. Furthermore, no matter what happens, the Cambridge Hospital will hold the license. However, once the contract is signed, the group will have trouble enforcing their policy because they will have no say in the day to day operations. Although the Hospital Director is about to sign the agreement, no extra personnel exist to staff the health station.

D. Findings and Analysis

This section summarizes and analyzes the problems concerning the role of citizen participation. The discussion is divided into several areas: the interests and goals of citizens who want to participate; the impact of citizen participation on the delivery of health services and on the political or economic redistribution of power to poor people; the problems of citizen participation in health issues, both within the groups themselves and as they relate to other groups or institutions in Cambridge; and the givens which any recommendations must acknowledge.

1. Interests and Goals of Citizens Who Participate

The kinds of interests expressed by citizens who participate in the neighborhood health station program are in many ways not unlike attitudes

of citizens who participate in other neighborhood health programs. The majority of citizens in Cambridge are unware of the existence of an advisory council, uninterested or unable to participate in it. Such unawareness and uninvolvement is not unusual in other communities.[23]

Those Cambridge citizens who do participate express the same kinds of interests as citizens in other places. These interests are primarily in nonmedical areas. Sparer found that citizen participation interests included "selection of key staff, service priorities, hours of service, budgets, and recruitment of outreach workers"[24] and case studies by Hollister concluded that citizens were interested in primarily nonmedical matters.[25] Even though citizens on the Health Care Policy Council want to participate in decisions concerning nonmedical matters, they have no voice in the decision making process. For almost three years, they accepted this passive role. Gordon found this kind of passivity to be common among citizens' boards which were initated by hospitals. He feels that such boards tend to be no more than rubber stamps of the sponsoring institution.[26] However, in early 1976, Health Care Policy Council members began to take active steps to participate in the decision making process over nonmedical matters. They have demanded a voice in the budget determinations and in planning for the health stations' expansion. The City Council Subcommittee is supporting them.

The NFCC Board is also interested in nonmedical matters, and since the Board controls the health center its role is much less passive. The North Cambridge Health and Social Service Committee is also interested in nonmedical matters. Whether this group will have a voice depends on the strength of its contract with the hospital.

Goals of citizens groups vary considerably. Hollister found that citizens in Denver had either goals of improved service delivery or increased community control, and, goals of achieving a board representative of the community or achieving increased personal growth and development.[27] Cambridge is similar to Denver in that both situations exist. Like some of the citizens in Denver, and like the citizens Hillman studied,[28] members of the Cambridge Health Care Policy Council are more interested in quality of service than in control. Unlike the citizens in Denver, HCPC members who are displeased with the health station program do not want increased control.[29] They would prefer that the hospital departments be reorganized so hospital personnel can do a better job of running the program. They see their role as being advisory, or perhaps as being a partner with the hospital in a joint decision making process, but not as controlling the health station programs. The North Cambridge Health and Social Services Committee feels that control to the degree of having the option to close the health station and find other providers will make the hospital more responsive. However, this group would like the hospital to retain full administrative control.

Both groups, the Health Care Policy Council and the North Cambridge Health and Social Services Committee are concerned that their boards be representative. The Health Care Policy Council is concerned that an equal number of representatives from each neighborhood sit on the Council, and that these representatives be <u>bona fide</u> Cambridge residents, who have lived in Cambridge and who are not transient students.

The NFCC Board operates under the other set of goals. Its members are interested in community control to the point of threatening the delivery of services. They are interested in gaining control of aspects of their own

lives which concern health matters, and in personal development at the expense of neighborhood representation. The difference in goals between the NFCC and the HCPC can be accounted for by the fact that the NFCC Board grew out of the Model Cities Board, which was an independent board controlling the Model Cities Program, and the Health Care Policy Council grew out of efforts made by the Cambridge Hospital. Unfortunately in this situation, no matter how cooperative and interested in citizen participation hospital personnel might be, conflict will be inevitable unless NFCC Board members change their goals.

2. Impact of Citizen Participation

Neither the NFCC nor the HCPC has been particularly successful in attaining its goals. Analyses of poverty programs have suggested that a poverty program tends to achieve either a redistribution of power or an increase in service delivery, but not both. A study of poverty programs in New York City and Chicago showed that in New York, people participated in setting policy for and administering programs, but that they did not receive substantial amounts of increased services, while in Chicago, Mayor Daley did not allow citizens to control the poverty programs, but he provided substantial material benefits in the form of services.[30] In his study of community control, Altshuler concludes that control is the only demand for poor people to make, since it allows them to be a legitimate part of the political system, but at the same time, he observes that "community control is a substitute for substantive changes" and that community participation was frequently correlated with ineffective service delivery in OEO poverty programs.[31]

The applicability of these studies to the Cambridge situation is limited for several reasons. The authors seem to imply a tradeoff between service benefits and political power. In the case of the NFCC, a group of citizens had full political power but did not use their power to run the neighborhood health center. As a result, the health station stayed open as long as there was Model Cities money to support it. However, after the Model Cities money ran out, the group was not able to use its power to keep the health center open. Thus the either/or situation--service benefits or political power--appears to apply with regard to the NFCC. Had the NFCC Board been interested in running a health center, the Board would have hired good administrators and Board members would have attended meetings in large enough numbers to assure a quorum.

However, analysis of the issue in terms of a tradeoff does not really apply to the other health stations. The lack of community control or even meaningful citizen participation was not accompanied by a high level of service delivery. The health stations presently serve only 2,500 people, but the demand is much higher (six week waits for new patients at most of the health stations). Service delivery was hindered by the large number of staff vacancies left unfilled. If the City Council and the Health Care Policy Council had not been involved in the health station program, the adult program probably would have been phased out, because hospital personnel did not provide adequate services. In a community where service delivery in the adult neighborhood health stations is not a high priority in the executive offices, advisory citizen participation has not been effective by itself. Cooperation with efforts of the City Council has been the only, and therefore, necessary pressure on the

hospital to maintain the program. Although it has been demonstrated at the NFCC that citizen control was not successful in insuring the delivery of health services, it has also been pointed out that the citizens who make up the NFCC Board are not representative of the neighborhood or of the patients, do not have the necessary administrative skills to run the health center, and appear to be more concerned with control as an end rather than as a means of improved serivce delivery. However, the NFCC did stay open as long as there was Model Cities money and did have a high number of enrolled patients relative to the other health stations. The experience of the other health stations indicates that citizen participation in some form is necessary, at the very least, to insure some degree of accountability within the health station program.

Thus, in terms of service benefits, an impact of citizen participation was to assure the continuation of the health station program. Citizen participation has had little impact in terms of increased political and economic power for poor people. While health aid and receptionist positions are supposed to be filled by people living within the health station neighborhood, neighborhood people are not always hired and vacancies are left for two or three months at a time. No nonprofessionals have been employed at the NFCC since spring 1975. Political power of poor people has not increased because the Health Care Policy Council has always had weak, advisory status. The HCPC's failure to influence important decisions and non-decisions indicates this. The NFCC Board is losing its control. The North Cambridge Health and Social Services Committee has spent the last seven years without a health station and without any control. The failure of poverty programs to redistribute power is not unusual.[32]

The redistribution of power is an important issue with regard to the NFCC since the Board may fight as long as it can to control the health center. The issue is not so important to the HCPC whose members would like the hospital to be actively responsible and accountable for the program, but who would not want to assume control over it. They want to know that their concerns--about locations of health stations, service mix, hours, billing--be incorporated into the decision making process, but they are searching for a process short of control to guarantee this.

3. Problems of Citizen Participation

Citizen participation in the neighborhood health station program has been a problematic, dissatisfying experience for both the citizens and the hospital personnel. The most basic problem is that neither the Health Department nor the citizen's groups have come to an understanding, either separately or mutually, as to what the role of citizen participation should be. Citizen's groups have a difficult time working with each other and an even more difficult time relating to the hospital. As a result, important issues are left unaddressed, and much energy is wasted in anger and resentment. The following two discussions--on the difficulties citizens have working with each other and on the difficulties citizens have working with other groups--illustrate the nature of these problems.

a. Problems Citizens Have Working with Each Other

Health is a comparatively difficult issue around which a group can organize: Citizen participation in Cambridge has worked more successfully in issues of transportation and education than in issues of health. Differences in the nature of the issues partially explain the discrepancy.

