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### Mount Sinai: A Special Hospital for a Special Community

**Benn Greenspan, MPH\***

For the last decade or more the directives to hospitals have been to operate like a business, to be self-sufficient and self-supporting. Because we operate in an area where few would locate a business, Mount Sinai Hospital Medical Center in the inner city of Chicago has been liberated from those directives. While we do not have to operate like a business, however, we do have to survive. Reaching out to the community and accepting the need to make the community's health our mission has helped us survive.

In the past 20 years many changes have occurred in the health care system, including dramatic new and expensive technologies. At the same time, tight new payment systems challenge our ability to deliver that technology precisely to the population that needs it most. There have also been significant social changes. In response, the role that many hospitals originally played as members of their communities is reemerging. In the past (and even today in many small towns), hospitals played an active role in the social construct of their community. Hospitals were not unlike the town's factory; they provided key jobs that were critical to the economic well-being of the community. Hospitals were not unlike the town church or synagogue, providing a center for social activities and community organizations. Hospitals were the broad extension of a town's concern for the health and well-being of all of its citizens. They were the vehicle through which the people of the town raised money for this purpose and through which were often established the public health services, epidemiology, mass immunizations, control of communicable diseases, and indigent care.

Industrial, economic, and social changes in the past decades altered the fabric of our communities. Our new cultural ethic told us that the "group concern" functions for which we took responsibility as communities became something that the payers, or the government, ought to provide for individuals. I, too, believe the government should fulfill its responsibility for the health services of our population. I, too, believe health care is a right and should be accessible to all. I, too, believe payment should be equitable and consistent, regardless of the economic status of the patient. However, in the process of making public health responsibilities a part of a government entitlement, we have lost the sense of connection that used to exist between hospitals and their communities, an element that was critical in the formation of most of our institutions.

One factor in our diminished sense of group responsibility is the specialization of our communities. Few of us live in complete towns anymore. We live in residential communities and we commute to industrial corridors. We travel to suburban offices, past endless miles of glass buildings occupied only 40 hours a week, to communities that disappear on weekends. Our lives have become geographically stratified and, as a result, our social institutions have become compartmentalized. It is rare to find a hospital in the inner city whose medical staff socializes together. Social institutions take care of those needs. Meanwhile, working and professional associations provide for their needs in the city. In this process, hospitals also have become increasingly specialized, not only in the medical sense. They have become regional resources, specialty institutions predicated on the kind of community in which they exist.

The 14 community hospitals that closed in Chicago during the last decade were almost all in the inner city. Suburban hospitals seldom close. People who formerly utilized neighborhood institutions for needed hospital services now travel greater distances to obtain care from other institutions with which they are less familiar and to which they are less attached. These distant facilities are less likely to provide them with personal attention, understanding, and insight. The farther away providers are from their patients, geographically and socially, the less likely these patients are to consider our institutions an important part of their life, something they value. In this era when hospitals and the existence of health services are threatened, we need the community to consider us an important part of its life and to fight for our existence.

Broad social changes in the declining cities and rural areas have created huge new problems in public health and health care. Some responsibilities essential to community health are just not being met. In many communities financial deficits prevent health care institutions from accomplishing the primary mission of safeguarding the health of each resident, let alone from assuming broader group responsibilities. Who is going to

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bridge the gap in the 1990s? For fiscal reasons, the government cannot do it. Many industries do not believe it is their job to do it via health insurance premiums. Therefore, the responsibility has fallen to us, hospitals with assets, as limited as they may be. Regrettably, bridging the gap is a responsibility that many hospitals, often those with the most assets, have rejected. These hospitals say it is not their job because they don't get paid for it. They are right; they do not get paid for it. However, it once was our job, and it seems likely that in the emerging social structure it again will be our job, if it is to be done at all.

We at Mount Sinai Hospital decided a long time ago that it is our job. The decision was made not only by management but also by medical staff, nursing staff, employees, and, most importantly, the board of trustees. We committed to the community as our partner in growing and surviving. We are a unit together, needing one another to survive and thrive. When we came to that understanding about two decades ago, we began to bring in other partners. We evolved the concept of partnerships very slowly, expanding our role not only in medical care but also in housing development, commercial revitalization, education, employment, public health, transportation, and many other areas that touch the lives of those we serve. A good example is our seniors program. Of the many commercially available plans, none seemed relevant to the seniors in our community. The seniors in our community are isolated. It is not simply that their children have moved away, but that they literally cannot leave their apartments after dark. They have no place to shop for essentials, and they cannot carry big bags of groceries a mile or two. They have no place to go for entertainment. There is not a single movie theater within three miles, even though we are within the city limits of Chicago. Our seniors program addresses the problem of their special isolation. We address shopping and socialization and also run monthly movies. We call them by telephone just to talk and we connect them with police department security programs. Needs may vary from one part of the country to another, but we must respond to those specific needs.

