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Acknowledgments

Providing Community-Based Primary Care: Nursing Centers, CHCs, and Other Initiatives grew out of a luncheon conversation between Katherine Kinsey of the La Salle University School of Nursing and Karen Matherlee, co-director of the National Health Policy Forum, at the U.S. Department of Health and Human Services’ Third National Primary Care Conference in 1997. Not having met before, the two women by chance sat next to each other at the conference’s closing luncheon. Following the usual “What do you do?” exchange, Karen was intrigued to learn that Kay directed the Neighborhood Nursing Centers at La Salle. Remembering that the W. K. Kellogg Foundation—an NHPF core sponsor—had shown interest in a site visit on nursing centers and essential community services, she learned from Kay that Philadelphia had the largest concentration of centers in the nation.

Another major sponsor, Pew Charitable Trusts, which is headquartered in Philadelphia and has supported various community-based efforts to improve essential services in the city, was interested as well. In addition, the Independence Foundation in Philadelphia, which was working closely with Kay and with nursing leaders at the Community College of Philadelphia, Temple University, and the University of Pennsylvania, quickly became a driving force behind the site visit. Foundation President Susan Sherman and Senior Program Officer Marjorie Buchanan hosted planning meetings, recommended hosts and presenters, and helped in myriad other ways. (One evening during the site visit, they also hosted a dinner reception for Philadelphia and Washington participants that gained “off the charts” raves.) Foundation nursing chairs Elaine Tagliareni of the Community College of Philadelphia, Nancy Rothman of Temple University, and Lois Evans of the University of Pennsylvania—along with Kay, nursing center leaders—formed a core organizational group with the two foundation officers and the Forum team to bring the site visit to fruition.

Zane Robinson Wolf, dean of nursing at La Salle; Tine Hansen-Turton, then a key staff member of the Philadelphia Housing Authority; and Marcia Starbecker, nurse consultant at DHHS’ Health Resources and Services Administration; also provided valuable support, as did Donna L. Torrisi, director of the Abbottsford Community Health Center; and Susan Heckrotte of the center’s sponsoring organization, Resources for Human Development, Inc.

The decision was made early on, however, not to limit the site visit to nursing centers’ provision of essential community health services but to expand it to community health center and other initiatives. Bruce Riegel, director of HRSA’s Northeast Cluster of Field Offices, gave wise counsel on this effort, as did federal participant Bonnie Lefkowitz, associate bureau director in HRSA’s Bureau of Primary Care. Natalie Levkovich, executive director of the Health Federation of Philadelphia, played a key role in opening up site visit themes and tours to CHCs. Included was Philadelphia Health Services’ Maria de los Santos Health Center, with Patti Deitch, the president and chief executive officer of PHS, as well as the president of the board of directors of Community Health Network, giving guidance as well as expertise. She was joined by Carolyn Baxter, executive director of Spectrum Health Services, in providing valuable assistance.

Sister Mary Scullion—executive director of Project H.O.M.E., a multi-faceted service program for the homeless, and inspirer of all with whom she comes in contact—helped develop the segment for “persons on the edge” (or “off the edge,” in the words of one presenter). Albert Black, Jr., and Theresa Brodick of Temple University Hospital gave graciously and generously of their time in setting up Temple’s three-part emergency department segment.

Indeed, all those who provided overviews, served on panels, hosted tours, and provided information for the briefing book contributed significantly to the success of the site visit. Many thanks to them and to the Forum staff members—particularly Michele Black for spearheading the briefing book, consultant Barbara Skydell for writing briefing book theme and site descriptions and doing the “Philadelphia Marketplace” list, and Dagny Wolf for handling logistics—who worked with Karen to develop the briefing book and this report. Richard Hegner deserves appreciation for helping with the initial scoping of the site visit and providing materials on Pennsylvania Medicaid and public health to the briefing book. And thanks to all the Washington participants (and Kellogg evaluator Peter Pratt, from Lansing, Michigan) who brought concern for the effective delivery of essential community services, expertise on various policy aspects, curiosity for “the Philadelphia experience,” and enthusiasm to the site visit.

Judith Miller Jones
Director
Providing Community-Based Primary Care: Nursing Centers, CHCs, and Other Initiatives
—Karen Matherlee and Barbara Skydell

BACKGROUND

The National Health Policy Forum (NHPF) took 18 federal congressional and executive health staff and a foundation grant evaluator to Philadelphia March 29-31, 1998, to examine essential community health services in the city. The trip was funded by grants to NHPF from the W. K. Kellogg Foundation and Pew Charitable Trusts; the Independence Foundation provided planning support and hosted a dinner reception for local and visiting participants. The purpose of the site visit was to provide federal health staff opportunities to visit facilities and engage in discussions on essential community health services, especially community-based primary care provided by nursing centers, community health centers (CHCs), and public-mission hospitals, as well as community support to people who were or had recently been homeless. The core of the site visit was to examine the impact of managed care—in terms both of the rapidly reconfiguring private health marketplace and the Medicaid HealthChoices program—on access to and the delivery of care to publicly insured and indigent persons.

Following the site visit, the Forum sent detailed evaluation forms to federal participants, most of whom completed and returned them. NHPF also held a debriefing meeting on June 4, 1998, to gain additional perspectives from Washington participants about the site visit. Drawing on both the evaluation responses and the views expressed at the meeting, this report is a summary of impressions of the visit. It also reflects notes taken during the site visit and comments made by some participants during calls made to follow up on evaluation comments. Some portions are reinforced by information provided in the site visit briefing book as well as in post-visit supplementary materials and comments of Philadelphia participants. The responsibility for the report belongs to the Forum.

THE PHILADELPHIA HEALTH CARE ENVIRONMENT

Philadelphia, the birthplace of American democracy, is a city of firsts and mosts. The first hospital in the nation was founded in Philadelphia. With one osteopathic and four allopathic medical schools, the city ranks first in the country in medical school enrollments relative to population. The city also has a greater concentration of nursing centers than any other metropolitan area in the United States, and it outranks other metropolitan areas in the percentage of physicians who conduct research. At the same time, Philadelphia was ranked in 1997 as one of the nation’s leading regions for providing “potentially unnecessary or inappropriate hospital care.” The city’s oversupply of hospital beds, combined with shorter inpatient stays and shifts of services from the inpatient to the outpatient setting, is often cited. Moody’s Investors Service calls Philadelphia “one of the most volatile [health markets] in the country.”

In addition to an excess of capacity, the volatility seems to be due to the reconfiguration of the health care system that is happening across the country. The most prominent change is the rapid growth of managed care in both the public and private sectors. As this growth shatters traditional arrangements—resulting in establishment of nurse-managed centers, the purchase of physician practices, the consolidation and closure of hospitals, and other trends—payers strive to contain costs through contracted arrangements while providers attempt to protect their bases and increase their market share. With payers and providers alike seeking leverage and generally losing flexibility in the process, access to and availability of services are becoming even more constrained for low-income and indigent persons. This is particularly significant for those who have recently lost benefits due to welfare and health reforms and those who are employed without health benefits in the fast-growing service sector.

Academic Health Centers and Systems for Care

Philadelphia possesses several distinguishing characteristics. It is a city of academic health centers (AHCs) where managed care comprises a little more than one-third of the private market. These centers are at the core of a movement toward consolidation; preparing for an expected
rapid penetration of the city by managed care, AHCs have bought up physician practices—especially those oriented to primary care—and affiliated with community hospitals, transforming the city’s medical marketplace. It is a city with few large for-profit employers and no dominant employer. It is a city in which the for-profit hospital or system has not yet made inroads, although one system, Allegheny Health, Education, and Research Foundation, having filed for bankruptcy, may be purchased by Nashville-based Vanguard Health Systems, Inc.

