# THE other CITY HOSPITAL

*When The Cambridge Hospital merged with Somerville Hospital, it got far less local attention than Boston City Hospital's deal with Boston University Medical Center. But the scrappy public institution across the river is helping to set the pace for health-care reform nationwide.*

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BY ROBERT KEOUGH

The story sounds familiar: A major public hospital, one of the few left in Massachusetts, sheds its ties to city government and joins forces with a neighboring private, nonprofit hospital. Only by cutting the municipal umbilical cord, it is argued, can the healer of last resort survive to fulfill its mission of bringing medicine to the masses. And only through a merger can the two institutions, each with uncertain finances, bulk up for the battle of heavyweights that health care in Greater Boston has become.

Boston City Hospital, right? Well, yes and no.

On July 1, the same day that BCH – to much fanfare and with considerable acrimony – merged with Boston University Medical Center Hospital, The Cambridge Hospital quietly converted from city agency to public authority and merged with private, nonprofit (and nonmunicipal) Somerville Hospital.

Despite the similarity – and simultaneity – of the two events, the stories unfolded very differently. In the Cambridge transformation, there were no threats from the unions, no charges of abandoning a public mission, no nail-biting City Council votes a day before the legislative deadline. And while BCH disappeared from view, dissolving into the ambiguously named Boston Medical Center (does the medical center belong to the city or just reside there?), Cambridge Hospital absorbed Somerville Hospital into a growing health-care network that bears the Cambridge Hospital name.

"They're going in opposite directions," says Rob Restuccia, executive director of Health Care for All, a statewide patient advocacy group. "Boston is backing away from its historical commitment toward health care, trying to limit its liability in a world where competition has become the driving force. In Cambridge, the institution has become even more committed to the health care of its citizens."

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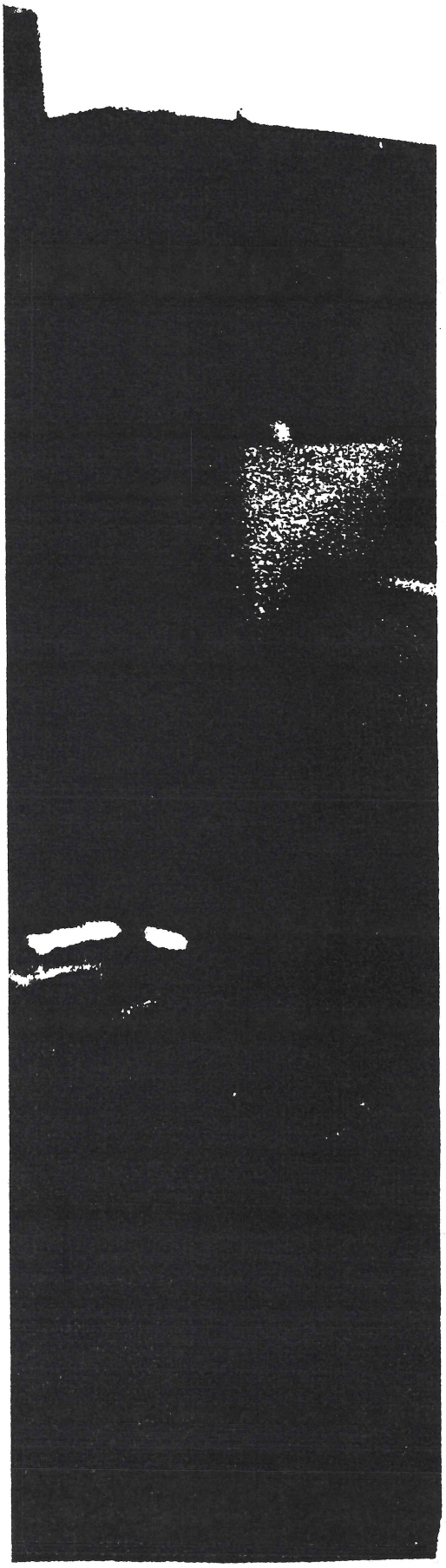

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## The other hospital

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Not everyone would agree that Boston is in retreat. But no one disputes that Cambridge is on the move. Overshadowed locally by its larger (and noisier) counterpart across the Charles River and by the dozen renowned private hospitals that dominate Boston medicine, Cambridge Hospital has made a national reputation in health-care circles for its innovation and community service. And while hospitals across the country are shrinking and merging into oblivion, Cambridge's little-hospital-that-could is expanding its market and its reach.