### **A Mission for Community Health**

Mount Sinai has an interesting history in that we were one of the first failed hospitals in Chicago. In 1912, what is now known as Mount Sinai opened as Maimonides Hospital. Six years later it went bankrupt. Today, because the fiscal pressures on inner-city hospitals have worsened, people frequently suggest that Mount Sinai should have stayed closed or moved to the suburbs in 1916. We disagree. In those early years concerned local business people formed a new board and decided that they needed a new community hospital. They reopened the facility as Mount Sinai, which at that time served an almost entirely eastern European Jewish immigrant population. That population was very poor. The community has never been well-to-do, living largely in four- and five-story walk-up tenements.

The community leaders in the early 1900s realized that the people of Lawndale did not have access to the health care they needed. Their documents contain much the same language we use today. The people needed the kosher food mandated by their religious observance, and they needed access to training and

staff privileges for health professionals from their community. (Jewish physicians and nurses had difficulty gaining access to the predominantly church-supported hospitals of the turn of the century.) Thus, there was a need for a special hospital for a special community, and Mount Sinai was opened.

Today we have a similar mission but a different constituency. We are a 469-bed teaching, research, and tertiary care facility, offering all major clinical specialties. We are a Level III high-risk maternity institution and a Level I trauma network hospital (both the highest level). We are a state- and city-designated trauma center; we provide all specialty services, with the exception of organ transplantation, major reconstruction, and burn care. We provide teaching at the residency level in all the major specialties and fellowships in many major postgraduate areas. We operate a neonatal intensive care unit and a high-risk perinatal service. We have a permanent affiliation with the 77-bed Schwab Rehabilitation Center, an institution owned by our parent corporation and located across the street from Mount Sinai. Both institutions were threatened with closing for many years, but we stayed together and survived.

The traditional business wisdom in Chicago is that a Level I trauma center is either foolish or altruistic because it will lose a lot of money. In our community, Lawndale, 55% of the people purchase medical care with Medicaid. Of the remaining 45%, 25% have Medicare. Of that 25%, approximately 22% have both Medicare and Medicaid. Accordingly, about 77% of the people in our community purchase health care with public aid.

Because we are a trauma center, we receive patients from throughout the Metropolitan neighborhood. In fact, we attract more commercially insured patients as a trauma center than we ever could draw from our own community. We have many trauma cases from the local community, too, and overall we lose some \$2.2 million a year by providing trauma services. But our community needs those services, and we are committed to maintaining them.

Mount Sinai's original constituency moved to other areas 30 to 40 years ago, and today the community is far different. Our patients are mainly African-American and Mexican-Hispanic residents whose institutions and resources have been eroded by racism, ignorance, poverty, and hopelessness, particularly to the north of us, a predominantly African-American area. That part of the community has lost many commercial resources—grocery stores, pharmacies, other common conveniences. There are no major chain stores in the area, which means the people have to pay higher prices, compared to more affluent areas, for items that are often of lesser quality. Mothers in our community fear gang violence and frequently will not allow their children to play outside. These children lack "normal" childhood experiences. Gangs affect all sorts of decisions. Patients select their medical care sites because of gang territorial lines; to keep from crossing the territorial lines, they will avoid seemingly natural providers and travel as far as they have to for medical care.

Mount Sinai provides services with an understanding that none of us has been taught in graduate school. We are in a community struggling with some of the worst conditions in this nation. Without a hospital like Mount Sinai and the other institutions that are our partners in this community, the struggle would



probably have been abandoned. What we mean to this community is demonstrated by the high occupancy of our beds. The community has a desperate need for health service. In 1990 our occupancy was 81%, and this year it is frequently over 90%. In the city of Chicago the average hospital occupancy is 57% despite declining bed numbers. Even in the suburbs, the average occupancy is only 67%. We have possibly the highest hospital occupancy in the city. In fiscal 1990, Mount Sinai and Schwab Rehabilitation Center, our affiliate, provided 129,000 inpatient days, 39,000 emergency room visits, 7,900 surgical operations, and 545,000 outpatient services. More than 2,700 babies were born; if we had more room, more than 3,500 babies would have been born at Mount Sinai. (Note: In fiscal year 1992, the number of deliveries increased to 3,331.) We are not simply a hospital for a community without other medical resources. We are also the primary physician and pharmacist as well. In 1990, we filled 1.2 million prescriptions for the people of our community, and we filled all kinds of other needs as well.

In order for us to survive, we must have a viable community. In that sense, there is an element of enlightened self-interest in carrying out our mission. None of us at Mount Sinai or at any other hospital has the power to protect or resurrect a community. However, we do have the ability and the responsibility to be a catalyst.