Health is a vague, abstract issue. It is difficult for people to organize around the issue of "good health" or "good education" when the meaning of each of those terms in unclear. While the meaning of "good transporation" may also be unclear, the idea of a highway running through Cambridgeport was painfully clear, and therefore served as a focus for community action. Health care is not an issue that concerns people unless they are sick.[33] People can think about transportation with some degree of regularity if a highway is about to go through their neighborhood and they can think about education with some degree of regularity if they have children in school, but for many people, health seems to be an important issue only at times of illness, and a sick person is not bound to be in a community group. In Cambridge, people have tended to express concern about health issues only when the neighborhood health program has been in desperate straits--when the program was cut from the City Manager's budget in April, 1973, and in early 1976, when the number of filled positions in the health stations was dwindling.

Patients are very dependent on medical professionals who encourage their passivity and submissiveness.[34] Unlike the areas of transportation and education, where the professionals--Department of Public Works engineers and teachers--do not receive an unusually high degree of reverence and respect, health professionals, particularly doctors, are virtually worshipped. Few patients doubt a doctor's word, and few are anything but submissive under a doctor's care.

Consequently, groups whose functions include disagreeing with physicians have difficulty because they are reluctant to challenge physicians when their normal relationship with a physician is more passive. In

Cambridge, an example of this phenomenon is the relationship between the Health Care Policy Council and the Department of Medicine during the first year of the HCPC's existence, when its members constantly deferred to physicians.

Another reason that people may not become excited about health center issues, is that there are alternative sources of care, however less attractive they may be. If a highway is to go through Cambridgeport, everybody is affected, and most people in that neighborhood probably do not have second homes or alternative places to live. Few people in Cambridge's low income neighborhoods have any alternative to sending their children to neighborhood public schools. If a crisis develops, either in the schools or in a highway plan, people would organize to do something more quickly because they have no real alternatives. If a health center closes, people are less likely to react because a closed health center does not affect them unless they are sick, and, if they are sick, they could always go to the Outpatient Department, Emergency Room, or nowhere at all.

However, enough patients perceive neighborhood health station care to be highly preferable to other alternatives so that there have been large turnouts at City Council meetings whenever the program is threatened, despite the problems that citizen participation in health care faces. Large turnouts would occur with or without the Health Care Policy Council (the crisis relating to the nurse practitioner vacancy in North Cambridge is an example).

A final difficulty is that health care is not perceived as a right. While people generally believe that education is a right and are beginning

to believe that transportation planners must be attentive to community needs, health care is still considered by most people to be a commodity that is purchased. Consequently, people are less prone to demand high quality health care if they cannot purchase it themselves.

The characteristics of health issues make citizen participation difficult in the health area, and so do the characteristics of Cambridge neighborhoods, which consist of different, and sometimes competing ethnic groups. Because the program is so small, these different groups are expected to work together. However, in Boston, for example, individual neighborhoods are big enough so that city-wide cooperation is not absolutely necessary. The East Boston Neighborhood health center, for example, serves a population of 60,000 in a very dense area. Cambridge neighborhood health stations serve much smaller population areas, ranging from 6,000 to 12,000. people. Consequently, in East Boston, all the community support is directed toward one health center, while in Cambridge, support is fragmented over several neighborhoods. People who live in North Cambridge do not respond to problems of people in East Cambridge, because of the ethnic differences and because of the geographic separation.

Cooperation in a continuous way between neighborhoods on a city-wide basis happens rarely. The Parent Teachers Associations, for example, work well in individual neighborhoods and individual schools, but there is little interest in a city-wide PTA Council. Neighborhoods worked together to stop a major interstate highway designed to cut through the City, but the different groups were able to come together only when they all perceived a crisis. Although neighborhood cooperation is beginning to occur through the Health Policy Council as it seeks to address health station issues before they

reach crisis proportions, the majority of people have tended to be concerned only with their own neighborhoods. However, when a crisis occurs, people from every health station neighborhood came to the City Council en masse.

Ethnic differences between neighborhoods and geographic isolation of neighborhoods make neighborhood coalitions infrequent, but the Health Care Policy Council and the Neighborhood Family Care Center Board have trouble working together for additional reasons. The goals of the two groups are different and most of the time conflicting (service vs. community control). The NFCC Board does not consider the Health Care Policy Council a legitimate group, and the Spanish Council considers neither group legitimate.

Each group (Health Care Policy Council, NFCC Board) has internal problems which hinder its effectiveness. Crenson[35] found that citizen groups, some of whose members are affiliated with other groups, tend to have high levels of conflict. High conflict levels in turn are associated with ill defined agendas and low levels of demands, and a lack of direction or goals. These characteristics are associated with both the Health Care Policy Council and the NFCC Board, and add to the difficulties these groups have relating to the hospital.

b. Problems with Citizen's Groups as They Relate to Other Groups or Institutions

The major difficulty the NFCC Board and the Health Care Policy Council have in their attempts to have a meaningful role in the participatory process is that they lack legitimacy. Key decisionmakers at the hospital do not view community groups as legitimate participants in the policy making process, and therefore exclude them from decisions and do not communicate with them.

Such actions on the part of sponsoring institutions are common. In an analysis of the poverty program, Bachrach and Baratz suggest that decisionmakers spend time preventing undesirable decisions by preventing any decisions from being made at all (non decisions).[36] An example of this is the way the hospital does not decide about the relocation of the M. E. Fitzgerald health station. Bachrach and Baratz suggest that decision-makers: 1) prevent citizens' groups from issuing demands by coopting them and by allowing them to participate in decisions without giving them any real authority or role; 2) deny any demands that may be issued by denying the legitimacy of the group; 3) construct barriers which block entry into the decision making process.[37]

Hospital personnel have used all these forms of exclusion. They have questioned the legitimacy of the Health Care Policy Council when that group has demanded to know what steps the hospital was taking to insure the availability of a nurse practitioner in North Cambridge when it was clear nobody had taken effective steps in that direction. They have neglected to inform the Council of meetings which the City Manager declared the Council could attend, and when a Council member finally went to one meeting, she was told she could not participate. The NFCC, but not the Health Care Policy Council, has also used exclusionary tactics when it has refused to meet with hospital personnel. Although the Cambridge situation may be somewhat extreme, controversies over the jurisdiction and role of a citizen's group are common.[38,39]

Excluding community groups by denying their legitimacy leads to several problems. There are important differences between community groups and hospital personnel and ignoring these differences is not only detrimental

to service delivery but also brings on conflict. Again, these differences are not uncommon. March and Simon, in analyzing organizational conflict, have suggested three sources of conflict: "the existence of a felt need for joint decision making, a difference in goals and/or a difference in perception of reality among the parties."[40] Both Gordon and Hollister found these qualities to be characteristic of organizational conflict in neighborhood health center controversies.[41]

This analysis holds in Cambridge. The need for joint decision making manifests itself in the hospital Medical Excecutive Committee, in the Neighborhood Health Services Committee, and in the new health ordinance, which requires that the Health Commissioner make policy decisions in conjunction with the Board of Health and Hospitals. At the hospital, however, joint decision making means that decisions are jointly made by the Chiefs, not by the Chiefs and community groups.

The difference in goals between the hospital and the NFCC and the hospital and the Health Policy Council has already been described. Basically, the NFCC wants community control at any cost, and the hospital personnel are more interested in service. The Health Care Policy Council wants a higher level of service at the other health stations than does the hospital. The difference in perception of reality manifests itself consistently when members of the hospital staff who have key decision making powers tend not to act on community concerns because they do not believe the health stations are experiencing any problems.

A major problem with joint decision making at an almost nonexistent level is that community groups tend to lose out, and do not achieve many of their goals. Braeger has suggested that the outcome of any bargaining

process is determined by the resources and power of the bargainers, the way the issues are framed and raised, and the skills and strategies each party uses.[42] When all the power is at the hospital, when the hospital personnel identify and define issues and when community groups do not have clearly defined strategies, community groups do not gain much in the bargaining process. Braeger feels that groups on the outside who want change, need to identify their goals, formulate demands, and persist, even with threats, until they are satisfied.[43]

The Health Care Policy Council has adopted such a strategy, much to the distress of many hospital personnel who do not support community participation.