Of the 70 hospitals in the region, only about a dozen have chosen not to partner. The remainder have organized around four health systems anchored by the city’s AHCs. In addition to Allegheny Health, Education, and Research Foundation, the systems include Jefferson Health System, Temple University Health System, and the University of Pennsylvania Health System. (Please see the “Philadelphia Health Marketplace” on page 10 for a detailed list of these systems.) While four health plans—Keystone Mercy Health Plan, Health Partners of Philadelphia, Health Management Alternatives Inc., and Oaktree Health Plans—contract to provide Medicaid services under HealthChoices, there are various health plans in the private marketplace. Aetna/U.S. Healthcare offers indemnity, preferred provider organization (PPO), health maintenance organization (HMO), point of service, and managed Medicare. Independence Blue Cross provides indemnity, PPO, HMO, managed Medicare, and behavioral health and substance abuse coverage. Together, they control 87 percent of the commercial HMO business in the eight-county Philadelphia region. Other plans include Medigroup (owned by Blue Cross/Blue Shield of New Jersey), Qualmed Plans for Health (run by Foundation Health Systems, Inc., of Colorado), HIP Health Plan, Oxford Health Plans, and Prudential Health Care Plan.

While the AHCs are struggling with the rapid expansion of managed care, essential “safety net” providers are also in a state of flux. Newer providers—nursing centers and health centers for the homeless—are emerging and in some cases spreading. New partnerships—such as those between the Philadelphia Housing Authority and community groups—are being forged and services are being developed in places accessible to community residents. Long-established providers—particularly CHCs—are grappling with ways to stay solvent as they experience shrinking subsidies and face competition from health plans for contracted services.

Caring for the Vulnerable: Nurse-Managed Clinics and Community Health Centers

Nursing centers are clinics that are nurse-managed in partnership with medically underserved communities in the city. Although they care for predominately low-income women and children from minority, immigrant, and other vulnerable groups, men in need of services are targeted as well. Generally oriented to preventive and primary care, the centers utilize nurses as their major service providers. However, physicians are on call for consultation and referral and on site from time to time to review records. Sponsored by schools or departments of nursing of three of the universities in the city, the centers have thrived as a result of funding and advocacy from the Independence Foundation. Recognized as primary care providers by three of the four health plans in HealthChoices, they have been struggling for market share. A Regional Nursing Centers Consortium—covering Delaware and New Jersey in addition to Pennsylvania—is providing support by, for example, developing preliminary data to back centers’ claims for effective services.

CHCs, traditionally providers of the underserved, are being forced to reinvent themselves in light of a competitive managed care environment for Medicaid beneficiaries, an in-process phaseout of cost-based reimbursement (under “federally qualified health center,” or FQHC, status), and a growing burden of uninsured patients. Organized as the Community Health Network for collectively contracting with health plans, they tend to lack capital for improvement of facilities and reserves to overcome operating losses as they seek to become “providers of choice” rather than “providers of last resort.”

Managed Medicaid: The HealthChoices Program

Various policy changes are affecting both newer and older essential community providers. Medical assistance, known as MA, is a Pennsylvania program that administers the Medicaid program and pays almost half of its costs. Because Medicaid is a federal-state entitlement program, as Medicaid rolls increase so do the costs to the Commonwealth of Pennsylvania. Act 35, enacted July 1, 1996, was an attempt to control overall MA costs by eliminating coverage for an estimated 220,000 low-income single adults in Pennsylvania between the ages of 21 and 59, who are without dependents and are deemed healthy enough to work. They are eligible for benefits only if they work at least 100 hours a month. Although this adult group is not MA’s most costly population, it is the only group over which the commonwealth has control, given the federal mandates for women and children. It is estimated that 62,000 Philadelphia residents, about a quarter of those affected in the commonwealth, have lost coverage.

HealthChoices, started in February 1997, mandates that all MA recipients in the five-county Philadelphia region enroll in a Medicaid managed care program. About 500,000 Medicaid eligible individuals were enrolled during the first year of the program. Of the four managed
care companies that participate in HealthChoices, Keystone Mercy—whose parent organization, Keystone Health Plan East, is owned by Independence Blue Cross—has 44 percent of the market share; Health Partners of Philadelphia, owned by a group of seven Philadelphia hospitals, has 27 percent; Health Management Alternatives, Inc., has 17 percent; and Oaktree Health Plans has 12 percent (Oaktree is the local operation of Oxford Health Plans, which has stopped providing Medicaid managed care services in some states but has remained in Philadelphia, under a partnership arrangement with a Minnesota firm to do utilization review and quality assurance).

During the first year of operation, all four plans lost money: more than $50 million, according to a Keystone Mercy internal analysis of the HealthChoices program. The plans maintain that their losses are a result of underfunding of the program. In response to complaints about funding levels, the Pennsylvania General Assembly’s Legislative Budget and Finance Committee engaged Arthur Andersen to perform an actuarial analysis of the reimbursement rates. The report, released in February 1988 and excerpted in the site visit briefing book, concluded that the premiums paid to the plans to cover the cost of the Supplemental Security Income (SSI) population were inadequate. The report also stated that the rate for administrative costs, profits, and contingencies was also too low but was neutralized by the high inflation adjustment that was provided. It concluded that, except for the SSI population, premium rates were adequate. The actuaries suggested that corrections be made to the rates for SSI recipients and that the rating process incorporate key risk factors that would correct for the understatement. The Department of Public Welfare, questioning the validity of these recommendations, has not acted on them.

A Public-Mission Hospital

Safety-net Philadelphia hospitals (such as Temple University Hospital) contend that they have recorded major deficits as a result of the HealthChoices program. At Temple, Medicaid reimbursements were reduced by $22.3 million, an amount representing 8.5 percent of the hospital’s budget. While Medicare is overshadowed by Medicaid as an essential community provider concern, Temple and other hospitals are confronting reductions in Medicare spending stipulated to be phased in through 2002 by the Balanced Budget Act of 1997. The Delaware Valley Healthcare Council anticipates that these reductions will translate into a minimum of $1 billion in lost revenue for inpatient care in Philadelphia area hospitals and health care systems. Temple University Hospital, which some call a “public mission” hospital in a city that has no publicly owned hospitals, operates three emergency rooms that are part of the city’s safety net. They include an adult emergency room and walk-in facility; a pediatric emergency room; and psychiatric emergency services, which take care of people in crisis—more than 80 percent of them diagnosed with both mental illness and substance abuse problems.

A Big Role for Public Health

The reconfiguration of the private and public health marketplace has put pressure on both public health and private philanthropy in the city to look anew at the safety net for vulnerable populations—to fill in gaps or address the need for replacement. The Philadelphia Public Health Department runs eight health centers that are “look-alikes” to federally qualified CHCs in the city. The centers provide primary care as well as pharmacy services and most also do laboratory work, take x-rays, and provide dental services. The city also operates HealthChoices’ behavioral health carveout program, Community Behavioral Health. While Pennsylvania does not have an uncompensated pool, Philadelphia uses city funds for uncompensated services at the centers, which are places of last resort—sometimes with long waits for care—for patients who otherwise would go without.

Two Service Organizations Cited as Models for Other Cities

The Philadelphia Health Management Corporation (PHMC), a unique not-for-profit organization started in 1972 by a group of public and private organizations addresses problems of persons who have gone “over the edge” as a result of violence, substance abuse, homelessness, HIV, and other reasons, in addition to poverty. Manager of the Health Care for the Homeless program, it too operates clinics. It also conducts research, provides technical assistance, collects and analyzes social service and health data, and monitors changes in health status.