It has done so in part by capitalizing on premium payments it gets for serving the uninsured, payments that rankle other struggling hospitals, which currently fund those payments. But Cambridge Hospital is also charting a course in urban medicine that the entire health-care world is watching. "Rather than be overshadowed [by larger competitors], Cambridge Hospital chose to be a beacon in its own community," says Dick Davidson, president of the American Hospital Association. "In doing so, it became a national model."

Cambridge's community-service mission "is an important vision to sustain when so much in modern health care is being bought and sold and so many hospitals are run just like any business enterprise," says Paul Jellinek, vice president of the Robert Wood Johnson Foundation, a major funder of health-care innovations. Indeed, while the question at Boston Medical Center is whether the new hybrid institution will fully embrace the BCH mission of health care for the poor, the question posed in Cambridge is this: Can a hospital devote itself to the health of the community, not just its own bottom line, and survive?

The man providing the acumen behind Cambridge Hospital's bold strategy is an unlikely visionary: a 20-year city employee who has never worked outside the four walls of the hospital. Whereas Boston turned to a private-sector leader, former BU Medical Center head Elaine Ullian, to lead the merged Boston Medical Center, Cambridge continued to rely, as it had for the past decade, on John O'Brien, public servant. But O'Brien is more public-sector entrepreneur than bureaucrat, health-care experts say.

"John O'Brien is trying to shape the future role of hospitals," says state Rep. John McDonough, a Democrat from Jamaica Plain and the Legislature's leading expert on health care. "The reputation of public hospitals nationally is that they're less than first-class. At Cambridge, he's been able to create a reality and an image of a place that is vibrant, on the move, cutting-edge."

THE FARE IS COFFEE AND cookies, not champagne, but at Cambridge Hospital's first monthly management meeting post-merger and post-secession, the mood is celebratory. "It's a wonderful day," says O'Brien as he stands before an auditorium full of department chiefs, neighborhood health-center directors, program heads, and their Somerville counterparts. He calls Carl Zack, who remains the president of Somerville Hospital but will report to O'Brien, to the front of the room. "We have a little gift for you – very little." He hands Zack a Cambridge Hospital Community Health Network T-shirt. "If we were private, I'd be giving out clocks."

Then he gets down to business. "We're going toward immediate integration of the two hospitals," declares O'Brien. "Unlike a lot of systems, we're jumping in right away. We just do not have the luxury of time."

The medical staffs will merge straight off, and as administrative positions open up, they will be consolidated into a single post-for both hospitals. This fall, Cambridge's addiction-treatment unit moves to Somerville, joining an existing unit there – and creating the awkward situation of better-paid, unionized Cambridge nurses and support staff working side by side with lower-paid, non-union Somerville employees. Time will tell how the pay and power inequities will be resolved.

Nor is the deal-making done. Soon O'Brien will be negotiating an affiliation with one of the big boys of Boston health care, such as Partners HealthCare System, the Massachusetts General-Brigham and Women's conglomerate, or Pathways Health Network, the Beth Israel-Deaconess combination. Last spring, Mount Auburn Hospital, in Cambridge, announced a merger with the Beth Israel network. That deal, O'Brien explains, "puts pressure on us to move quickly."

JOHN O'BRIEN'S SENSE of urgency is palpable, and appropriate. The let's-make-a-deal atmosphere of hospital agglomeration is just one of the crushing pressures on public hospitals, the endangered species of the health-care habitat. Between 1980 and 1993, nearly one-quarter of the nation's public hospitals disappeared. While public hospitals controlled about one-third of the nation's beds in 1950 and one-seventh in 1980, they control less than 10 percent today, according to Alan Sager, of the Boston University School of Public Health.

In part, the disappearance of public hospitals is just a special case of the frenzied competition and consolidation that have recently replaced boundless expansion as the defining feature of the hospital business. Managed care has put pressure on hospitals to cut prices and shorten stays, leaving beds vacant. Competition to fill those beds has heated up to the point that patients, such as those on Medicaid, once gladly left to public hospitals, are fought over.

A year ago, in California, Los Angeles County threatened to close all its public hospitals; only a last-minute federal bailout kept them open. In New York City, Mayor Rudolph W. Giuliani has put three city hospitals up for sale. As for Massachusetts, the commonwealth at one time boasted 20 municipal hospitals. Before the July 1 conversions, just four remained: Boston City, Cambridge, Quincy, and Hale, in Haverhill.

Trying to survive a devolutionary process that Sager calls "survival of the fattest," public hospitals across the country are doing what Boston City and Cam-

bridge have done: freeing themselves from the constraints of city management and seeking out business partners in the medical private sector. "Public hospitals are going broke, and small ones are going broke faster," says Richard deFilippi, chairman of Cambridge Hospital's governing board before the merger and now chair of the Cambridge Public Health Commission. "So maybe we've got to stop being small and stop being municipal."