Gordon has suggested that the process of community interaction with a sponsoring institution is one of "disequilibrium, arbitration, and compromise."[44] In this process, both Hollister and he found Coser's categories of how groups influence each other useful. These modes of influence are: "inducement, coercion, rational persuasion, selling, friendship and authority."[45] In Cambridge, the situation can be identified as one of "disequilibrium" where, in the case of the NFCC, parties cannot reach a compromise and in the case of the Health Care Policy Council, some parties refuse to negotiate. While Hollister found that physicians tended to use "rational persuasion" as a form of influence,[46] in Cambridge, hospital personnel tend to use "authority" at least as much as "rational persuasion." Citizens in Cambridge have begun to use, as did citizens in Denver,[47] "coercion" through the political process as a means of influence. How successful this strategy will be remains to be seen.

So far substantial improvements in service delivery in one health station have resulted (the hiring of a nurse practitioner in North Cambridge), the City Manager has issued a directive to hire a medical director for the program and an affirmative action policy for hiring minorities, especially bilingual personnel has been signed by the City. Since these latter two policies have not been implemented, the effect of the "coercion" strategy is not yet known, but at the very least, it produced a policy when earlier there was none.

The attitude of some hospital personnel has been another problem of citizens' groups. Professional "helping" assistance has, with few exceptions, been highly unsatisfactory. The patronizing, condescending tone many professionals take toward citizens reinforces the conclusion that in many cases, they meet with community groups because they are told to, not because they wish to provide an opportunity for citizens to share major decisions which affect them. Such an attitude takes many forms. William Ryan calls it "blaming the victim," where any difficulties patients may have with a program are always in some way the responsibility of the patient and never of the provider.[48] Gordon notes that many problems which patients have which bring them to neighborhood health centers (drug addiction, alcoholism, nutrition) have treatments which require extensive cooperation between patient and physician, and that physicians do not accept approaches to patient care where they are not in total control.[49] Lipsky has also noted that when a provider's job is very demanding and the expectations of the job very ambiguous, one common solution is for the provider to take on clients who are easiest to treat because they conform the most to the values of the provider.[50]

The lack of hospital leadership also poses a problem for community groups. Because there is no central direction to the neighborhood health station program, if a community group does want to engage the hospital in an issue, the group has no way of knowing who at the hospital is responsible for that issue and from whom they should expect action.

Further, community groups are isolated from potential allies within the hospital structure because they have no relationship with the Hospital Board. At this point, the Board is fairly inactive, but even in its advisory capacity, it has the potential for acting as a pressure for change. In the future, it is likely that the Hospital Board will be given, by the new ordinances, more than an advisory role, and lack of a relationship (in the form of joint discussions of policy and administrative issues) will be detrimental to community groups because they will have overlooked a place where issues will be aired and decisions made.

Since there are no active and effective neighborhood health station advocates within the hospital structure, community groups are forced to rely for support on groups which have no direct power. The Health Care Policy Council tends to rely on the City Council Health and Hospital Subcommittee to pressure the hospital into dealing with problems of the health stations. Such reliance has results, but only in a limited way. The Council Subcommittee usually feels it is going beyond its responsibilities to interfere in problems which are not crises. Like any legislative body, the Council is not supposed to interfere in executive functions. The Subcommittee has no full-time staff and does not always have the information to solve problems, although it has developed a much more constructive program budget review. When the Subcommittee does

intervene, hospital personnel resent it, and complain to each other and to the Council that "politics" are entering into the hospital operations. While Subcommittee intervention can, and has been, very constructive, there is no assurance that the future chairpeople of the Health and Hospital Subcommittee will be as interested and responsive as the present one, so it is unwise to rely so heavily on a group which is removed from the immediate situation, without direct power, and whose leadership may not be consistently responsive.

4. Givens

The nature of goals and interests of some citizens who participate in the health station program suggests that a certain amount of conflict between citizens and the hospital is inevitable. Inability to resolve the conflict between the goal of control (expressed by the NFCC Board) and the goal of service delivery (expressed by the hospital) has resulted in the closing of the NFCC.

Differing perceptions of reality are also givens, especially when groups do not communicate regularly with each other. Differing perceptions of reality were prevalent in Denver, where a certain amount of conflict occurred because citizens and the sponsoring institutions had very different perceptions of reality.[51]

Such differing perceptions of reality occur also in Cambridge in such extreme forms as the Health Care Policy Council believing that the hospital is abandoning the health stations by not filling vacant positions and some hospital personnel not giving the program priority because they feel it has no problems.

Even if citizens want no more than an advisory role or to be part of an informed, joint decision making process, conflict will result when citizens (the NFCC Board for example) refuse to acknowledge that professionals have a contribution to make or when professionals want citizen participation, as some did in Denver,[52] only on their terms and according to their needs. In Cambridge this latter approach would mean either no participation at all, which is the preference of most hospital personnel, or participation on a very limited and weak advisory basis. While placing more neighborhood health center advocates in powerful positions within the Health Department may make citizen participation easier for interested citizens, the potential power of a coalition of doctors to undermine a program cannot be ignored, and the Chiefs have already declared their opposition not only to citizen participation, but also to the hiring of a neighborhood health station advocate in the form of a full-time director.

Although the conflict will probably never be resolved, the recommendations that follow in Chapter V seek to establish a process where citizens play a role in the decision making, and have the opportunity to acquire the skills necessary in making informed decisions. The recommendations seek to prevent another situation like the NFCC, where citizen participation was doomed to fail because the citizens did not have enough knowledge to run the health center.

A final given is the disinterest of most citizens in city-wide participation. While it is possible that the Health Care Policy Council may become the vehicle for citizen participation in health, the preference of people to work on a neighborhood level should not be ignored.

IV. FOOTNOTES

1. Gordon, J. "The Politics of Community Medicine Projects: A Conflict Analysis," in Hollister, Kramer, Bellin (ed.) Neighborhood Health Centers. Lexington: Lexington Books 1974, p. 116.

2. CEOC draft memorandum Health Stations Crisis Coalition April 9, 1973. Memo written by Al Martin, M.D. April 10, 1973 for Health Stations Coalition.

3. Health Care Policy Council by-laws.

4. Gordon, op. cit. p. 116.

5. Chief of Community Medicine's HEW family planning grant budget proposal 1973-74.

6. Demonstration Cities and Metropolitan Development Act of 1966. Section 103(a)(2).

7. Economic Opportunity Act of 1964 78 Statute 508 Title II 202(a).

8. Skiffer, G. "Community Participation in Cambridge Model Cities. Why It Failed." M.C.P. thesis at M.I.T. 1972.

9. Ibid.

10. Discussion with Justin Gray, October 75.

11. Memo to City Council Subcommittee from the NFCC administrator, Health Commissioner and City Council staff. March 12, 1974.

12. Letter from the Hospital Director to the City Manager explaining why the nurse practitioners were removed from the NFCC.

13. HUD Neighborhood Facilities Grant Program NFP MA 01061006.

14. Letter from Hospital Director to the State Office of Health Facilities Development. October 6, 1975.

15. Letter from City Manager to HUD regional office August 11, 1975.

16. Letter from City Manager to HUD regional office October 1, 1975.

17. City Solicitor's opinion, included in Hospital Director's letter to State Office of Health Facilities Development October 6, 1975.

18. Staff summary for certificate of need application #34252 for the Massachusetts Public Health Council, February 10, 1976.

19. Ibid.

20. Memorandum of agreement by and between the City of Cambridge, and the Cambridge Hospital, and Concilio Hispano de Cambridge, included in the staff summary, ibid.

21. Letter from the City Manager to the area 311 board of the Comprehensive Health Planning b agency. January 20, 1976.

22. Staff summary, op. cit.

23. Gordon, op. cit. p. 216.

24. Sparer, Dires, and Smith. "Consumer Participation in OEO Assisted Neighborhood Health Centers." American Journal of Public Health vol. 60, June 70, p. 1091-1102.

25. Hollister, "Neighborhood Health Politics in Denver." Symposium on Decision Making and Control in Medical Care. New York Academy of Medicine, 1970, p. 49.

26. Gordon, op. cit. p. 116.

27. Hollister, op. cit. p. 53-54.

28. Hillman and Charney, "A Neighborhood Health Center: What Patients Know and Think of Its Operation" in Hollister, Kramer, Bellin, op. cit. p. 244.

29. Hollister, op. cit. p. 49.

30. Greenstone and Peterson. "Reformers, Machines and the War on Poverty," in Wilson (ed.) City Politics and Public Policy. New York: Wiley 1968.