While PHMC is a bridging organization that provides direct services, serves as a data center, and brings both public and private funding sources together, Project H.O.M.E. has its own unique role in the city. Both are recognized as organizations that work, that are potential models for other stressed urban areas. Also a not-for-profit, Project H.O.M.E. partners with low-income, at-risk communities in North Philadelphia on homeless prevention, outreach to chronically homeless persons on the streets, save havens for persons who want off the streets, and transitional and permanent supportive housing. Rebuilding North Philadelphia from within, it runs a bookstore and cafe and offers various other services—including on-site health care provided by PHMC, Jefferson Medical College, and PHS’ Fairmount Health Center—at its headquarters on Fairmount Street.
In a city of approximately 1.6 million people, with adverse statistics on poverty, distressed neighborhoods, crime and violence, teen pregnancy, and various health status measures, providers are struggling to address the needs of vulnerable populations while confronting major changes in the health care infrastructure and the delivery and financing of care. PHMC traces the causes to the past: “Health care in the United States in the 1990s is a reflection of economic and political decisions of the past. In the 1960s, attempts to finance health care for the old and poor were initiated without sufficient attention to organizational, structural, and cost-containment issues.” The statement continues: “Medicare and Medicaid, the major federal insurance programs for the elderly and the poor, have been outstripped by the rising costs of health care. This country’s distressed populations have increased as a result of economic and social problems unforeseen 30 years ago.” For PHMC, as for many others with whom site visit participants met, “As a major metropolitan area, Southeastern Pennsylvania reflects the status of health care nationally and offers unique opportunities for developing meaningful responses.” The responses they experienced made various impressions on the site visit participants, who saw firsthand the complexities of providing essentially community-based primary care services and considered the policy implications.

**IMPRESSIONS**

Following are some impressions that arose from the site visit’s opening briefings, facility tours and sessions, and panel discussions:

*The status of health plans remains uncertain relative to competitive pressures, resources for working with vulnerable populations, and means of accountability.*

Health plans that cater to the commercial market and those that contract to offer care to Medicaid beneficiaries are buffeted by market forces, as the Philadelphia health marketplace undergoes rapid change. As health plans, hit by middle-class consumer backlash, seek to offer “kinder and gentler” managed care, in the words of one presenter, they face considerable cost pressure in a private market in which Aetna/U.S. Healthcare’s HMO and Independence Blue Cross’s HMO have about a third share and the rest is divided between indemnity and PPO coverage. The plans also operate in an environment without a public hospital and with the ongoing possibility that a for-profit system will buy up a large segment (the potential sale of Allegheny’s Philadelphia holdings to Vanguard is an example). For the HealthChoices plans—Keystone Mercy, Health Partners of Philadelphia, HMA, and Oaktree—the rate structures, particularly for SSI and special needs populations, continue to be issues, given the need and service profiles of these beneficiaries.

Most presenters agreed that the resources available in the reconfiguring marketplace to serve vulnerable populations—especially the uninsured—are declining, as private and public purchasers alike are contracting with health plans on a discount basis. Declining opportunities for cross-subsidizing and cost-shifting were cited by nursing center, CHC, and hospital representatives as well, while most traditional essential community providers pointed to a lack of reserves to make up losses and a dearth of capital to fund improvements.

While some panelists mentioned accountability to vulnerable people to provide safety-net services, it was only the Philadelphia Health Department that acknowledged responsibility. Even then, an increase in the uninsured, the shift of responsibility for persons with substance abuse problems from the state to the city, increased costs of care (such as for pharmaceutical products), and the burden of special populations (persons with HIV and those who are homeless, disabled, and/or mentally retarded, as well as children with special needs) were burdening the department. “It’s a question of how to make ends meet” was repeated several times.

**Challenged by Philadelphia’s having taken the lead for the commonwealth in capitulating Medicaid beneficiaries, the four contracting health plans have had a rocky experience in the HealthChoices program.**

The February 1998 “An Actuarial Review of the HealthChoices Program in Southeastern Pennsylvania” that was prepared for the Pennsylvania General Assembly highlights various health plan concerns: an increase in administrative and reporting requirements, rates set too low, the absence of adjustments for special circumstances (providing graduate medical education [GME], having a disproportionate share of poor patients), and a “secretive” and “arbitrary” proposal and negotiation process. For providers, payment adequacy and disproportionate share/GME were also problems, as was the inclusion—without special consideration—of special needs populations.

Although HealthChoices became operational in February 1997, it waited until October 1997 to add the SSI and special needs populations. Health plans have indicated that they lost money in the program the first year and the first quarter of the second year, due to (a) inadequacy of rates
(particularly because of the addition of the SSI/special needs beneficiaries) and (b) the burden of fulfilling increased regulatory requirements.

The Pennsylvania Department of Public Welfare is completing a report on the performance of the managed care organizations in the first year. A source in the department indicates it will say that the plans generally met the department’s expectations and that the 500,000-plus persons in Philadelphia and the surrounding counties covered under HealthChoices are well-served.

The nursing center is a fairly new model of providing services under Medicaid to vulnerable populations. As it is developing in the city, it seems to be a provider of last resort (under Medicaid, sliding-scale self-pay, and indigent care) in communities with large numbers of vulnerable people.

Nursing centers, which are about 20 years old, have their roots in nurse-run settlement houses that date to the early 1900s. Given impetus from the American Association of Colleges of Nurses and foundation, federal, and state support, they provide comprehensive primary health care, health promotion and disease prevention services, or single-purpose functions, such as women’s health. Philadelphia, with more nursing centers than anywhere in the country and the headquarters for the three-state Regional Nursing Centers Consortium, is striving to develop comprehensive primary health care centers with broad-range funding, including capitated payments from health plans in HealthChoices (three of which recognize certain nursing centers in Philadelphia as primary-care providers).

The Philadelphia centers that participants visited—Abbottsford Community Health Center, La Salle Neighborhood Nursing Center, the Health Annex at Myers Recreation Center, and Temple Health Connection at Norris Homes—provide services to vulnerable populations in poor neighborhoods, at times based in recreation centers or housing projects. With service delivery overseen by a nurse who has control over the budget and with services provided by nurses (especially but not exclusively nurse practitioners, nurse midwives, and public health nurses), the centers tend to be identified with schools or departments of nursing. For example, La Salle’s center combines both service delivery and training, as do those of Temple and the Health Annex (a part of the University of Pennsylvania). Nurse providers refer to physicians for specialty care; moreover, a physician visits each center periodically to review records. (Some participants contended that the role of the physician was unclear.) Nursing personnel maintain that their practice is appropriate for preventive and primary care and that partnership with other practitioners and community groups is key—collaboration rather than competition.

Because nursing centers are safety-net providers that are serving a growing number of uninsured, they are concerned about survivability. In addition to the Abbottsford center, La Salle’s, Temple’s, and Penn’s centers are designated providers under managed care; they are seeking to broaden their bases under HealthChoices. Abbottsford, already an FQHC, is a model for the rest, which also would like to get cost-based reimbursement (although the others recognize that it is being phased out under the Balanced Budget Act of 1997). Moreover, the centers receive funding for categorical programs, such as HIV outreach, prenatal home visiting, and family planning, but see this support declining.

Pressed by participants, a few of whom did not see the centers’ viability as equal to that of CHCs and some other providers, the centers acknowledged that they need data to show their effectiveness. They indicated that they are developing the capacity through the consortium to show (a) the services they provide; (b) their impact, in terms of the number of persons served and the costs of doing so; and (c) the outcomes of the services, in terms of health status. Preliminary data, according to the consortium, show that 100 percent of women giving birth in several of the nurse-managed centers have had normal birthweight babies, that emergency room visits have declined by 50 percent for nursing center clientele, and that average hospital days have decreased for center patients.

Reconfiguration of the health marketplace and the implementation of HealthChoices are altering the mission and status of CHCs.

Most participants were familiar with the initiation of the federal CHC program in 1966 and the placement of centers in areas characterized by a shortage of health resources, particularly primary care physicians; by high infant mortality rates; and by a high percentage of poor people. The briefing book pointed out that CHCs served more than 8 million vulnerable and uninsured persons in 1996, 42 percent of whom were children. (In fact, statistics for CHCs in the city showed that women and children made up the overwhelming majority of their patients.) It also traced the history of FQHCs, which apply to migrant health centers and to health care for the homeless programs as well as to CHCs, under Medicaid and then Medicare, and the Balanced Budget Act phasewout of the cost-based reimbursement that special status brings.

The spread of managed care arrangements at CHCs—an increase of 129 percent from 1994 to 1996, covering
1.28 million enrollees—drew the most discussion. Panelists and visitors alike commented on the shift in mission and status that seemed to be occurring as CHCs respond to incentives to maintain Medicaid market share (as Medicaid rapidly moves to capitated contracts, as it has in Philadelphia), to develop health networks, to learn managed care skills, and to address capital and other improvement issues.

