

# Introduction

## *The Northern Manhattan Community Voices Collaborative*

ALLAN J. FORMICOLA and LOURDES HERNÁNDEZ-CORDERO

The Great Society legislation of the 1960s started a social, economic, and medical transformation in America signaling to all that poor people and older people should have access to health care supported by government sponsored insurance. With the enactment of Medicaid and Medicare, particularly, many believed that such access would no longer be a privilege, but a right for everyone. However in the intervening years we have learned that the government and private system of health care has still left approximately 45 million Americans with no access to basic health care coverage, and that there are well over 108 million Americans with no dental insurance. America's unique and historical link between health care insurance coverage and some forms of employment is partly responsible for this gap.

However, while our spotty insurance coverage furnishes part of the explanation, it does not account for the whole picture of the health of our nation. In addition, even for many full-time employed Americans, there are large gaps in health status based on race, ethnicity, and income. Reports from the Institute of Medicine, such as *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, Stith, and Kelson 2003), urge a keener sense of cultural awareness to improve the health of all Americans. Greater attention to poor health behaviors through prevention and better management of chronic disease can lead us to a higher

quality of health while containing costs. These reforms to improve the health care system in the United States are now well known and their effectiveness well documented. As we completed this book in the fall of 2009, the nation was once again in the midst of actively considering reforms to the health care system that will cover all Americans and improve the quality of care. It is clear to us, however, that no matter how the debate turns out—the compromises that government will make to provide greater access to health and the systemic changes that the medical field puts into place to improve the quality of care—there will continue to be underserved population groups living in inner cities and rural areas that are marginalized in regard to health. These groups will continue to depend on a safety net of providers—some of them outside the formal health care system—to serve them.

The safety net, however, is ill defined, stretched thin, and difficult to access. While this book is not a cure-all, it deals with how northern Manhattan, an underserved low-income area, brought together a wide collaboration to shore up the safety net and make the health care system more responsive to local conditions. Solutions to health care system problems will be found at the national and state levels, but it is the changes that happen at the local level that can have a major impact on improving health. This book tells the story of how, through an academic–community partnership, a group of organizations went about making strategic changes to improve health care access and preventive care for its constituents.

In the late 1990s the W. K. Kellogg Foundation recognized that community-driven change has the potential to improve access and quality for the most vulnerable members of our society. In the call for proposals, the foundation recognized the importance of the safety net in providing basic care for underserved populations. In 1998 it launched a major \$55 million initiative, *Community Voices: Health Care for the Underserved*, to form local partnerships to undertake grass-roots efforts to make the health care system better for their residents. The foundation selected thirteen sites from around the nation. At the same time as this book is published, a book describing the national *Community Voices* program will also be published by Jossey-Bass. Entitled *Community Voices: Health Matters*, the book has descriptions of all of the participating sites.

This book tells the story of one of the thirteen sites funded by the Kellogg Foundation, the Northern Manhattan Community Voices Collaborative (NMCVC). It describes the development of partnerships, the challenges

faced by the collaborating entities, the processes put into place, and the outcomes, both successful and unsuccessful, between people in the institutions and community-based organizations striving to make northern Manhattan a healthier and better place to live.

For ten years, from 1998 to 2008, the NMCVC brought together leaders from institutions, churches, and community-based organizations to carry out a far-reaching plan to improve the general and oral health in the Washington Heights/Inwood and Harlem communities. With a high proportion of African Americans (in Harlem) and Latinos (in Washington Heights/Inwood), the socioeconomic markers and community health profile showed that both communities suffered from many of the problems typical of inner city residents.

Northern Manhattan has a population of approximately 400,000 people living in crowded neighborhoods and facing challenges related to poverty and the synergy of comorbidities of asthma, diabetes, and a host of other chronic illnesses. During the decade, managed care for the Medicaid population was being phased into the community, thus complicating many of the long-standing relationships that had built up between providers and community residents. There was considerable unrest in the community over health care issues. In general, the residents were suspicious of the large institutions in the community, which included Columbia University, Columbia University Medical Center, New York Presbyterian Hospital, and Harlem Hospital, because of past grievances about job opportunities, research studies without a lasting service component or translating the results into practice, and facility expansion plans in the neighborhoods.

Each of the communities has its own distinct character. Harlem is steeped in the African American culture, predicated partly on the fact that local churches are expected to provide important religious—as well as social, economic, and political—leadership to its residents. Washington Heights/Inwood, on the other hand, has served as a welcoming community to many waves of immigrants over the better part of the twentieth century. There have been successive changes in a variety of immigrant groups. Once largely an Irish and later an Eastern European Jewish enclave, today the community's makeup is largely Latino, the result of an influx of immigrants from the Dominican Republic beginning in the 1960s, and most recently of Central and South Americans beginning in the 1990s. This required lifestyle changes that were dramatic for both the receiving community and newcomers alike.