31. Altshuler, A. Community Control. New York: Pegasus, 1970 p. 197, 54.

32. In a rather scathing criticism of OEO legislation and programs, Saul Alinsky declared that nobody was really interested in waging a war on economic and power poverty and that poverty agencies or city governments would squash any independent leadership or motion to gain power made by poor people and that furthermore, the compromises necessary in consensus decision making would keep poor people out of the political structure. In an analysis of Model Cities programs, Katznelson argues that reforms in the shape of limited citizen participation (i.e. the establishment of advisory bodies), were actually repressive because the balance of power was left in tact, under the guise of "liberal participatory reform." Alinsky, S. "The War on Poverty--Political Pornography" Journal of Social Issues vol. 11, no. 6, January 65, p. 41. Katznelson, I. "Urban Counterrevolution" in Wolf, ed. 1984 Revisited New York: A. Knopf, 1973 p. 139-165.

33. Gordon, op. cit. p. 114.

34. Ehrenreich and Ehrenreich. "Health Care and Social Control" Social Policy May-June 74.

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V. RECOMMENDATIONS

The major difficulties of the neighborhood health station program have been analyzed and some suggestions for alleviating these difficulties will be presented. However, care must be taken to insure maintenance of those aspects of the program which are not riddled with problems or which are desirable from the point of view of delivering quality neighborhood health care. Before suggesting recommendations which may address some of the difficulties in the program, a section will be included which indicates those qualities of the program recommendations should bolster, rather than inadvertently undermine.

A. Qualities of the program which should be preserved in other program changes

Accessibility. Neighborhood health centers are answers to several problems, one of which is the decreasing quality of available health care in low income areas resulting from the decreasing number of physicians practicing there.[1] Neighborhood health stations in Cambridge provide access to medical care for low income people in several ways. The health stations are geographically accessible. Acton has pointed out the importance of time (both waiting time and travel time) in determining people's use of medical services.[2] Waiting time at the health stations is shorter than at the Emergency Room or outpatient department, and travel time for patients who use health stations instead of hospital services is considerably reduced.

Most patients live within a ten minute walk of the health stations, and many would receive considerably less health care if they had to spend a great deal of time (two buses, according to Acton) getting somewhere. Neighborhood health stations are virtually the only alternative for health care within a neighborhood, because there are few practicing physicians, all of whom are old.

The neighborhood health stations are also financially accessible to patients. The outpatient department provides financial accessibility, not by scaling down the fees, but by maintaining a loose credit and collection policy. The difficulty with this method of providing financial accessibility is that increasing Medicaid cutbacks have resulted in the hospital's tightening its credit and collection policy. Because the health stations provide care without charge, the care is financially accessible, and any billing system should preserve that accessibility as much as possible by charging what people can pay, rather than billing the full fee and expecting people to pay less. The billing system would be different from the OPD billing in that the charges would vary with a person's income.

The third kind of accessibility provided by neighborhood health stations is psychological accessibility. Often, people are reluctant to go to the hospital for care, because going requires an admission of illness. For people with psychiatric problems, the neighborhood health stations provide a point of access into the health care system without stigmatization. The head of the outpatient psychiatry department feels that the neighborhood health stations provide psychological access to care for people which the hospital cannot duplicate, because going to the hospital requires a person to recognize and admit that she or he needs help, and

because hospital staff may not be sensitive to neighborhood or cultural norms.[3]

Type of health care. Comprehensive health care delivered by a team of professionals is a key concept in the design of many neighborhood health centers.[4] Rubin and Beckhardt have analyzed the organizational factors which influence the performance of health teams, and Banta analyzed the health teams at the Columbia Point Health Center and ascribed their failure to the same kinds of organizational factors Rubin and Beckhardt stress as important (role conflict, lack of communication, unwillingness of physicians to delegate responsibility to anyone).[5,6,7] Health teams in the Cambridge neighborhood health station program do not suffer from very many of these difficulties. Generally, the nurse practitioners and consulting physicians have worked out mutually satisfactory roles and patterns of communication. With the exception of the Neighborhood Family Care Center, nurse practitioners, psychiatric nurses, and social workers do not have much trouble defining their roles and cooperating with each other. The team concept breaks down at the hospital but seems to work in the health stations. Consequently, comprehensive care which extends over a wide range of problems is an actuality, rather than merely an idea, and "multi-problem" families can be provided services in a way which does not force them to go through several bureaucracies, each of which is concerned with only a piece of their problems. Various observers have praised the neighborhood health center and the nurse practitioner as a source of comprehensive primary health and medical care.

Certainly, keeping the nurse practitioners as the main providers of primary medical care should be an assumption in any set of recommended

changes in the neighborhood health station program. Evidence suggests that nurse practitioners provide the same, if not better, quality medical care than doctors.[11,12,13,14,15] The most striking data on this point is a blind study in Canada where the researchers did not know whether the patients they were studying were treated by a nurse practitioner or a doctor and where attention was paid to clinical results rather than clinical records.[16] Studies of neighborhood health center care indicate that the care is of the same if not higher quality than other sources of care.[17,18] While no quality of care study has been done in Cambridge, the doctors who are familiar with the program feel that the nurse practitioners provide at least as good medical care both in terms of process and outcome as any general practitioner.[19]

Not only do nurse practitioners provide quality medical care, they also provide quality health care. Gordon points out that many problems providers encounter in neighborhood health centers require motivating and educating patients to cooperate in a treatment program and to take care of themselves, and that physicians are not always interested in this approach, which is considerably different from giving a patient a prescription.[20] Merenstein and Skrovan have shown that nurse practitioners are especially skilled in patient education, and are sensitive to health, as well as medical concerns.[21,22] Nurse practitioners would tend to have these skills because patient education and health concerns are important aspects of nurses' schooling. These added skills are desirable in a neighborhood health station program, where many of the users have concerns which are not limited to medical problems.

A broader approach not only allows a greater sensitivity to health problems, but allows patients a greater role in their treatment programs. The outpatient department of psychiatry at the hospital feels very strongly that a prerequisite for mental health is the ability to exercise control over one's life, and that one route to such control is the development of a cooperative relationship with a provider consisting not only of patients taking orders but also of their learning how to take care of themselves and providers learning to meet needs patients perceive as well as needs providers perceive.[23]

The neighborhood health station program was designed to replace the disappearing neighborhood family physician--the person who not only took care of acute medical problems, but provided followup for hospital care, provided psychiatric services in a nonstigmatized environment, and was able to do so in a context where she or he was in touch with neighborhood needs and norms. The nurse practitioner provides precisely these services.

Public ownership and administration of service. Public ownership of a service means that ultimate accountability rests with a public body, even indirectly. Public ownership of the hospital has insured responsiveness to community needs, and would provide protection of those needs in the future. Privately run provider organizations are not accountable to the public interest.

Any recommendations, then, should preserve the accessibility--geographic, psychological, and financial--of the health station program, and should provide for the delivery of comprehensive, coordinated health services by nurse practitioners in a program owned and run by the City.

B. Recommendations regarding the role of the City in setting policy for and administering a neighborhood health station program

In order for the neighborhood health station program to be more effective and more efficient, the Department of Health and Hospitals must make a commitment to the program. This commitment should take the form of hiring a person responsible for the program and giving her or him adequate power and authority to insure a well run program. Hiring a neighborhood health station director is the most crucial step for the City to take in order to address the program's difficulties. The following discussion describes the position a director should hold within the organizational structure of the Department of Health and Hospitals, what her or his responsibilities would be, and how she or he should work with other health related groups or institutions. Although hiring a neighborhood health station director should be a first priority of the City, a section describing recommended roles for other City health actors who relate to the neighborhood health station program is also included since the opportunity for changing these roles exists and since some changes improve the program's operation and would make the director's job easier.

1. Establishing a new department for neighborhood health services, hiring a department head who will be program director and whose duties will be specified.

Recommendation: The low priority and lack of attention given to this program by hospital personnel, the size and complexity of the program, (which makes it difficult for hospital personnel to run it as well as run the hospital) and the large number of people making decisions concerning the program indicate the need for a new

department and for a medical director of the department.

The department should be within the hospital organization, but not under the jursidiction of the in-patient service.