Some difficult issues were raised: Are CHCs retaining their traditional mission of serving vulnerable populations or are they more intent on marketing to persons who are publicly (and some privately) insured? Are CHCs vested in their communities, in terms of determination of service needs? How can they provide nonmedical or enabling services (without direct financing)? Do CHCs have safety valve status as places of last resort? What is the impact of an increasing number of uninsured in the city?

The point was made several times that CHCs have had protected status for the past 30 years. Some said this insulation prevented the development of the business and entrepreneurial skills that are necessary to survive in the current environment, the capacity to be a provider of choice rather than of last resort. Most agreed that CHCs were “between a rock and a hard place,” challenged to retain their traditional status as safety-net providers while transforming themselves into competitive business managers. The Health Federation of Philadelphia, Inc., the association for CHCs, and the Community Health Network, the negotiating organization, are playing central roles in addressing this dilemma.

Unlike the nursing centers, the CHCs did not have structural links to AHCs. Some had residents rotating through, with CHC staff members functioning as preceptors, and some served as teaching sites for medical, nursing, and physician assistant students, but formal links were few. Whereas health center physicians had referral and admitting privileges at certain hospitals and ad hoc relationships had developed concerning research projects and clinical trials, the CHCs—for good or ill—seemed to be for the most part outside the AHC-dominated health systems.

### Public health is taking an aggressive role in advocating for those falling off the edge, in providing direct services, and in establishing a carveout for behavioral health under HealthChoices.

As the role of public health is debated across the country, public health in the city of Philadelphia seemed to bridge several roles: direct delivery of services, operation of the Community Behavioral Health carveout program for HealthChoices, and monitoring of health status. As indicated in “The Philadelphia Health Care Environment,” the city, with its eight “look-alike” clinics, is the provider of last resort. It is also where the buck stops for persons with substance abuse, HIV, chronic mental illness, and similar problems. As one participant phrased the city’s role in maintaining essential community services, “The city is the underpinning of it all.”

#### The role of the public-mission hospital as safety-net provider is changing as Medicaid is capitated, hospital subsidies and opportunities for cost-shifting decline, and service needs evolve.

The hospital emergency department is sometimes viewed as the barometer for the rest of the safety net: If its population rises, it means that pressure is building up elsewhere. In Philadelphia, Temple University has developed an interesting approach to triaging persons who come to the emergency department, whether for level-one trauma, a lower level of emergency care, primary services, or behavioral health care. It has adult, pediatric, and psychiatric emergency areas that target different patients.

The adult service, with a high rate of uninsured, experiences a lot of street violence. Serving persons older than 14, it had 28,821 patient visits from July 1997 through May 1998. Its payer mix was 18.0 percent Medicare, 3.5 percent Medicaid, 5.0 percent Blue Cross, 3.5 percent commercial insurance, and 70.0 percent “other.”

The pediatric service, receiving patients 14 and under, sees children—in terms of diagnosis—similar to those cared for in primary care practice. Its number of visits was 9,046. Its payer mix was 0.0 percent Medicare, 2.1 percent Medicaid, 4.6 percent Blue Cross, 2.5 percent commercial insurance, and 90.8 percent “other.”

The psychiatric service, which operates as a crisis response center mainly for persons with both substance abuse and behavioral diagnoses, recognizes the prevalence of dual diagnoses and provides a range of services to address them. Its caseload was 5,737. Its payer mix was 7.6 percent Medicare, 4.4 percent Medicaid, less than 1.0 percent each of Blue Cross and commercial insurance, and 87.3 percent “other.”

In a city without a publicly owned hospital, Temple and other systems, such as Jefferson, have assumed responsibility for some vulnerable people. For them, there are links between service delivery and medical education and training—links recognized in Medicare and Medicaid policy—that are affected by Balanced Budget Act provisions. Safety-net hospitals are looking at ways in which they must change, as employers limit employee options in
the private health marketplace, as the state’s adoption of HealthChoices affects their market shares, as federal subsidy reductions (for example, disproportionate-share adjustments) impact their bottom lines, as the number of uninsured rises, and as other shifts occur.

Dedicated initiatives to serve persons who are homeless—those “over the edge”—seemed dynamic and positive, despite scarce resources. Both programs—the Philadelphia Health Management Corporation and Project H.O.M.E.—are not-for-profits.

Headed by energetic leaders, PHMC and Project H.O.M.E.—described earlier in “The Philadelphia Health Care Environment”—draw widespread support in the city. At a discussion, “Services for Persons on the Edge,” in which both Richard J. Cohen, director of PHMC, and Sister Mary Scullion, executive director of Project H.O.M.E., were panelists, impressions emerged of organizations with clear missions, ability to draw funds, community support, and empathetic understanding of those they serve. Prior to the discussion, a bus tour of Project H.O.M.E.’s North Philadelphia neighborhood gave participants an opportunity to see the renovated community centers, row houses, and apartment buildings that Project H.O.M.E. had made available to the homeless and formerly homeless in “building from within.” These, as well as the tot lots, gardens, and community-centered services were supported by grants from the U.S. Department of Housing and Urban Development and other government sources, the Independence Foundation and Commonwealth Fund, and other funders. In terms of health care, Project H.O.M.E. works with Jefferson Medical College physician trainees and other volunteers as well as PHMC to integrate housing and health care and to address environmentally linked health problems, such as violence, asthma, and lead-based paint.

PHMC’s capacity for partnerships was revealed as well. Whereas Project H.O.M.E. has partnered with government, business, religious, and philanthropic organizations as well as individuals to raise money for housing and other projects, PHMC has worked with various groups to operate the Health Care for the Homeless program. For example, it subcontracts with the city’s Office of Mental Health for outreach services which nurse practitioners, community health nurses, and social workers provide to homeless persons in shelters and soup kitchens and on the street. It also subcontracts with PHS for homeless services in North Philadelphia (some of the persons helped by Project H.O.M.E.) and with the Philadelphia College of Osteopathic Medicine and ChesPenn Health Services to extend outreach and primary care beyond the city center.

Recently, PHMC opened the Mary Howard Health Center, a nurse-managed clinic that specifically targets the most hard-to-reach homeless. The center, staffed by nurse practitioners and social workers, provides primary care services to a population with the following characteristics: 52 percent female and 48 percent male; 52 percent between the ages of 25 and 44 and 29 percent between the ages of 45 and 64; and nearly 76 percent black, 20 percent white, 3 percent Hispanic, and less than 1 percent each Asian, Native American, and other. Of this population, 62 percent live in shelters, 15 percent on the street, nearly 11 percent in “other” settings, over 5 percent in doubled-up conditions, and less than 1 percent in public and Section 8 housing, while 4 percent are unaccounted for. The overwhelming majority—over 93 percent—are at 0 percent to 100 percent of poverty.

Essential community providers tend to have rationed, unevenly flowing funding streams, including funds from Medicaid capitation; a small amount of Medicare; federal, state, and local grants; charitable contributions (for example, foundations); and/or some contributions from recipients of services.

Scrambling for funds and piecing various dollar sources together seemed to be a way of life for the essential community providers that participants encountered in Philadelphia. There seemed to be recognition that some of the subsidies of the past—for example, government grants and “adjustments”—as well as opportunities to cost-shift from private payers had ended, that cross-subsidization was becoming a “thing of the past.” For health plans involved with HealthChoices and for safety-net providers to Medicaid patients as well as to the uninsured working poor and to the indigent, financial pressure came up again and again, as did concern about a second class of care for those who were not privately insured.

Various types of new primary-care partnerships are developing with both public and private support (for example, the Philadelphia Housing Authority fosters health care in housing projects and recreation centers).

PHA’s health care initiatives, in which nursing centers had been established at several housing projects in the city (including Abbottsford and Norris Homes) as well as at a recreation center (the Health Annex at Myers Recreation Center), provided strong examples of public-private partnerships, as well as sensitivity to the needs of residents
who wanted on-site health services. The Maternity Care Coalition, an outreach program (with a Mom-Mobile) for prenatal care which also gets involved in advocacy; the Philadelphia Bridging the Gaps Program; the Consortium for Latino Health; and the Pennsylvania Health Law Project are other examples.