The Northern Manhattan Community Voices Collaborative believed that it could bring something different and worthwhile to the table within this social dynamic: a group of representative individuals from the institutions and the community committed to improving the overall health of the community while strengthening the safety net providers. This book brings out the manner in which the NMCVC worked and the results of its efforts. It describes and provides insight into the NMCVC itself, and its various achievements and struggles. We believed that it was necessary to write this book in order to put into perspective the massive effort that went into this collaboration.

In retrospect, the working symbiosis that resulted from the NMCVC between the local churches, community-based organizations (CBOs), and the large university and hospitals can be viewed as an important step in a *détente* between the lack of trust and differing viewpoints of community and institutional leaders. The churches and the CBOs had little trust in the large institutions and wanted health matters viewed in the context of social conditions. The institutions, on the other hand, were wary of inviting the community into their deliberations and viewed health matters pragmatically, that is, from the perspective of providing treatment for diseases, rather than through measures to promote health, prevent disease, and improve the social environment.

The tug between socioeconomic factors at play in the community and specific disease prevention interventions was often obvious throughout the life of the NMCVC. Nevertheless, by working together in the collaboration, a measure of trust was established between community and institutions over the years, even though major issues continue to separate them. Most important, though, is the fact that the collaborative demonstrated that solutions worked out on the grass-roots level between institution and community can lead to benefits for both. The lesson is clear: that open and frank dialogue brought about in a constructive environment can yield solutions to difficult problems for all involved.

One of the problems associated with large-scale community programs such as this one is how to design and implement evaluation procedures. The literature shows that most collaborative, community-wide programs struggle to assess the outcomes of their efforts, and the NMCVC is no exception. However, evaluation measures were built into the original collaborative model, and the Kellogg Foundation hired external evaluators to view the progress of each Community Voices site. While we draw upon this

information wherever possible, this book itself is our way to provide qualitative analysis of the challenges and accomplishments of the NMCVC. Another important clarification about this type of project is that the Northern Manhattan Community Voices Collaborative was set up to respond to service needs and not to be a classic research project, but as the reader will note in the various chapters, research did come out of the project. For example, the outcomes of the asthma and immunization projects (chapters 4 and 5) and the SASA project (chapter 7) are reported. Many of the other chapters report outcomes data; the principle we followed was that the research findings were a *by-product of the service initiative* rather than vice-versa.

The NMCVC addresses a major question: can urban research universities successfully collaborate with their surrounding communities? For that collaboration to be effective, the NMCVC set forth to initiate four major systems changes:

1. Enhance community-based primary care network services to include neighborhood-by-neighborhood health promotion and disease prevention efforts.
2. Extend outreach to increase enrollment in Medicaid and Child Health Plus.
3. Improve the provider network's capacity to offer targeted services for difficult-to-cover services, including dental and behavioral/mental health services.
4. Develop and implement an insurance product to enroll more of the uninsured.

These very ambitious goals were set out in 1998. The NMCVC mission statement drafted at the inception of the project included the following: "An ultimate goal is to create a northern Manhattan community that educates itself about health issues and secures needed health resources from public authorities and private sources." In other words, the collaboration intended to build the capacity of the community to deal with its health problems.

Since the goal of building community capacity was a priority, the Northern Manhattan Community Voices Collaborative did not set out to be a research project, as mentioned earlier. However, throughout the years, principles of Community Based Participatory Research (CBPR) were used to

lead the examination of health issues and determine programmatic direction. Furthermore, CBPR strategies were used in the development of an agenda for the Health Promotion Working Group and for the background research leading to the White Paper on Mental Health.<sup>1</sup>

To build capacity from the onset, the collaborative sought to implement community mobilization strategies to engage partners from the community, local institutions, and government agencies. Community mobilization has its roots in political and social movements and has been documented extensively in the political science, sociology, and anthropology literatures (Vanecko 1969; Jackson 1978). With the increased attention that public health practitioners and researchers have given to the study of health disparities over the past fifteen years, community mobilization has emerged as an important strategy for facilitating change to address these disparities. In our work, we have relied on Freire's work on education for action, specifically his *Pedagogy of the Oppressed*. Freire's work proposes education and engagement as a means to leverage the social and political power of—using public health language—underserved populations. We expanded the interpretation of Freire's work to propose that through education and engagement health needs can be identified, innovative solutions proposed, and resources leveraged. Thus, we built on the resources available in the community and worked to build the capacity of the community to better itself in regard to health. Working through existing community-based organizations to plan and implement various initiatives and building the human resources by the education of community-health workers, for example, are classic ways to involve the community in initiatives.