Reasons to keep the health station program within the hospital are: the program is too small to justify separation from the hospital. Although the Chief of Medicine cannot run his department and the neighborhood health stations at the same time, the Chief of Pediatrics and the Chief of Ob-Gyn, whose departments are smaller, have no trouble running their departments and their portions of the neighborhood health station program. Even though coordination of services is poor now, separating the program from the hospital might result in less coordinated services because no one would be at the hospital to see that such coordination (i.e. between the health stations and the Emergency Room or in-patient service) took place. The City infirmary, City nursing home and the hospital are separate departments that do not coordinate services well.

Reasons not to keep the program under the jurisdiction the Department of Medicine are: the priorities of the leadership will probably remain with the in-patient service; the Chief of Medicine has no authority over other deparments and thus cannot guarantee coordinated services. (This is not to minimize the difficulty of coordinating services from any organizational base.) Because the adult health station program has so many difficulties right now, its department should be limited in jurisdiction to the neighborhood health station program. (This jurisdiction would include the pediatric program too, since there will be decisions which will involve

coordination between adult and pediatric medicine--adolescent clinics and relocation of health stations, for example.)

In the future, when the program is running more smoothly, the department could be expanded into an ambulatory services department, and would include neighborhood health stations, the outpatient and emergency services. Creating a neighborhood health services department within the hospital does not preclude the possibility of such integration in the future. By giving the department head jurisdiction over services delivered in the health stations, somebody will have the authority to coordinate services delivered there. No director will be able to run the program smoothly unless there is cooperation from the Chiefs, but the creation of a new department will provide a full-time neighborhood health station advocate in the hospital who will have control over care delivered in the health stations and a stronger say in the decisions and compromises made which relate to the interface between the health stations and other hospital departments.

Creating a department specifically for neighborhood health services legitimizes the concept of comprehensive, coordinated neighborhood health care. The department, in the hospital, but with its own jurisdiction, will be able to maintain all the characteristics of the program outlined in section A--care delivered in a neighborhood setting, a wide range of health and medical services coordinated in one location. At the same time, establishing a department will result in the authority and commitment necessary to address the problems relating to the health stations themselves and to the coordination with other departments.

Implementation: The department could be created by an order of the City Manager, or a Health Commissioner if the position were filled.

Recommendation: The director of the neighborhood health station program should be a physician whose position would be Chief of Neighborhood Health Services (equal to the Chief of Medicine, Chief of Pediatrics, etc.). Since the previous program director was unable to exercise any authority over the physicians, and did not meet the Medicaid requirements for a medical director becuase he was not an M.D., the director should be, for the time being, a physician. Hiring a physician will allow the program to qualify for Medicaid payments without dismissing the nurse practitioners, whose services do not qualify for Medicaid reimbursement unless a physician is present.

Implementation: The City Manager or Health Commissioner could determine the qualifications necessary for the job of medical director and could determine the place of the position within the hospital organizational structure (i.e. the director would be the Chief of Neighborhood Health Services).

The establishment of a new department with a specific jurisdiction over neighborhood health services and the establishment of a new position--Chief of Neighborhood Health--should provide the vehicles necessary to address the problems of fragmented leadership, diffused authority, lack of accountability, and poor coordination among services. Naming one individual to be responsible for running the health station program clears up questions of leadership, authority, accountability and coordination within the health stations. The medical director should control the budget of the program, a budget

separate and distinct from the hospital budget. Such separation should cut down the resentment on the part of some hospital personnel who feel the clinics are draining hospital funds. While health station and hospital personnel would continue to receive supplies from the same place, careful accounting would be crucial.

The medical director should control the health station staff. Staff should be accountable to the health station director and not to the respective heads of service at the hospital, although for the purpose of better coordination and mutual respect, hiring of nurse practitioners should be done jointly by the medical director and other relevant department heads. For example, the medical director should hire psychiatric nurse practitioners with the approval of the nursing and psychiatry departments. Agreement over personnel should facilitate coordination.

The medical director should have the power to negotiate with, rather than take orders from, the medical executive committee of the hospital, especially pertaining to such issues as medical backup and referral procedures. Coordinated interface between the health stations and other hospital departments will be a result of cooperation, not an exercise of authority, and a director should recognize the need for such cooperation.

Recommendation: The duties of the health station director should be clearly specified in these areas:

Administration. The health station director should be in charge of coordinating health station services. Coordination should consist of:

---supervising the staff in each health station, helping them

develop more efficient ways to deliver team health care. The director should meet with and supervise all health station staff, whether their salaries were from the City or the HEW family planning grant.

---providing for a central record keeping system, perhaps even a family record keeping system to assure coordinated care.

---preparing plans for the expansion of the program for approval by the Commissioner.

Increasing the financial stability of the program. The health station director could address financial instability in the following ways:

---provide the forum for discussion and decision on the nature of a billing system compatible with the needs of the community, and then provide for the institution of that system. The billing system should not provide financial accessibility only by maintaining a loose credit and collection policy (like the OPD), but also should incorporate a sliding fee schedule into its charges.

---determine the availability of alternative sources of funding, especially the availability of federal categorical grants.

---structure the program to comply with Department of Public Safety and Department of Public Health licensing standards in order to apply for reimbursements.

---apply for all necessary certificates-of-need awarded by the Department of Public Health in order to qualify for reimbursement.

---structure the program so that it complies with Medicaid

reimbursement standards. These include: adequate on-site physician coverage; a comprehensive, coordinated program of health care with adequate medical backup at the hospital; a definite organizational structure defining the administration leadership and the relationship with the hospital; and a definition of the role of citizen participation. Such a structure should not mean that nurse practitioners are replaced with physicians in group practice, simply because at the moment Medicaid will not pay for nurse practitioners. Nurse practitioners can be less expensive than physicians, can be as capable as physicians in delivering primary medical services, and can be more capable than physicians in delivering health services.[24] At the same time, however, distinct efforts must be made to qualify the Cambridge neighborhood health stations for reimbursement. Comprehensive national health insurance is not in the immediate offing, so some structural change in the program is necessary. However, other neighborhood health stations staffed by nurse practitioners receive third party reimbursements, so that altering the program to meet reimbursement requirements until there is national health insurance does not mean sacrificing the nurse practitioner program.

---improve economic efficiency. Improving economic efficiency would include a consideration of the appropriate allocation of services between the hospital and the health stations, the development of sufficient examining room space to allow better use of the health stations by nurse practitioners, physicians

and social workers, and streamlined administrative procedures to allow the nurse practitioners more time to treat patients.

Responsiveness to community needs. The health station director must meet with the community groups and patients to find out what their needs are, and then must provide the structure in the program to meet those needs. Some of these needs are:

---determining whether the service mix at each health station responds to local needs.

---determining how health station hours can be rearranged to allow working people to use the health stations, i.e. evening hours.

---determining how, in some health stations, more low income, needy people can become patients, i.e. perhaps allowing new patients to come in on an emergency walk-in basis, and perhaps developing ways of advertising the clinics.

---developing a hiring policy which includes community input.

In order to ascertain what the community health needs are, the medical director should develop surveys, meet with health oriented community groups, such as the Health Care Policy Council, and also meet with other community groups who are concerned with health related issues, such as the Spanish council and tenants' organizations. She or he should also meet with community health oriented groups who are not affiliated with the Cambridge Hospital, such as the Cambridge-port Problem Center or the Women's Community Health Center. The health station director should determine with community groups what their relationship will be (joint policy making, for example), what the scope

of the relationship will be, and what the formal communication mechanism will be. (See citizen participation recommendations.)

Relating to other groups or institutions.

---Federal government. The health station director should apply for federal grants, working with the Commissioner and with her or his approval. Such approval is necessary to preclude competition with other agencies in the City and to allow the City to speak as a whole. The health station director should prepare, working with the Commissioner and with his or her approval, testimony on behalf of bills in Congress which have consequences for the health station program. Nobody is doing that now, and several bills that would have benefited the program have been introduced and failed.

---State concerns. The health station director should prepare and submit to the Commissioner for his or her approval any applications to the State for certificate-of-need or for Medicaid reimbursement so there is no competition with other agencies or other physicians. The Commissioner should then represent the City in negotiations with the state, or delegate that responsibility to the director. The health station director should prepare and submit to the Commissioner for his or her approval any testimony regarding any bills relating to the health stations in the Massachusetts legislature so there would be no conflict or competition. The Commissioner should then represent the City, or delegate that responsibility to the health station director. The health station director

should join the Massachusetts League of Neighborhood Health Centers, an organization which can provide her or him with a great deal of information and technical assistance.