Charitable foundations, such as the Independence Foundation, Pew Charitable Trusts, and the W. K. Kellogg Foundation have played strong roles in developing resources for vulnerable persons in the city.

The Independence Foundation, in establishing nursing center chairs at the Community College of Philadelphia, La Salle University, Temple University, and the University of Pennsylvania and in supporting the Regional Nursing Centers Consortium, has played a coalescing and facilitating role for nursing centers. Its goal has been to provide an infrastructure to develop and implement comprehensive primary care centers. The W. K. Kellogg Foundation, which directs much of its funding to services for vulnerable populations, has been supportive of the centers as well. Pew Charitable Trusts has been a prominent and long-standing backer of PHMC’s efforts to expand services to persons needing mental health services who have moved from the street to shelters to independent housing.

The importance of relationships—person to person, program to program, and program to person—cannot be underestimated in working with people who are vulnerable.

A top-down approach to working with people who are vulnerable was rejected across-the-board by panelists, who stressed the importance of partnering with communities and relating one-on-one to people needing services. It was evident in the relationship between Project H.O.M.E. staff and those receiving services and in the sense of community at Maria de los Santos. This CHC served 23,400 patients in 1997, most of them Hispanic, and was said even “to have name recognition in Puerto Rico.”

Data systems are horrendous, especially Medicaid’s. The dearth of data says something about the lack of investment in infrastructure in Philadelphia and elsewhere.

Whether from health plans in HealthChoices, nursing centers, CHCs, homeless initiatives, or hospitals, meaningful data were difficult to obtain. Philadelphia and Wash-

ington participants alike decried the lack of data, but solutions for addressing the problem were few. One came from the Regional Nursing Centers Consortium, which has established a data warehouse for nursing centers and is incorporating data from membership centers into its database. Another came from PHMC, which exists in part to track health status.

The concept of a continuum of services with coordinating providers—physician practices, advanced nursing practices, CHCs, hospital services, emergency care, and so on—is but a dream to those who serve vulnerable populations and to vulnerable persons themselves.

From time to time during the site visit discussions, some panelists and participants expressed a desire for a continuum of care, particularly when the word “system” was raised. At the same time, those from the private sector pointed out that, while essential community services may be piecemeal, with significant gaps, commercially provided services are fragmented as well. The ongoing development, through public-private partnerships, with diverse funding seemed to be the most practical way of building a continuum, although few thought it would ever be seamless.

LINGERING QUESTIONS

Following are some questions that perplexed participants during the site visit or were raised at the debriefing session:

- The picture of the uninsured is confused: Is it largely the working poor or an increasing number of disenfranchised persons?
- What is the role of essential community providers?
- In addressing services for vulnerable populations, which is preferable: use of entitlement programs or categorical (targeted) approaches? Is it more appropriate to target certain populations or take a block grant approach?
- What effects is reconfiguration of the health marketplace having on access to and quality of services for vulnerable populations? Are opportunities opening or doors closing to vulnerable people?
- Should safety-net providers have special status?
- Where should governance of safety-net providers reside?
- What is the intersection of federal and state policy, especially in expansions of coverage for children?
What are the costs of treating patients, especially persons with special needs? How are the costs figured and taken into account by HealthChoices? By providers of essential community services?

Are those on or over the edge becoming increasingly marginalized? Is an explicit two-tiered system being developed?
Philadelphia Health
Marketplace*

Health Plans

- Aetna/U.S. Healthcare: indemnity, PPO, HMO, point of service, managed Medicare
- Independence Blue Cross: indemnity, HMO, PPO, managed Medicare, Greensprings (mental health and substance abuse coverage for commercial employer purchasers)

NOTE: Together the above two health plans control 87 percent of the commercial HMO business in the eight-county Philadelphia region.

- Other plans:
  - Medigroup (owned by Blue Cross/Blue Shield of New Jersey)
  - Qualmed Plans for Health (parent corporation is Foundation Health Systems, Inc. of Pueblo, Colorado): HMO, PPO, point of service
  - HIP Health Plan
  - Oxford Health Plans
  - Prudential Health Care Plan

Health Choices

- Philadelphia market share of managed care companies that participate in Health Choices (Medicaid managed care plan):
  - Keystone Mercy, 44 percent (parent organization is Keystone Health Plan East owned by Independence Blue Cross)
  - Health Partners of Philadelphia, 27 percent (owned by a group of seven Philadelphia hospitals)
  - Health Management Alternatives, Inc., 17 percent
  - Oaktree Health Plans (Oxford Health Plans, Inc.), 12 percent

- Community Behavioral Health (behavioral health HMO—a private, not-for-profit organization that the Philadelphia Health Department created for managing the day-to-day operation of the behavioral health contract)

Health Care Systems

- Jefferson Health System
  - Created in 1996
  - Union of Thomas Jefferson University Hospital and Main Line Health System
  - Albert Einstein Healthcare Network (including Belmont Center for Comprehensive Treatment, Germantown Hospital and Medical Center, and Moss Rehabilitation Hospital) joining effective July 1, 1998
  - Children's Rehabilitation Hospital
  - Jefferson Medical College

- University of Pennsylvania Health System
  - University of Pennsylvania School of Medicine (first medical school in the nation, founded in 1765)
  - Pennsylvania Hospital (nation's first hospital)
  - Hospital of the University of Pennsylvania
  - Presbyterian Medical Center
  - Clinical Care Associates, the network of 270 primary care physicians employed by the system (not all are in Philadelphia)
  - Clinical Practices of the University of Pennsylvania (CPUP) is the mostly specialist faculty of the University of Pennsylvania. Of the 600 to 700 physicians in CPUP, approximately 50 are in primary care fields

  - Philadelphia region's largest health care system
  - Operator of six Philadelphia acute care hospitals as part of Allegheny University Hospital: Hahnenmann, Graduate, City Avenue (formerly the Hospital of the Philadelphia College of Osteopathic Medicine), East Falls (formerly the Medical College of Pennsylvania Hospital), Parkview, St. Christopher's Hospital for Children.
  - Owner of Allegheny University of the Health Sciences, the medical school formed through the merger of Hahnenmann University and the Medical College of Pennsylvania.
  - The third-largest hospital chain in Philadelphia, based on revenues, trailing Jefferson Health System and the University of Pennsylvania Health System.
  - Physician network—more than 450 community-based practices in Pennsylvania and New Jersey
Temple University’s Health Network
- Temple University School of Medicine
- Temple University Hospital
- Northeastern Hospital of Philadelphia
- Jeaneas Hospital
- Neumann Medical Center
- Temple Physicians, Inc., a physician practice network

North Philadelphia Health System
- Girard Medical Center
- St. Joseph’s Hospital

Catholic Health Initiatives
- Nazareth Hospital
- St. Agnes Medical Center

Independent Hospitals
- Chestnut Hill Hospital—affiliated with the University of Pennsylvania Health System
- Children’s Hospital of Philadelphia
- Children’s Seashore House
- Episcopal Hospital
- Fox Chase Cancer Center—American Oncologic Hospital
- Frankford Hospital of the City of Philadelphia—alliance with Jefferson Health System
- Friends Hospital—affiliated with the University of Pennsylvania Health System
- John F. Kennedy Memorial Hospital—alliance with Temple University Health System
- Roxborough Memorial Hospital
- Shriner’s Hospital for Children—Philadelphia Unit
- Wills Eye Hospital

Hunting Park Health Center

Philadelphia Health Services
- Fairmont Health Center
- María de los Santos Health Center

Quality Community Health Care, Inc.
- Finley Place

Spectrum Health Services, Inc.
- Haddington Health Center
- Broad Street Health Center