Small was not the problem for BCH, but municipal was. Judith Kurland, commissioner of health and hospitals under Mayor Raymond L. Flynn, broached the idea of a public-authority spinoff in 1992, but to no avail. By 1994, however, both BCH and its Harrison Avenue neighbor, Boston University Medical Center Hospital, faced grim prospects on their own, so a new mayor, Thomas M. Menino, and a close ally, Ullian, of the BU Medical Center, began an institutional courtship. It took two years to seal the deal, and only on the morning of the June 30 City Council vote did Ullian, who had refused to bargain with the BCH interns-and-residents association, agree to abide by a union-recognition vote to be held one year after the merger, avoiding an 11th-hour deal breaker.

In Cambridge, there was little furor. The unions were brought into the merger process early on and, after some initial skirmishes, were assured that conversion to an authority would not be used to break the unions or extract concessions. O'Brien's track record didn't hurt. "Frankly, John's leadership in the time he's been there has proved to be successful," says Alice Kessler, business agent for the Cambridge house officers' association. "That's sort of hard to argue with."

TALL AND LANKY, O'BRIEN, who is 46, strides purposefully through the hallways of the only workplace he has known since college. O'Brien on the prowl is a familiar sight around the hospital. He knows an astonishing number of employees by name and greets each one with a broad grin framed by a salt-and-pepper mustache.

Indeed, there is an intimacy to Cambridge Hospital – and to Cambridge politics – that O'Brien both enjoys and uses to great advantage. "There's a village mentality there, in the best sense of the word," says Judith Kurland.

Things at the hospital can be a bit too intimate, partly a function of its recent success. Ambulatory visits have leaped from 100,000 in 1987 to 250,000 a year now, and exam rooms in the 30-year-old main building are always at a premium. The hospital's patients range across the social spectrum. "In one bed, there could be a Harvard professor who isn't feeling well," says Dr. Thomas Workman, chief of the emergency department. "In the next, there'll be someone who lives on the streets." Since one out of two patients is an immigrant, Workman says, "every attending [physician] sees malaria, typhoid fever . . . "

Upstairs, there is crowding as well, some of it self-imposed. As in every hospital, inpatient care is declining, and one-third of Cambridge's 176 beds are empty on average. With a seasonal drop-off of surgical admissions, the hospital closed a unit for the summer, to save money. Some days, space was so tight that new admissions had to be postponed.

This fall, construction begins on a $60 million upgrade of the facility. But a new ambulatory-care center and two stories of underground parking will simply be the brick-and-mortar manifestation of a more profound renovation O'Brien has had under way at Cambridge Hospital since he took the helm, in 1986. It's a transformation that has led, by a surprising route, to the cutting edge of community medicine.

O'BRIEN GREW UP IN ARlington, with four brothers and five sisters. His father, a schoolteacher, died suddenly of a heart attack when John was 12. His mother, Eleanor, went to work as an administrative assistant in a Massachusetts Institute of Technology research office to support the family. "She had us convinced we were affluent," remembers O'Brien.

In 1968, O'Brien entered Harvard College; rebellion was in the air. But "O.B.," as his roommates called him, got his politics as much from his mother as from his peers. "She was just the most warm and caring person," he says. "She was focused on equity and social justice, if you will."

O'Brien emerged from Harvard with an economics degree but no direction. At the urging of his brother-in-law Bill Lane, an administrator at Methuen's Holy Family Hospital, he entered Boston University's business-administration program, concentrating in hospital management.

In 1976, O'Brien presented himself to Les MacLeod, administrator of what was then Cambridge City Hospital (renamed The Cambridge Hospital in 1981). O'Brien said he wanted to work in a public hospital and would take any job; he started out as an outpatient-registration supervisor, then worked his way up the ladder. "I loved it from day one," O'Brien recalls.

He became controller, then chief financial officer of the hospital. It was a time of turmoil. Several chief executives came and went, a search fizzled out, and, in 1986, O'Brien found himself chief executive officer. It wasn't entirely a natural succession. "People can be prejudiced against CFOs – you know, bean counters," says O'Brien. But Robert Healy, Cambridge's city manager, thought a finance guy was just what Cambridge Hospital needed. "I felt that John, with his strong financial perspective and strong social consciousness, would be the person who could turn the institution around," says Healy, who appointed him. "If he couldn't do it, we would have had to consider getting out of the hospital business."