---Regional concerns. The health station director should provide information to the Commissioner regarding the relationship of the program to the regional Health Systems Agency regarding neighborhood health centers. With approval of the Commissioner, the neighborhood health station director can apply for development grants from this agency.

---City concerns.

City hospital. The health station director should negotiate with the medical executive committee or individual department heads to reach agreements on a backup and referral pattern, an appropriate division of services between the hospital and the neighborhood health centers, a billing system, and an education and information program which would create an awareness within the hospital of the health station program and make known the responsibilities of hospital personnel to the health stations (such as doing lab tests and sending discharge summaries back to the health stations).

City Manager. The health station director need not relate to the City Manager unless there is not a Commissioner because the Commissioner will be the Manager's right hand person in charge of health.

Planning Department, Community Development office. The health station director need not relate to these groups because any people in these departments who work on health issues should be moved into the Commissioner's office as her or his staff, where they would provide assistance to the health station director.

The Health and Hospital Board of Trustees (Health Policy Board). The health station director should be responsible for providing any information about her or his program requested by the Board, since the Board may recommend program policy to the Commissioner. There should be a subcommittee of the Board concerned with community medicine, and the health station director should attend those subcommittee meetings.

City Council. The health station director should meet with the City Council Health and Hospital Subcommittee, preferably at Health Policy Board meetings, so that the City Council Subcommittee is aware of what neighborhood health center budget requests mean, and so that the City Council Subcommittee can be responsive if communications break down between the health station director and the Commissioner, the health station director and the Board, or the Commissioner and the Board.

Cambridge Economic Opportunity Committee. The health station director should provide information requested by the staff of the citizen's group, who is an employee of CEOC.

The health station director, working with the Commissioner should assist CEOC in making federal health grant applications.

Commissioner of Health. The health station director should be accountable directly to the Commissioner of Health, who would settle policy conflicts among the various department heads. A strong Commissioner could support the program but would not have the time to run it himself or herself because the responsibilities of the Commissioner are very broad. They include supervising all the health departments, paying attention to environmental health issues, and coordinating public and private services.

Implementation: Either the City Manager or the Health Commissioner could state that the neighborhood health station director's job would include the responsibilities just described. Because the medical executive committee is also accountable to the Commissioner, she or he would be able to guarantee that coordination among departments occurs and that neighborhood health station policy is implemented. To help insure a smooth running program, the director should make a concerted effort to obtain cooperation from other department heads, rather than rely completely on the Commissioner or City Manager.

2. Changing the role of other City health actors.

While the most crucial recommendation for the neighborhood health station program is that of establishing a neighborhood health station

department with a medical director, changes in the roles of other City health actors could provide additional support and authority for the director. Since the City health ordinances are being rewritten, and the priorities and policies of the Health and Hospital department reordered, the opportunity for other kinds of changes exists. The following recommendations are all politically feasible.

Recommendation: The Commissioner. The previous Commissioner spent most of his time overseeing the day to day management of the hospital. He spent little time encouraging health service coordination, either within the hospital, among the departments, or between the hospital and other health providers, both City and private. A Commissioner must be able to resolve disagreements between the health station director and other hospital or health department services. Since there is no Commissioner, the only person who can demand compliance from the hospital regarding neighborhood health services is the City Manager, who does not have the time to be involved in the health area at this level. The Commissioner should play the following role:

---establish policy for coordinating hospital activities with health station activities. Recommendations from the Board, from the hospital, from the health station director, and from the community may form the basis of such policy, but the final authority rests with the Commissioner. Furthermore, in her or his capacity to make policy decisions concerning environmental health and housing, the Commissioner could use the neighborhood health station program as a way to identify important health related housing problems.

---approve any certificate-of-need applications submitted by the health station director, any federal grant applications, any testimony concerning legislation, or concerning activities of regional planning agencies, and any proposed negotiations with any state or federal agencies. The Commissioner must have this responsibility so that competition or conflict within the City is resolved before any applications or testimony is public. As coordinator of health resources, the Commissioner has the responsibility of resolving such conflicts, so that the City can present itself in a unified and solidified way before state and federal agencies. State and regional administrators would then know with whom they should negotiate.

---approve any expansion plans submitted by the health station director to avoid duplication of services. Furthermore, if at any point the Commissioner decides that the neighborhood health station program is running well and that all outpatient services (neighborhood health, ER, OPD) should be combined, she or he will have the power to do so.

Implementation: The existing City health ordinances implicitly give the Health Commissioner these powers and responsibilities just described. The new health ordinances, not yet passed by the City Council, state most of these responsibilities explicitly. To guarantee that the Health Commissioner addresses city-wide health issues and does not become involved in the day to day operations of the hospital, her or his office will be moved from the hospital to City Hall.

Recommendation: Community Development office, Planning Department. People in these offices who work with health issues should become part of the Commissioner's staff, so that the Commissioner can have needed staff, and so that the work now being done in these offices will not take place in a vacuum.

Implementation: The new health ordinance should provide staff for the Commissioner and the City Manager could arrange for the transfer of staff. Staff for the neighborhood health station director could be provided by a directive from either the City Manager or the Health Commissioner.

Recommendation: Health Policy Board. If the Commissioner does not choose to address herself or himself to issues involving neighborhood health stations and to set policy, and the Board feels these issues are important, the Board should have the power to insure that the Commissioner responds to these issues. The Board should have more than an advisory capacity, some of its members should be concerned with community health, and it should have access to information about programs.

Implementation: The new health ordinance should provide for all these concerns, by directing the Board to pay attention to community medicine, providing it with staff, requesting the City Manager to insure consumer representation, and by stating that the Commissioner is expected to reach policy agreement with the Board. This Board, whose members can devote more time to health issues than the City Council, should replace the City Council Health Subcommittee as the forum for public discussion of health issues. Because the City Council is ultimately accountable for the budget of the program, the Chairperson of the Subcommittee should sit on the Board.

Recommendation: City Council. With an active Commissioner (who has specific responsibilities toward the health station program and who is accountable both to a board and to a group of citizens), with an active Board, with an active group of citizens, and with a neighborhood health station director, there should be no need for the City Council to take an active role in any area other than budget review. However, if there should be no powerful neighborhood health advocates, the City Council is a last resort mechanism which can demand a response from the Health Department by pressuring the City Manager. Since City councillors are ultimately accountable and responsible to their constituencies, since using the City Council as a last resort mechanism to make the system respond to health station needs has been a common way of doing business and since the City Council must approve the budget, the City Council Health and Hospital Subcommittee should not disappear once the new organization is in place. The chairperson of the Health and Hospital Subcommittee should sit on the Health Policy Board as an ex officio member, and should continue to meet with the citizens' groups and the Commissioner to keep informed about issues and developments. As all these groups begin to communicate with each other and to relate to each other, it may no longer be necessary for the chairperson to act as mediator. The chairperson should not be the only mediator because the interest of City councillors in health issues and their ability to address those issues (without staff) is not consistent.

Implementation: The new City ordinance should state that the chairperson of the City Council Health and Hospital Subcommittee should be an ex officio Board member. In the event that the ordinance does not

state this explicitly, the City Manager can, in making his appointments, suggest that the Council Subcommittee chairperson sit on the Board as an ex officio member. The Board itself could ask the Subcommittee to attend and participate in meetings.

Recommendation: Health Station Administrator. The job of health station administrator has been phased out, because the health station administrator could not control the program. The administrator position could become a business manager or administrative assistant position, and the person hired could assist the director in establishing the billing system and record keeping system, and in keeping track of supplies, purchasing, and physical maintenance of the health stations.

Implementation: Either the City Manager or Commissioner could decide to use the health station administrator this way.

Recommendation: Nurse Practitioner Supervisor. For over a year, this position was vacant. The new supervisor is accountable to the director of nursing at the hospital. Such a person should be accountable to the neighborhood health station director, and should have the following responsibilities:

---helping the nurse practitioners and health station director establish and implement a public education and information program,

---help develop programs for training the paraprofessional staff to expand their roles,

---coordinate programs which provide for the continuing education of the nurse practitioners,

---represent the nurse practitioners at meetings with the health

station director concerning health station programs,

---represent the nurse practitioners at community meetings,

---represent the nurse practitioners at meetings of the professional group and lobby group for nurse practitioners.