Philadelphia Department of Public Health
- Eight district health care centers

Primary Health Care Nursing Centers
- Temple Health Connection at Norris Homes and Fairhill Apartments (Temple University)
- Mary Howard Health Center (Philadelphia Health Management Corporation)
- La Salle University Neighborhood Nursing Center (La Salle University)
- Health Annex at Myers Recreation Center (University of Pennsylvania)
- Abbotsford Health Center (Resources for Human Development)
- Schuylkill Falls Health Center (Resources for Human Development)

Largest Physician-Hospital Organizations (PHOs)
- Allegheny Health, Education, and Research Foundation
- University of Pennsylvania Health System
- JeffCare Inc.
- Prestige Health
- The Children’s Health Net

* In order to provide federal and foundation participants a “schematic” of the Philadelphia health marketplace, NHPF compiled this listing from various sources, written and oral, and invited corrections by April 30, 1998. Not intended to include every provider organization in the Philadelphia area, it was used as a reference for the site visit discussions.
Agenda

Sunday, March 29, 1998

6:00 pm  Informal dinner for federal and foundation participants [City Tavern]

Monday, March 30, 1998

7:45 am  Opening breakfast briefings [Sheraton Society Hill—headquarters hotel]

THE PHILADELPHIA HEALTHCARE MARKETPLACE AND ESSENTIAL COMMUNITY SERVICES

Mark V. Pauly, Ph.D., Vice Dean, Wharton Doctoral Programs; Bendheim Professor and Chair, Department of Health Care Systems; Professor of Health Care Systems, Insurance and Risk Management, and Public Policy and Management, Wharton School; Professor of Economics, School of Arts and Sciences, University of Pennsylvania (OVERVIEW)

Christopher P. Gorton, M.D., M.H.S.A., Medical Director, Office of Medical Assistance/Office of Mental Retardation, Department of Public Welfare, Commonwealth of Pennsylvania

Estelle B. Richman, Health Commissioner, City of Philadelphia

Nancy L. Sirolli-Hardy, Senior Vice President, Regulatory and Legislative Affairs, Keystone Mercy Health Plan

PREVIEW OF DAY’S VISITS

10:00 am  Visit to Centers for Family Health’s Abbotsford Community Health Center

   Donna L. Torrisi, M.S.N., Director

   Susan Lum Heckrote, Development Director, Resources for Human Development, Inc.

   Melinda L. Jenkins, Ph.D., R.N.-C.S., Director, Family Nurse Practitioner Program, and Assistant Professor, Primary Care, University of Pennsylvania School of Nursing

11:15 am  Visit to La Salle Neighborhood Nursing Center (Wister St.)

   Katherine K. Kinsey, Ph.D., R.N., F.A.A.N., Director (also Associate Professor and Independence Foundation Chair, School of Nursing, La Salle University)

12:30 pm  Lunch at La Salle University [Dunleavy Room, Student Union], followed by panel discussions

   Zane Robinson Wolf, Ph.D., R.N., F.A.A.N., Dean and Professor of Nursing, La Salle University School of Nursing

1:30 pm  THE NURSING CENTER: NEW DIRECTIONS IN MANAGED CARE [Dunleavy Room]

   Richard J. Baron, M.D., F.A.C.P., Medical Director for Provider Education and Acting Associate Medical Director, Health Partners

   Marjorie Buchanan, M.S., R.N., Senior Program Officer, Independence Foundation

   Neil Goldfarb, Executive Director, MEDISYS QI, Inc.

   Katherine K. Kinsey, Ph.D., R.N., F.A.A.N. (see title above)
Donna L. Torrisi, M.S.N. (see title above)

2:45 pm COMMUNITY HEALTH CENTERS: RECONFIGURATION TO ADDRESS MARKETPLACE CHANGES [Dunleavy Room]
Carolyn G. Baxter, R.N., Executive Director, Spectrum Health Services, Inc.
Patricia (Patti) Deitch, M.B.A., President and Chief Executive Officer, Philadelphia Health Services, and President, Board of Directors, Community Health Network
A. J. Henley, M.H.A., Vice President for Planning and Development, AmeriChoice (former president and chief executive officer of Healthcare Management Alternatives, HMA, the AmeriChoice Medicaid managed care plan in Philadelphia)
Bruce M. Riegel, M.B.A., Director, Health Resources and Services Administration, Northeast Cluster of Field Offices (Department of Health and Human Services Region III)
Claudia H. Siegel, M.A., M.P.A., Project Consultant, Philadelphia Bridging the Gaps Program

4:15 pm Visit to University of Pennsylvania’s The Health Annex at Myers Recreation Center
Lois K. Evans, D.N.Sc., R.N., F.A.A.N., Viola MacInnes Chair, School of Nursing, University of Pennsylvania
Margaret M. Cotroneo, M.S.N., Ph.D., Associate Professor and Chair, Psychiatric-Mental Health Division, School of Nursing, University of Pennsylvania
Beth Ann Swan, Ph.D., C.R.N.P., Practice Director

6:00 pm Reception/dinner with Philadelphia participants [Independence Foundation]
Susan E. Sherman, M.A., R.N., President, Independence Foundation

Tuesday, March 31, 1998

7:45 am Breakfast briefings [Sheraton Society Hill]

THE PHILADELPHIA HOUSING AUTHORITY: PRIMARY CARE PARTNERSHIPS
Frederick Purnell, Deputy Executive Director, Philadelphia Housing Authority
Tine K. Hansen-Turton, M.G.A., Vice President of Program Development, Rehab Options, Inc.

ASSESSMENT OF PREVIOUS DAY AND OVERVIEW OF DAY’S VISITS

9:00 am Bus tour and visit to Project H.O.M.E.
Sister Mary Scullion, M.S.W., Executive Director

SERVICES FOR PERSONS ON THE EDGE [Project H.O.M.E. Community Room]
Louis M. Bonilla, M.A., M.P.A., Executive Director, Consortium for Latino Health
Richard J. Cohen, Ph.D., F.A.C.H.E., Director, Philadelphia Health Management Corporation
JoAnne Fischer, M.S.S., Executive Director, Maternity Care Coalition
Sister Mary Scullion, M.S.W. (see title above)
Ann S. Torregrossa, Esq., Director, Pennsylvania Health Law Project
Lara Carson Weinstein, M.D., Chief Resident, Family Medicine Department, Thomas Jefferson University

10:45 am Departure—Description (on bus) of Community College of Philadelphia’s Zip Code Project
M. Elaine Tagliareni, M.S., R.N., Associate Professor, Department of Nursing
11:00 am  Visit to Philadelphia Health Services’ Maria de los Santos Health Center
  Patti Deitch, M.B.A. (see title above)
  A. Scott McNeal, D.O., Medical Director, Philadelphia Health Services

12:15 pm  Visit to Temple Health Connection at Norris Homes (with Maternity Care Coalition’s Mom-Mobile)
  Barbara Rideout, M.S.N., N.P., Director, Temple Health Connection
  Nancy L. Rothman, Ed.D., R.N., Interim Chair, Department of Nursing, College of Allied Health Professions, Temple University

1:00 pm  Lunch at Temple University [Room 106, Student Faculty Center], followed by tour of Temple University Hospital’s Emergency Department
  Albert P. Black, Jr., M.B.A., Associate Vice President for Behavioral Health and Long Term Care and Associate Hospital Director, Temple University Hospital
  Theresa M. Brodrick, R.N., M.S.N., Associate Hospital Director for Patient Services, Temple University Hospital

2:15 pm  DELIVERY AND FINANCING RELATIONSHIPS AND THE CONTINUUM OF CARE FOR VULNERABLE POPULATIONS [Conference Room C, Student Faculty Center]
  Albert P. Black, Jr., M.B.A. (see title above)
  Natalie Levkovich, Executive Director, Health Federation of Philadelphia, Inc.
  Nancy L. Rothman, Ed.D., R.N., (see title above)

CLOSING DISCUSSION

3:30 pm  Departure for 30th Street Station

4:14 pm  Metroliner departure to Baltimore-Washington
Federal and Foundation Participants

Rhoda Abrams  
*Associate Bureau Director*  
Bureau of Primary Health Care  
Office of Program and Policy Development  
Health Resources and Services Administration  
Department of Health and Human Services