O'Brien got off to an inauspicious start: In his first year, the hospital posted a record loss of $10 million. "We took a hard look in the mirror, and it wasn't pretty," says O'Brien. There was inefficiency, patronage, government-job work ethics, and condescension, if not hostil-

ity, toward patients – "all those traits associated with city hospitals."

But, most damning of all, the hospital was out of touch with its city. Cambridge's large and growing immigrant communities – Haitian, Central American, Portuguese, Brazilian, and Indian – "were not on our radar screen." If the hospital couldn't make more of a connection, O'Brien concluded, "not only were we going to close, but very few tears would be shed."

O'BRIEN PUT AN END TO competing agendas among the Harvard Medical School-affiliated medical staff and established a single mission: providing primary care to Cambridge's diverse population. This mission led to a marketing strategy geared toward the least lucrative of targets: the poor and uninsured. Patients whom other hospitals grudgingly tolerated – if they didn't put them in a cab bound for Boston City Hospital – Cambridge sought out.

What made that strategy work was government funding of free care. In 1985, the state had created the uncompensated-care pool, funded by a surcharge on hospital bills paid by insurers. The $315 million fund became the financial lifeblood of BCH and a growth opportunity for Cambridge Hospital.

Cambridge reached out to underserved populations with a flurry of new programs: a multidisciplinary AIDS program; a health clinic for teen-agers at Cambridge Rindge & Latin High School, the first school-based clinic in the state; house calls for shut-in elderly and a recently opened Senior Health Center; and a Men of Color Task Force, which visits private social clubs and hosts Hoops for Health, a basketball tournament-cum-health fair. In 1993, programs like these won Cambridge Hospital the Foster G. McGaw Prize, the hospital industry's highest honor nationally for community service.

And the new business – subsidized by $3 million a month from the free-care pool, which covers 37 percent of the hospital's patients – put Cambridge Hospital in the black for the first time since its founding, in 1917. Since 1991, when it first broke even, the hospital has amassed cash reserves of more than $82 million, which the hospital has taken with it, not without controversy, into public-authority independence.

"He made money taking care of people who had no health coverage," says City Councilor Anthony Galluccio, who pressed for the closest scrutiny of the hospital's finances during the conversion, with some wonderment.

Not that there have been no missteps. The hospital's relations with its neighbors remain touchy. It took months of negotiation – and costly concessions by the city – to get the Mid-Cambridge Neighborhood Association to drop its opposition to the impending hospital construction. Residents just over the city line in Somerville are as hostile as ever to the methadone and needle-exchange programs that, they say, infest their neighborhood with addicts.

And early last year, O'Brien drew fire from his own board members when he considered closing the hospital's maternity service. New obstetrics units at New England Medical Center and, especially, Mass. General had cut the number of the hospital's deliveries. But the board would not hear of abandoning childbirth at Cambridge Hospital. "It's a very central thing for a community hospital to have babies," says board member and former mayor Barbara Ackermann.

O'Brien reversed course, pledging to upgrade labor-and-delivery facilities. The merger will help, because Somerville's 250 deliveries a year will be referred to Cambridge instead of to Saint Elizabeth's, in Brighton. But in light of the competitive pressures ahead of them, it worries O'Brien that the idea of giving up a service could be portrayed as heresy. "Many people were holding on to a view that we had to offer a full array of services to be a competitive hospital," he frets.

Still, the business turnaround and community-service revival have been dramatic enough to give Cambridge Hospital a solid local following and a national reputation. "John has done a terrific job with what had been a moribund hospital," says Larry Gage, president of the National Association of Public Hospitals. "He's certainly one of the better hospital administrators in the country, and I don't limit that to public hospitals. There are a number of institutions out there that would love to pry him away."

Indeed, O'Brien could easily parlay his achievements into a more lucrative position in a private hospital, where, according to industry sources, CEO salaries average $346,000 – three times what he makes now. But for O'Brien, who is married, with two children, there's nothing like being in a place where he can get things done. Several years ago, Kurland tried to recruit him to Boston, but "he just laughed," she says. "He thinks working in Cambridge is a delight. He often said to me, 'Judith, you come up with the ideas, and I'll do them in Cambridge.' "

RUNNING A CITY hospital puts John O'Brien at the nexus of health-care reform, business management, and politics – three disciplines that O'Brien practices with equal enthusiasm. And under O'Brien – thanks in part to the enthusiastic support of Charlie Flaherty, the Cambridge representative and former House speaker, Cambridge Hospital has fared well in legislative battles. But O'Brien's leadership, particularly as an officer and, for a year, chairman of the Massachusetts Hospital Association, has also helped reshape the ethos and image of the industry as a whole. "He helped us recognize the importance of having a clear and explicit set of values and of keeping those values front and center," says Ron Hollander, president of the MHA. "When we go to testify, we're not there just to talk about the [free-care] pool, but also about access. That serves us well."