Implementation: The City Manager or Health Commissioner could make the decision to place the nurse practitioner supervisor in the neighborhood health station department. To insure better coordination among the nursing services, the director of nursing and the neighborhood health station director could make joint hiring decisions.

Recommendation: Neighborhood Health Center Committee. This committee at the hospital now has control of the health station program. Control of the program should go to the health station director. The group should remain a standing committee of the medical executive committee and should be responsible for working out agreements with the health station director concerning the relationship between the health stations and the hospital, but the health station director should be responsible for health services provided in the health stations.

Implementation: A decision by the Commissioner or the City Manager is necessary to bring about this change.

C. Recommendations regarding the role of citizen participation in the neighborhood health station program

The most important recommendation for improving the role of citizen participation in the neighborhood health station program is that of establishing a process for citizen participation which provides a mechanism for citizens and professionals to deal with health issues on a continual basis, and provides citizens with access to the necessary skills

and expertise so citizen participation will not continue to fail. However, few of the specific suggestions will be possible to implement in the absence of a firm commitment to citizen involvement on the part of the City, a recognition of its merits, and a clear understanding of how mishandling of citizen participation has hampered the program in the past.

The recommendations recognize that most consumer health groups do not want total policy or financial control of the health stations. The recommendations take into consideration that citizen participation, through the Health Care Policy Council and the City Council, has been the primary means by which the City Manager has become concerned enough with the issue to hold the hospital accountable. The recommendations identify a process where citizens can become involved before decisions are made and before problems reach a crisis. At the same time, the recommendations recognize that the NFCC Board does not represent its neighborhood and does not have the capability to maintain control over the health center. Detailed specification of the role of citizens' groups is not included because specific functions and roles will inevitably grow out of dialogue and negotiation among the parties involved. These recommendations discuss the possible roles for citizen participation and the necessary mechanisms which will establish a process of meaningful dialogue and participation. Basically, the recommendations include providing citizens' groups with staff support, defining substantial concrete jobs for them to do, creating a mutually agreed upon and continuous process for relating to the hospital (specifically the medical director) and increasing the membership in the citizens' groups. While many of the problems with citizen participation have been related to the nature of the citizens' groups, a crucial

problem has been the lack of an authority at the hospital to whom citizens could relate and the lack of an established decision making process in which citizens could participate. The implementation of recommendations regarding the role of the City in administering the program--specifically the establishment of a department for neighborhood health and the hiring of a medical director whose responsibilities include addressing community needs--should alleviate those problems of citizen participation which are related to the hospital's role in administering the program.

Recommendation: Provide the necessary skill and expertise for both groups to become effective boards.

Implementation: The NFCC Board should have a coordinator to be its staff. The position can be established by the City Manager and the person could be hired by both the new NFCC Board and the City, although she or he will be responsible to the NFCC Board.

Both the NFCC and the Health Care Policy Council staff need to learn how other effective neighborhood health center boards work and how effective boardsmanship skills can be developed. People in Boston knowledgeable in these areas have offered their time and assistance. Another means of providing access to this kind of expertise is by having professionals sitting on both boards.

Recommendation: The NFCC and the Health Care Policy Council need to develop a process for relating to the hospital and to other City officials. In the present structure, there is no mutually agreed upon process. Under a new structure, the public official who would deal most directly with the health stations would be the health station director. The process for relating to this person would include:

1. Holding meetings with the director on a regular basis. The director could go to community meetings to discuss proposals and/or include community representatives in her or his staff meetings.
2. Defining the role of citizen participation, both in terms of scope, i.e. defining the issues in which community groups would participate, and in terms of level of participation, i.e. determining whether community groups would maintain an advisory role, or whether they would enter into a partnership with the City. Any definitions of the role for community groups would have to be reached through a discussion between the City and the groups. The problem now is that no process exists because hospital personnel do not support citizen participation. Once a neighborhood health station director is hired, (one who supports citizen participation) arriving at a mutual understanding and agreement between the director and the HCPC will not be difficult.

Implementation: Based on present City and consumer group attitudes, implementation of this recommendation could take several forms. The Health Care Policy Council is interested in continuing for an undetermined amount of time in an advisory capacity, provided that the Council has the opportunity to meet regularly with hospital personnel, have access to information, and be included when policy or budget decisions are made. Since the City Manager agrees that the group should have at least this much authority, the Council should write a memorandum of understanding, including these provisions, to be signed both by

the Council and the City. To insure implementation, the Council and the City must take care to hire a neighborhood health station director who wants to work with community groups. Any further agreements, such as the development of joint policymaking and budgetary powers, can be made when the Council feels it has the expertise and interest in such an agreement. At the moment the Council does not have the expertise to assume full or partnership responsibilities and does not want to undertake a project that will fail. However, by making informed proposals and contributions to the decisionmaking process, the Council will increase both its credibility and its authority.

The NFCC, however, is a different situation. The Public Health Council is demanding that a process of significant citizen participation in the running of the NFCC be established now. The difference between the NFCC and the Health Care Policy Council is that the NFCC wants control. The City does not feel the NFCC Board has the necessary skills to run the health center. A compromise which may be amenable to both groups is the development of a written agreement which gives a new NFCC Board advisory status to begin with, and over a specific period of time increases the power of the Board until the Board and the City are in a policy making partnership, similar to the City of Boston/neighborhood health center partnerships. A necessary element of such an agreement is the provision of staff and information by the City so that the NFCC Board will develop the necessary expertise. The Jefferson Park group (the North Cambridge Health and Social Services Committee) would like to exercise complete policy control over their health center by leasing the health center to the hospital

with conditions set by the Committee. Should the hospital not implement policy, the Committee is free to break the contract. Since both the City and the Committee are about to sign the agreement, no substantial changes can be made.

While from the City's point of view, signing one agreement with one city-wide group, probably the Health Care Policy Council, would be preferable to signing three agreements with three groups, the Health Care Policy Council has considerably less power than the other two groups, so the possibility of all the groups coming together is nonexistent at the moment. These recommendations do not preclude that possibility in the future, when all the groups may be on more equal footing.

Recommendation: Regardless of the agreed upon status of consumer health groups, these groups should:

a. reach agreement with the City on the following issues: level of health station staffing, health station hours, service mix, hiring, billing and expansion policy. These agreements could take a variety of forms. One possible hiring policy could be that the neighborhood health center director chooses ten candidates and the Health Care Policy Council narrows it down to three. In terms of expansion, residents from one neighborhood could submit a proposal stating their perception of their needs, and the health station locations which would best meet those needs. The health station director would then incorporate the proposal into her or his plan and submit that to the group for

discussion. In both cases, ultimate authority rests with the health station director, a sitution which Health Care Policy Council members would be happy with as long as the director was responsive, and the members feel that hiring a director who is a neighborhood health station advocate and who could devote full time to running the program, guarantees adequate responsiveness. If an advisory role proves inadequate, the Council could work out a partnership agreement, similar to the Boston neighborhood health centers. If this route is taken, the group should make sure it has adequate and competent staff to carry out is responsibilities.

b. establish regular meeting times with the medical director and appoint someone to make up the agenda and keep the minutes so all parties are accountable for their statements and decisions.

c. establish a relationship with the Health Policy Board (Department of Health and Hospitals Board of Trustees). In the event that the new City health ordinances are passed, the Board will be required to address issues of community health. Community groups could relate to whatever mechanism is established, probably a subcommittee. Relationship with this Board is necessary because the Board and the Commissioner will be responsible for making health policy and community groups would want to participate in policy decisions which would affect them.

d. continue the relationship with the Health and Hospital Subcommittee of the City Council. The City Council ultimately controls the budget, so it should be kept aware of citizens' needs. Furthermore, at the moment, it is a strong ally of citizens.

Implementation: The City and the consumer groups must hire a medical director in order to implement recommendations a and b. The new ordinance must be adopted for the implementation of recommendation c. Recommendation d is in effect. Consumer groups need only call the City Council Subcommittee chairperson and include her in their meetings to continue a meaningful relationship with the Subcommittee.