Lynn Cates, M.D.  
*RWJ Health Policy Fellow*  
Committee on Labor and Human Resources  
U.S. Senate

Lynne Davis  
*Senior Legislative Assistant*  
Office of Rep. Ralph Regula  
U.S. House of Representatives

Robin Funston  
*Chief*  
Health and Social Services Branch  
Assistant Secretary for Management and Budget  
Department of Health and Human Services

Carol Galaty  
*Director*  
Office of Program Development  
Maternal and Child Health Bureau  
Health Resources and Services Administration  
Department of Health and Human Services

George Greenberg  
*Senior Advisor*  
Office of Health Policy  
Assistant Secretary for Planning and Evaluation  
Department of Health and Human Services

Marcy Gross  
*Senior Associate*  
Office of Planning and Evaluation  
Agency for Health Care Policy Research  
Department of Health and Human Services

Thomas Gustafson, Ph.D.  
*Deputy Director*  
Office of Strategic Planning  
Health Care Financing Administration  
Department of Health and Human Services

Hope Hegstrom  
*Counsel*  
Special Committee on Aging  
U.S. Senate

Sharon Kearney  
*Technical Information Specialist*  
Education and Public Welfare Division  
Congressional Research Service  
Library of Congress

Bonnie Lefkowitz  
*Associate Bureau Director*  
Bureau of Primary Health Care  
Office of Evaluation, Analysis and Research  
Health Resources and Services Administration  
Department of Health and Human Services

Diane Lifsey  
*Legislative Assistant*  
Office of Sen. John Glenn  
U.S. Senate

Marsha Lillie-Blanton  
*Associate Director*  
Health Services Quality and Public Health  
General Accounting Office

Nelson Miranda  
*Health Systems Specialist*  
Office of Health Care Inspections  
Department of Veterans Affairs

Judith Moore  
*Deputy Director*  
Center for Medicaid and State Operations  
Health Care Financing Administration  
Department of Health and Human Services

Marcia Starbecker, R.N., M.S.N.  
*Nurse Consultant*  
Special Projects Grants Branch  
Division of Nursing  
Health Resources and Services Administration  
Department of Health and Human Services
Patricia Stroup  
_Professional Staff Member_  
Committee on Labor and Human Resources  
U.S. Senate

Caroline Taplin  
_Senior Policy Analyst_  
Office of Health Policy  
Assistant Secretary for Planning and Evaluation  
Department of Health and Human Services

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**NHPF Staff**

_Judith Miller Jones_  
_Director_

_Karen Matherlee_  
_Co-Director_  
_(Site Visit Director)_

_Barbara Skydell, Ph.D._  
_Consultant_

_Dagny Wolf_  
_Program Coordinator_  
_(Site Visit Arrangements Coordinator)_

**Other**

_Peter Pratt, Ph.D._  
_Vice President for Health Policy_  
Public Sector Consultants, Inc., and  
_Program Evaluator_
Biographical Sketches—
Philadelphia Participants

Richard J. Baron, M.D., F.A.C.P., is medical director for provider education and acting associate medical director of Health Partners. Before assuming that position in November 1996, he was for eight years the organization’s chief medical officer and senior vice president for medical affairs. He is also president of Greenhouse Internists, PC, a community-based market-risk primary care medical practice, and assistant professor at the Medical College of Pennsylvania/Allegheny University.

Carolyn G. Baxter, R.N., is executive director of Spectrum Health Services, a post she has held since 1979. After joining the organization in 1969, she served first as its director of nursing and then as director of clinics. Ms. Baxter was also president of the Health Federation of Philadelphia between 1990 and 1996 and, for the past two years, has been first vice president of the Philadelphia Citizens for Children and Youth.

Albert P. Black, Jr., M.B.A., has been associate vice president for behavioral health and long term care and associate hospital director at Temple University Hospital since 1985. His previous experience includes 10 years as vice president for administration, Egleville Hospital.

Louis M. Bonilla, M.A., M.P.A., since 1994 has been executive director of the Consortium for Latino Health, a coalition of hospitals, HMOs, insurers, Latino community organizations, and other organizations that focus on reducing barriers to health care for Philadelphia’s Latino population. He is also a national fellow in the W. K. Kellogg Foundation national leadership program.

Theresa M. Brodrick, R.N., M.S.N., is associate hospital director for patient services, Temple University Hospital. Before joining Temple in 1997, she was director of nursing at Presbyterian Medical Center for six years. Since 1993, Ms. Brodrick has also been a clinical associate and part-time faculty member at Villanova University.

Marjorie Buchanan, M.S., R.N., has been senior program officer at the Independence Foundation since 1996. Earlier, she was a consultant to the foundation on nursing centers and primary health care. Her prior experience includes service as project director of the Philadelphia Department of Public Health’s Healthy Start Initiative and as director of community services and grants management for the Philadelphia March of Dimes. For seven years before that, she held the post of assistant professor at Thomas Jefferson University.

Richard J. Cohen, Ph.D., F.A.C.H.E., is president and chief executive officer of the Philadelphia Health Management Corporation. Before accepting that position in 1989, he was for nine years the corporation’s executive director. Previous experience includes seven years with the City of Philadelphia’s Coordinating Office/Drug and Alcohol Abuse Programs, where he served first as treatment coordinator and associate director, then deputy director, and finally as acting director. Prior positions include director of drug treatment, St. Luke’s Children’s Medical Center, and assistant director, Project Upward Bound, at Temple University.

Margaret M. Cotroneo, R.N., Ph.D., faculty director of the Health Annex Family and Community Health Center, is also associate professor of psychiatric-mental health nursing and chair of the Psychiatric-Mental Health Division, University of Pennsylvania School of Nursing. She also holds a secondary appointment as associate professor of nursing in psychiatry. Before joining the school in 1986, she was for ten years a family therapist and supervisor of the Family Psychiatry Department, Eastern Pennsylvania Psychiatric Institute.

Patricia (Patti) Deitch, M.B.A., is president and chief executive officer of Philadelphia Health Services. She was previously an assistant vice president at the Medical College of Pennsylvania Hospital and Allegheny Health Education and Research Foundation. She has also served as administrator of the pediatric faculty practice at Cooper Hospital and as a health care loss control specialist at CIGNA. Ms. Deitch is currently president of the board of Community Health Network.

Lois K. Evans, D.N.Sc., R.N., F.A.A.N., is professor and director, Academic Nursing Practices, School of Nursing, University of Pennsylvania. A faculty member at the university since 1984, she has also served as associate professor and director of geropsychiatric nursing and executive director of the CARE Program. Before moving to Philadelphia, she held several other positions, primarily
in Washington, D.C.; among these were chair of nursing practice and nursing education, Greater Southeast Community Center for Aging; director of nursing at the 180-bed Health Care Institute; project director, Robert Wood Johnson Teaching Nursing Home; and faculty positions at Georgetown University School of Nursing.

JoAnne Fischer, M.S.S., is executive director of the Maternity Care Coalition, a position she has held since 1989. Her career has also included stints as vice president, maternal child specialty home care, at Family Help, Inc.; director of parenting, social services, childbirth education, and adolescent programs at the Booth Maternity Center; and acting center director, Camden Area Health Education Center, at the College of Medicine and Dentistry of New Jersey. In addition, Ms. Fischer served as director of the Women’s Health Concerns Program of the Pennsylvania Department of Health.

Neil Goldfarb is executive director of MEDISYS QI, Inc., a healthcare management consulting firm specializing in quality improvement and medical record review. Prior to launching this company in 1997, he spent five years as vice president of health services and provider relations for Healthcare Management Alternatives, a large Medicaid HMO. Mr. Goldfarb’s career includes more than 15 years in health services research positions at the University of Pennsylvania and Thomas Jefferson University. He remains a senior fellow of Penn’s Leonard Davis Institute of Health Economics and a research consultant to Jefferson’s Office of Health Policy and Clinical Outcomes.