But Cambridge's political success makes it a target as well. As hospital free-care expenses have grown, while the pool has not, most hospitals have seen their reimbursement fall to pennies on the dollar. But because the Boston and Cambridge city hospitals have a disproportionately large share of uninsured patients – making the loss of free-care funds particularly damaging – the two institutions persuaded the state, in 1991, to keep their reimbursements at more than 90 percent of their free-care costs. This advantageous financing, in part, made the hospitals attractive merger partners for BU Medical Center and Somerville.

"Boston City and Cambridge hospitals have both done quite well with favorable treatment from the uncompensated-care pool," says Stanley Krygowski, president of Malden Hospital. "They've been able to take advantage of this funding to enhance their cash position and serve their communities better than

they could without it."

And it's an arrangement that increasingly comes at the expense of hospitals like Malden. In this era of intense bargaining in the health-care marketplace, the free-care surcharge has all but disappeared, as hospitals cut the prices they charge managed-care organizations and other insurers. Now, when suburban hospitals make their monthly payments into the state-administered pool – funds they previously collected from insurers – it seems like money taken out of their own pockets and given to the two city hospitals. "There are a lot of people with their knives out" for Cambridge and Boston, says McDonough, the legislator.

BUT THERE IS NO greater threat to the new Cambridge and Somerville partnership than that posed by the health-care marketplace in the Boston area. "They have to be viewed as acceptable, equal, or even better alternatives to the world's greatest hospitals," says Ann Thornburg, health-care partner at Coopers & Lybrand. "That's a challenge."

Cambridge Hospital, however, is already a few steps ahead of the world's greatest hospitals in an area critical to the industry's future: primary care. Only in this era of managed care have the mega-hospitals discovered the virtues of routine and preventive medical care, by which they capture both a bigger chunk of the managed-care dollar and future candidates for inpatient services. Thus, Mass. General gobbles up suburban medical practices, and Beth Israel buys Boston's Bowdoin Street Health Center in order to form their own "health networks."

But the Cambridge Hospital Community Health Network starts off with seven neighborhood health centers, which, unlike even Boston's, are owned by the hospital and staffed by its doctors. It's a competitive leg up that Cambridge owes, ironically, to its public-health mission. "Perhaps public hospitals understood sooner that causes of disease had nothing to do with medicine and hospitals," says Kurland. "If you can do a public-health approach, you can save money, and insurers ought to want to do business with you."

A primary-care focus is not, by itself, enough to bring customers – and their payers – through the door and keep them coming back. O'Brien knows his traditionally high-cost hospital also has to cut expenses. His point man for this drive is James Schlosser, the hospital's chief clinical officer. An internist and business-school graduate, Schlosser has put more than 500 hospital employees – from chiefs of service to dietary workers – through so-called quality-improvement training in the past three years.

But training was not enough. A year ago, Schlosser talked O'Brien into a management overhaul that broke down traditional hierarchies. The shake-up pushed some Cambridge Hospital stalwarts out the door, which made it "personally difficult" for O'Brien, Schlosser observes. "These are people he grew up with, people who supported him, deputies who helped him win the McGaw Prize," says Schlosser. "But he put the goal of improving the hospital ahead of his personal connection."

Even those who left following the shake-up voice no complaints, however. "Change was in order," says Judy McTiernan, a former associate administrator and nursing director who is now associate director of the University of Massachusetts Medical Center, in Worcester. "Essentially, eliminating the senior [management] structure as it was in the past was something we all talked about. It's not something that got done in the dark of the night."

The result is a hospital abuzz with improvement projects – 300 at last count. "Despite everything we have achieved," says O'Brien, "we need to lean into the discomfort of change" – even when that means hiring somebody to kick O'Brien's own butt. A new program called "Somerbridge" – one of 25 demonstration projects in community care funded nationwide by the American Hospital Association and the Kellogg Foundation – has the program's director, Mark Rukavina, out looking for ways in which the Cambridge and Somerville hospitals are failing underserved groups.

For Rukavina, who as a former community organizer for Health Care for All has long been a thorn in hospitals' sides, it's a dream job. "I really wanted to figure out how to do what I do with the support of an institution," he says. "I'd tell this to people, and they'd say, why would anyone want to hire you to raise hell and make their lives more difficult? I'd say, I guess it would have to be a special place. And I found one in Cambridge Hospital." ▭