In carrying out its mission, the NMCVC emphasized the notion that pilot projects and programs around the systems changes it envisioned needed to identify the way in which they would be institutionalized and sustained. In keeping with Freire's work, this could be accomplished only by significant and well-informed engagement of community partners, not simply through academic or institutional leadership. The collaborative was limited by its intention to begin only those projects and programs that could be institutionalized after the grant funds ended. As readers will note, some of the initiatives were successfully institutionalized while others were not.

While this method of engagement permeated the ten years of the collaborative work postfunding, we acknowledge that there was limited time available for dialogue between the community and the institutions prior to

funding (in preparing and submitting the Kellogg grant proposal). Although the success of a community-based program can be tied to the manner in which the project was planned among the partners, the NMCVC needed to follow the goals and objectives set out in the grant as it was designed by the Kellogg Foundation and its team of experts. The three partners of the NMCVC—Columbia University Medical Center (College of Dental Medicine), Alianza Dominicana, and Harlem Hospital (Dental Service)—had little time to do more than touch base with many important constituents during the planning phase; however, in addition to these three organizations, many others endorsed the collaboration and participated in the collaborative. The three partners had intimate knowledge about each of the constituencies that would be involved, that is, the university/hospitals and the communities of Harlem and Washington Heights/Inwood. We further recognized that once funded, all the activities of the NMCVC needed to be widely collaborative and, over the life span of the NMCVC, more than thirty-five community-based organizations and institutions became involved in the collaborative endeavors.

The Kellogg Foundation initially funded the thirteen Community Voices sites as “Learning Laboratories.” Each would share its successes and failures, best practices would be determined, and each would receive five years of funding as a demonstration site. The foundation also provided another four years of follow-up support for eight of the thirteen sites—extra funding to carry out policy work that would be needed to maintain initiatives undertaken in the first five years. The NMCVC was one of the sites that received an initial five-year grant and a four-year follow-up grant to advocate for policy to sustain the initiatives. Thus, the NMCVC has had the rare opportunity to have almost ten years of experience working with a community in which providers strain to meet the needs of residents who often are suspicious of the motives of the institutions.

As is the case with Community Voices, this book itself represents a collaborative effort. The core editorial team gave the book its initial shape—a shape that changed as the chapters were written. From the beginning, we felt that each NMCVC project had a story that was unique and needed to be told in its own way. The chapter authors are the people who were in the thick of things: staff members of the partner institutions and community-based organizations. They aimed to tell the story in their own style, and they include relevant bumps in the road, setbacks, and unmet goals; similarly, they reveal strokes of fortune and events or conditions that made the

process easier and more successful. We directed the authors to prepare their chapters as engaging stories and to limit their references to only five or six. The resulting chapters show that the NMCVC attracted a variety of different people, and as unique individuals each decided the best way to tell their story. In addition, the literature supporting some of the initiatives is extensively quoted in some of the chapters (chapters 3, 4, 5, 7, and 10), while other chapters are written in a more narrative style without extensive supporting literature or theoretical framework. Wherever possible in the latter, a list of suggested additional references on selected topics that may be of interest to some readers follows the chapter references.

To gain further insight into the environment in which the NMCVC began its work, we interviewed a variety of individuals, from members of community-based organizations to community residents, and from key staff of the NMCVC to students. The interviews were conducted in two ways: written or oral responses to a set of questions posed to individuals and/or taped interviews. The taped interviews provided an opportunity for the interviewees to expand on their answers. In all, eighteen interviews were held over a period of approximately one year. Even though most of these interviews were conducted ten years after the initiation of the Community Voices program in New York, their recollections were astonishingly vivid and fresh. Those interviewed were able to reflect back on the collaboration as well as to assess accomplishments. Similar to the diversity of the community and the institutions in which the NMCVC was set, those interviewed had a diverse set of answers to the questions posed. Their answers enliven the chapters. In addition, archival materials (annual reports, meeting minutes, and internal documents) were utilized to provide context and factual evidence.

Each chapter in this book shows how the NMCVC went about the challenges in meeting the goals of the four systems changes it envisioned in its Kellogg grant: health promotion, outreach, provision of targeted services, and insurance for the underserved. The book articulates many specific, concrete lessons learned in the process and places them in the context of how the Columbia University Medical Center worked with its surrounding community, and vice versa, to improve the health safety net in northern Manhattan.

The book is divided into five parts. The first part—this introduction and chapters 1 and 2—provides background information on the Kellogg Foundation's Community Voices initiative and a description of the part-



ners who formed the NMCVC and the management and operation of the collaborative. The second (chapters 3–6), third (chapters 7–10), and fourth parts (chapters 11–13) tell the stories behind the specific projects designed to bring about the systems changes funded by the Kellogg Foundation and the other funders that the collaborative was able to attract. The final section (chapters 14 and 15) analyzes the accomplishments and challenges of the NMCVC, systems changes, and the lessons learned that can be applied to the national scene.