Christopher P. Gorton, M.D., M.H.S.A., has been medical director of the Pennsylvania Department of Public Welfare’s Office of Medical Assistance Programs (OMAP)/Office of Mental Retardation since 1996. His previous positions with the department were medical director of the Hamburg Center and pediatric consultant for OMAP. After completing his pediatric residency at Tufts New England Medical Center in 1987, Dr. Gorton was staff pediatrician at several community health centers.

Tine K. Hansen-Turton, M.G.A., is vice president of program development for Rehab Options, Inc., in Bala Cynwyd, Pennsylvania, a position she has held since November 1997. She was previously special assistant to the executive director, Philadelphia Housing Authority. She is an advisory board member of the Regional Nursing Centers Consortium.

Susan Lum Heckrote is development director for Resources for Human Development, Inc., a post she has held since 1985. She was previously program director for the organization’s Point-to-Point program, where she directed a transportation program serving elderly and disabled people in the greater Philadelphia area.

A. J. Henley, M.H.A., is vice president for planning and development of AmeriChoice. He was previously president and chief executive officer of Healthcare Management Alternatives, the AmeriChoice Medicaid managed care plan in Philadelphia, for more than five years. During his more than 35 years in the healthcare field, Mr. Henley has held positions in both the public and the private sectors, including executive director of Greater Philadelphia Health Action, Inc., primary care branch chief of the Division of Health Services Delivery of the U.S. Department of Health and Human Services; and deputy commissioner for environment and specialized health services for the Philadelphia Department of Health.

Melinda L. Jenkins, Ph.D., R.N.-C.S., is director of the Family Nurse Practitioner Program and assistant professor of primary care, University of Pennsylvania School of Nursing. She began her career as a nurse practitioner in 1983 and, since 1992, has been a family nurse practitioner at Abbottsford Community Health Center. She has co-authored several journal articles on advanced practice nursing and primary care.

Katherine K. Kinsey, Ph.D., R.N., F.A.A.N., is director, Neighborhood Nursing Center; associate professor; and Independence Foundation chair, all at La Salle University School of Nursing. Prior to accepting her current positions in 1996, she was assistant professor and director of home visiting and outreach at the Neighborhood Nursing Center. Previous experience includes service as director, R.S./B.S.N. program, and assistant professor, Thomas Jefferson University; public health coordinator and then public health consultant at Osborn Family Health Center in Camden, New Jersey; and hospice/home care public health nurse.

Natalie Levkovich has been executive director of the Health Federation of Philadelphia, Inc., since 1987, having previously served as the federation’s director of program development. Under her leadership, the federation launched Philadelphia’s first lay home visiting program (with funds from the William Penn Foundation) and established the Maternal and Child Health Training and Resource Center (with Department of Health and Human Services funds). Since beginning her management career in 1973, Ms. Levkovich has also held positions at Colonial Penn Life Insurance Company, Paul Revere Life Insurance Company, and the Bank of America.

A. Scott McNeal, D.O., has been medical director of Philadelphia Health Services for over four years. Board-certified in family practice, he is director of medical
education at North Philadelphia Health Systems, St. Joseph’s Hospital, where he runs a family practice residency training program that is incorporated into all the clinical sites operated by PHS. He is also the chairman of family medicine at St. Joseph’s, an associate professor in family medicine at the Philadelphia College of Osteopathic Medicine, and clinical instructor at Temple University Medical School and University of Pennsylvania Nursing School.

Mark V. Pauly, Ph.D., holds the positions of vice dean of the Wharton doctoral programs, Bendheim Professor, and chair of the Department of Health Care Systems. He is professor of health care systems, insurance, and risk management and of public policy and management, at the Wharton School as well as professor of economics in the School of Arts and Sciences at the University of Pennsylvania. Previously with the Leonard Davis Institute of Health Economics, he served as its director from 1984 to 1989 and its director of research between 1989 and 1995. Before joining Pennsylvania’s faculty, he was a visiting research fellow at the International Institute of Management in Berlin and a professor of economics at Northwestern University.

Estelle B. Richman is health commissioner for the City of Philadelphia. Formerly deputy health commissioner for mental health, mental retardation, and substance abuse, Ms. Richman served as acting commissioner for several months before being appointed to her present post in 1994. She joined the Philadelphia Department of Public Health as the director of mental health in 1989.

Barbara Rideout, M.S.N., N.P., is director of Temple Health Connection and adjunct professor, Department of Nursing, Temple University. Her 28-year career in nursing also includes stints as pool nurse for medical-surgical pediatrics at City Avenue Hospital, an ET nurse consultant at Etris Associates, and director of nursing education and quality assurance at Graduate Hospital.

Bruce M. Riegel, M.B.A., is director of the Health Resources and Services Administration (HRSA), Northeast Cluster of Field Offices, Division of Health Services (Department of Health and Human Services Region III), in Philadelphia. Before accepting his current position, he was for five years director, HRSA Office of Consultation, Analysis, and Evaluation.

Nancy L. Rothman, Ed.D., R.N., is interim chair of the Department of Nursing, College of Allied Health Professions, Temple University, where she is also associate professor and Independence Foundation professor of urban community nursing. Her previous experience includes faculty positions at Thomas Jefferson University (1990 to 1995) and Villanova University (1980 to 1990).

Sister Mary Scullion, M.S.W., a co-founder of Project H.O.M.E., has been its executive director since the project’s inception in 1989. She also co-founded and was from 1978 to 1990 director of Women of Hope Residences and Outreach Coordination Center. Between 1982 and 1995, she co-founded and served as vice-president and then president of Philadelphians Concerned about Housing. Since 1995, she has been a member of the Board of Managers of Mercy Hospital of Philadelphia. She also serves on the Board of Managers of Misericordia Hospital and on the Board of Trustees of St. Joseph’s University, both in Philadelphia.

Susan E. Sherman, M.A., R.N., has been president of the Independence Foundation since 1996 and previously served for three years as the foundation’s secretary-treasurer. From 1980 to 1996, she was professor and head, Department of Nursing, Community College of Philadelphia, and before that was an educational consultant for the National League for Nursing.

Claudia H. Siegel, M.A., M.P.A., is project consultant for the Philadelphia Bridging the Gaps Program. She also serves as project consultant for the Health Care Professional Development Commission, Indiana State Department of Health. Among her previous positions are associate director, Section of Community Health, Department of Family Medicine, Jefferson Medical College; director, Primary Care Institute, Temple University School of Medicine; executive director, Center for Rural Health Initiatives, Texas Department of Health; and director of medical programs, Texas Higher Education Coordinating Board, Office of the Deputy Commissioner.

Nancy L. Sirolli-Hardy is senior vice president, regulatory and legislative affairs, Keystone Mercy Health Plan, a position she has held since 1993. Before joining Keystone, she was a government relations lobbyist and consultant with S. R. Woydak and Associates for four years. From 1981 to 1989, she was with the Pennsylvania Department of Public Welfare, where she served first as a medical assistance program specialist and then as acting bureau director for managed care.

Beth Ann Swan, Ph.D., C.R.N.P., is practice director of the Health Annex at Myers Recreation Center. Before accepting that position in 1997, she was for three years lecturer, University of Pennsylvania School of Nursing, Adult Health and Illness. She served between 1990 and 1994 as director, Admission Evaluation Center, Hospital of the University of Pennsylvania.
M. Elaine Tagliareni, M.S., R.N., is an associate professor of nursing and the Independence Foundation chair in community-based nursing education at Community College of Philadelphia. An associate degree nursing educator for the past 15 years, she served as project director for the Philadelphia site of the W. K. Kellogg Foundation-funded Community College-Nursing Home Partnership from 1989 to 1994. She also holds a nursing faculty position at the Community College of Philadelphia.

Ann S. Torregrossa, Esq., director of the Pennsylvania Health Law Project, has been a legal services attorney for 28 years, specializing in health law for the past 16. She is author of legislation that created Pennsylvania’s Children’s Health Insurance Program. She is also an adjunct professor at the University of Pennsylvania, teaching a course on emerging issues in publicly funded managed care for law, medical, M.S.W., and graduate nursing students.

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