Recommendation: Strengthen the membership in existing groups. The Health Care Policy Council has only three official members, according to its by-laws, although attendance at meetings has been much higher. Both the constituency and the legitimacy of the group would be increased if people who consistently attend meetings and participate would be allowed to join. The Neighborhood Family Care Center Board is large, but the number who attend meetings regularly is very small, and there have been no new Board members who attend meetings in several years. The NFCC Board needs to be more representative of the patient population at the health center.

Implementation: Elections for seats on both the NFCC Board and the Health Care Policy Council have had very low turnouts, so elections are not necessarily the way to increase the number of active members on either board. A change in the Health Care Policy Council by-laws is required to allow people who regularly attend meetings to vote. If

the Health Care Policy Council planned and held meetings in the individual health station neighborhoods (rather than at CEOC), and called registered patients beforehand to inform them of meetings, attendance would be much higher. Low attendance will probably cease to be an important issue when a meaningful process of relating to the hospital is established, when a specific authority at the hospital is established to whom citizens can relate, a decision making process is defined in which citizens can participate, and when specific roles for citizens are defined. When these changes occur, people will have reason to remain in the group, and fewer people will leave because they are frustrated.

Implementation of this recommendation is slightly different for the NFCC. By order of the Public Health Council, which is voting on the City's certificate-of-need application for the new NFCC, the City and the present NFCC Board must come to an agreement on the composition and powers of the Board. Because the existing Board is not representative of the patients, and because existing Board members have held their positions since the health center opened in 1968, and because some existing Board members do not have the interest in attending meetings, some changes need to be made. Ideally, there should be a new interim board, one-third of which consists of NFCC Board members, and two-thirds of which consists of people selected by the City Manager from slates presented to him by neighborhood groups and professionals. At least two-thirds of the new group should be neighborhood residents and the composition of the group should reflect the patient population. At least a few members should be sympathetic

professionals who can provide expertise. The by-laws of the group should provide for the automatic resignation of those members who do not attend meetings regularly.

Recommendation: The NFCC and the Health Care Policy Council, as well as other health oriented groups in the City, such as the Women's Community Health Center, should begin to meet together occasionally. While it is important for individual neighborhoods to have individual meetings in their own neighborhoods, competing groups should meet together because a group representing the whole City can achieve much more than individual splinter groups without a constituency, and because many issues exist which are common to the different groups.

Implementation: The NFCC and the Health Care Policy Council staff could work with the groups to focus on common concerns. The staff could deal with the general difficulties of organizing around health issues by addressing these concrete, specific problems which health station patients are often more sensitive to than the present health station administrators: the need for enough nurse practitioners so that no health station is shortchanged by either having no nurse of its own or by having to accommodate another health station's patients, the need for bilingual staff, the need for a good referral system between the hospital and the health stations, the need for a billing system which meets the needs of the patients, the need for health station hours and service mix which meet the needs of the patients. The groups would then have specific proposals to make to the hospital. The tendency for groups to demand unnecessary or luxury programs is precluded by the fact that most consumers are taxpayers and understand how very expensive programs can raise the tax rate.

The establishment of a new department for neighborhood health services with a full-time medical director should provide the necessary structure within which the City can administer the neighborhood health station program. By providing the medical director with a department of her or his own, rather than keeping the program under the Chief of Medicine, the medical director would have the authority necessary to control and coordinate services within the health stations. By making the medical director a Chief of a department, (rather than within a department) she or he will be in a stronger bargaining position with other departments and therefore will be in a stronger position to bring about better interface between the health stations and the hospital. By making the medical director a full-time position, the neighborhood health stations will receive first, rather than second or third priority. A process for running the program on a continuous day-to-day basis, rather than on a crisis-by-crisis basis can be established within this kind of organizational structure and specific delineation of authority. Citizens would then know who was responsible for the program and with whom they must interact. The creation of a formal decision making process at the hospital creates the opportunity for citizens to participate. A mutual understanding between the hospital and citizens' groups of how citizens would participate should decrease considerably the tension between the two groups and allow each party to benefit from the perspective of the other. The development of an agreed upon process for citizen participation, the delineation of specific tasks for citizens to do, and adequate staffing of citizens' groups should increase their ability to make substantial contributions to the running of the program.

V. FOOTNOTES

1. Hollister, Kramer and Bellin. "Neighborhood Health Centers as a Social Movement," in Hollister, Kramer and Bellin (ed.), Neighborhood Health Centers, Lexington: Lexington Books, 1974, pp. 14-20.

2. Acton, J., "Nonmonetary Factors in the Demand for Medical Services: Some Empirical Evidence." Rand, #P5021, New York, 1973.

3. Macht, L., "Neighborhood Psychiatry," Psychiatric Annals, vol. 4, no. 9, September 1974, p. 53.

4. Zwick, D., "Some Accomplishments and Findings of Neighborhood Health Centers," in Hollister, Kramer and Bellin, op. cit., p. 78.

5. Beckhardt, R., "Organizational Issues in the Team Delivery of Comprehensive Health Care," Millbank Memorial Fund Quarterly, vol. 50, no. 3, July 1972, p. 320.

6. Rubin and Beckhardt, "Factors Influencing the Effectiveness of Health Teams," Millbank Memorial Fund Quarterly, vol. 50, no. 3, July 1972, p. 320.

7. Banta and Fox, "Role Strains of a Health Care Team in a Povery Community: The Columbia Point Experience," Social Science and Medicine, vol. 6, 1972, pp. 697-722.

8. Hillman and Charney feel that neighborhood health centers are one of the best sources of comprehensive care. Hillman and Charney, "A Neighborhood Health Center: What Patients Know and Think of its Operation," in Hollister, Kramer and Bellin, op. cit., p. 251.

9. Stoeckle and Candib believe that the orientation of neighborhood health centers is toward providing "expansive rather than efficient" services (i.e. health services as well as medical care). Candib and Stoeckle, "The Neighborhood Health Center: Reform Ideas of Yesterday and Today," New England Journal of Medicine, vol. 80, no. 5, June 1969, pp. 1385-91.

10. Skrovan concludes that nurse practitioners provide a wide range of health services, including health maintenance, preventive services and the alleviation of social and psychological stress. Skrovan, Anderson, and Goltschalk, "The Community Nurse Practitioner, An Emerging Role," American Journal of Public Health, vol. 64, no. 9, September 1974, pp. 847-53.

11. Flynn, B., "The Effectiveness of Nurse Clinician's Service Delivery," American Journal of Public Health, vol. 64, no. 6, June 1974, p. 604.

12. Henriques, Virgadamo, and Kahane, "Performance of Adult Health Appraisal Examinations Utilizing Nurse Practitioner-Physician Teams and Paramedical Personnel," American Journal of Public Health, vol. 64, no. 1, January 1974, pp. 47-54.

13. Merenstein, Wolfe and Barker, "The Use of the Nurse Practitioner in General Practice," Medical Care, vol. 12, no. 5, May 1974, p. 445.

14. Tagliacozzo, Luskin, Lashoff and Liama, "Nurse Practitioner Intervention and Patient Behavior," American Journal of Public Health, vol. 64, no. 6, June 1974, pp. 596-603.

15. Taller and Feldman, "The Training and Utilization of Nurse Practitioners in Adult Health Appraisal," Medical Care, vol. 12, no. 1, January 1974, pp. 40-49.

16. Spitzer, Sackett, Sibley, Roberts, Gent, Kergin, Hackett and Olynich, "The Burlington Randomized Trial of the Nurse Practitioner," New England Journal of Medicine, vol. 29, no. 5, January 1974, p. 251.

17. Morehead, Donaldson, and Seravelli, "Comparisons Between OEO Neighborhood Health Centers and Other Health Care Providers on Ratings of Quality of Care," American Journal of Public Health, vol. 61, no. 7, July 1971, p. 1294.

18. Sparer and Johnson, "Evaluation of Neighborhood Health Centers," American Journal of Public Health, vol. 61, no. 5, May 1971, p. 931.

19. Comments by Cambridge Hospital physicians at City Council Health and Hospital Subcommittee meeting, Spring 1975.

20. Gordon, J., "The Politics of Community Medicine Projects: A Conflict Analysis," in Hollister, Kramer and Bellin, op. cit., p. 114.

21. Merenstein, op. cit., p. 445.

22. Skrovan, op. cit., p. 847.

23. Macht, op. cit., p. 53.

24. That is, nurse practitioners tend to pay attention to social and psychiatric problems of patients, and tend to teach patients how to take care of themselves.

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