Thus, chapter 1 explains who the partners are and how they came together as the NMCVC, while chapter 2 specifically deals with the structure, operation, and management of the NMCVC.

Chapter 3 describes how and why community-health workers became a key strategy to implement many of the collaborative's initiatives, as well as the development of *Alianza Dominicana*, a community-based organization and NMCVC partner, as a major influence in improving northern Manhattan. Next covered are health promotion programs to improve asthma control in children (chapter 4), increase the immunization rate (chapter 5), and reduce tobacco use in the community (chapter 6). Chapters 5 and 6 were developed through extensive dialogue with the community and with a keen eye to sustainability. The tobacco initiative (chapter 6) grew out of a partnership between the Kellogg Foundation and the American Legacy Foundation to counteract tobacco companies' targeted advertisement to youngsters, especially in low-income communities.

Chapter 7 shows that an intervention at the level of the emergency room (department) can move habitual users into primary care. Chapter 8 describes the Health Information Tool for Empowerment, a partnership that improves the capacity of community-based agencies to find care for clients using the Internet. Health depends on good nutrition and exercise; chapter 9 describes a pilot project called Healthy Choices between the school system and the NMCVC, which educated parents and children to improve dietary intake and increase physical activity. The hard-to-cover services in most underserved communities are dental and mental health care. Chapters 10 and 11, respectively, tell the story of the development of a far-reaching dental network called Community DentCare and how a mental health report set the stage to improve mental health initiatives in the communities. Chapter 12 describes the saga of setting up and operating the Thelma Adair Medical/Dental Center, a primary care health facility in central Harlem. While the NMCVC was unsuccessful in developing a new insurance

product for uninsured, chapter 13 describes lessons learned in the process of developing such a plan and in a way foretells some of the same financial issues facing the nation as it tries to devise ways to provide coverage for all of the population.

The penultimate chapter, chapter 14 sums up and analyzes the systems changes and challenges, successes and failures, of the NMCVC; the final chapter, chapter 15 proposes that the lessons learned could be scaled up to the larger national picture. In this chapter the book returns to the broader question of how an institution and community collaboration can bring about a much needed reform to improve the health of society, especially for those living in low-income communities. We suggest a way the academic health schools and centers and their respective communities can develop, through collaboration and the lessons learned in the NMCVC, a national prevention program.

The overarching principle that emerged from the relationships that developed between the safety net providers, faculty and health providers, and the community was that we learned from each other. Community members came to the table with different experiences from those of the providers and faculty, and vice versa. By mixing them together in a structure that encouraged listening, the collaboration was able to create a cooperative working climate that often accomplished more than had been expected. Those who subscribe to John Dewey's and the aforementioned Paulo Freire's philosophies of education have long advocated active education of this type. Each individual and the community at large benefited from the interaction. The final chapter applies this principle to scaling up the program nationally. In the epilogue, we describe how the NMCVC became embedded into the fiber of the institutions and the community through the progress of the individuals who learned by working in the initiative. While the NMCVC as an entity no longer exists, it lives on through these individuals and through improved relationships between the safety net providers and the community.

In an interview Karina Feliz, program supervisor at Alianza Dominicana, the largest social services organization for Dominicans in the country and NMCVC partner, expressed the legacy by defining the collaboration: "it's basically what the name is, Community Voices, reaching out to the community, educating the community, empowering the community." Karina became one of the NMCVC's community scholars and through that scholarship completed her master's degree in public health. Essen-

tially, this is what we hoped to create: a structure that would help the community deal with the problems it faced. It is the desire to contribute to the national dialog about improving the health of underserved communities, by disseminating the story of these successes and failures, that drove us to write this book.

## Note

1. For an in-depth examination of CBPR principles and case studies, we recommend the work of Meredith Minkler and Nina Wallerstein.

## References

- Institute for the Future (2003). *Health & health care 2010: The forecast, the challenge*. San Francisco: Jossey-Bass.
- Jackson, Pamela I. (1978). Community control, community mobilization, and community political structure in 57 U.S. cities. *Sociological Quarterly* 19, no. 4: 577.
- Minkler, M., and N. Wallerstein (eds.) (2008). *Community-based participatory research for health: From process to outcomes*. 2nd edition. San Francisco: Jossey-Bass.
- Smedley, B., A. Stith, and A. Kelson, A. (eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Institute of Medicine. Washington, D.C.: National Academies Press.
- Vanecko, James J. (1969). Community mobilization and institutional change: The influence of the community action program in large cities. *Social Science Quarterly* 50, no. 3: 609.
- W. K. Kellogg Foundation (2002). *More than a market: Making sense of health care systems. Lessons from Community Voices: Health care for the underserved*. Battle Creek, Mich.: W. K. Kellogg Foundation. <http://www.communityvoices.org>.