North Lawndale, one of our primary service areas, is arguably the poorest area in Illinois and one of the poorest in the country. In 1980 its median income was under \$10,000. More than half its residents receive some form of public assistance. Only one-third of the local high school students graduate on time, and when they do they are 33 percentile points behind in reading and 25 percentile points behind in math. In 1987, the average ACT score for college-bound students from North Lawndale was 10.1, compared with almost 18.9 nationwide. Between 1970 and 1980, North Lawndale lost nearly 30% of its available housing after having already lost nearly 30% in 1968 and 1969. The majority of the housing is now gone and much of what remains is in deplorable condition. No new houses have been built in North Lawndale in the past 50 years, despite being in the middle of the city, three miles from Chicago's Loop. The recession in the early 1980s was associated with the loss of more than 40% of the businesses that had somehow managed to remain open until then.

The situation in North Lawndale is much like that in Detroit and other urban areas. Our community ranks low on issues of health status and social environment. The 1988 infant mortality rate in North Lawndale was 28 deaths per 100,000, nearly triple the national rate of 10.6 deaths per 100,000. One-third of the births that year were to teenage mothers, 98% of whom were unmarried. Of the babies born at Mount Sinai, 20% are considered high risk by all standards. A large majority of our cancer patients are diagnosed at a stage too late for effective therapy, and a substantial number of them, 58% at last count, come from our emergency room. Our trauma unit sees the highest percent of penetrating trauma (a polite term for stab and gunshot wounds) in Illinois.

It was easy to discern that the people in our community needed all the service we could possibly muster, but it took a

long time to understand that we needed our community, too. Such understanding is important. Sometimes it is difficult to realize that you need your community when reimbursement for your services is so low as to threaten your viability. It is hard for your nursing staff to sustain its commitment to the desperate kind of patient care they provide every day when they are understaffed and forced to borrow supplies from neighboring hospitals in the middle of the night. Still, we need the support of all our community members. We cannot select only those whose insurance pays us adequately. This is particularly true in a community like our own, where Medicaid reimburses the majority of our patient days. For years our institution, like many others around the country, reached out to commercially insured patients in areas outside our immediate community. We were very successful in that venture. Through the late 1970s and early 1980s we attracted many patients from the white-collar residential communities surrounding our area. One of our first satellite sites generated thousands of commercially insured inpatient days for the hospital, and we remained profitable for years. In my judgment, however, we began to make bad decisions in order to be profitable. We remained committed to keeping our hospital open but felt we needed to serve commercially insured patients in order to do that. We considered not accepting the patients of physicians who only had public aid patients and limiting the number of admissions for obstetrical patients whom we had not seen for prenatal care. When a hospital considers that kind of policy, the message travels quickly that you are no longer interested in the community.

More than half our community receives public assistance. How could we turn down patients on public assistance and keep the support of their family members who may be commercially insured? You can't pick and choose patients out of a community and expect the community to support you. We learned that in the early 1980s, when Illinois was hit hard by a recession. Many blue-collar city and state jobs were lost. During this recession, many patients from neighboring suburban and local blue-collar communities who had been coming to us through our satellites returned to their own community hospitals. Some suburban hospitals played on people's worst instincts to try to draw their patients back, saying "Why do you want to go to Mount Sinai? Think of who will be in bed next to you there." When our outreach efforts failed, Mount Sinai looked again at our own community and realized it had lost them, too. It was an important lesson. Subsequently, we spent 10 years working with our board, our medical staff, and our employees, trying to help them understand that our mission is serving the community in which we are located, not structuring programs that will bring in other people.

We had to help people recognize that in order to secure our future in our primary marketplace, we had to be adopted unconditionally by the community and therefore we had to accept the community unconditionally. It took a long time for all to accept this liberating notion. We developed a mission statement which contained four traditional elements: 1) to provide comprehensive health care services through a network of outpatient facilities, 2) to continue medical education, 3) to foster basic and applied research, and 4) to implement continuous improvement according to standards set by the Joint Commission on Accredi-



tation of Healthcare Organizations. The fifth and most significant statement was the willingness to accept the leadership role for the community's social and economic development as a means of assuring the health and well-being of the people. Our mission statement emphasizes that the four traditional hospital goals—medical care, quality improvement, research, and education—depend on success in our role as community leader.

Instead of spending money to compete for patients who had better insurance, as we had done for years, we had to develop the notion that we could be partners in serving the community and with the community. The people in our area had to be seen as equal partners. They need us; we need them. The concept of cooperative partnerships is often difficult for administrators, physicians, or trustees, for we traditionally function as leaders, not as equals. For Mount Sinai the concept of leadership had to include the concept of equality with community members.

### Partnerships for Community Health

As we enter the 1990s, Mount Sinai has seen the formation of dozens of partnerships with the local area and Chicago-based businesses, with government agencies at all levels, with community residents themselves, and even with other hospitals and providers interested in developing noncompetitive models for the most efficient delivery of health services to our inner-city community. Partnerships have developed in primary health care, community economic development, public health services, and community social services. Many of these efforts overlap: economic development projects create jobs and improve housing, and housing development projects affect health care delivery. We began with easy arrangements, less threatening to those who grew up with the competitive model. Gradually, we are taking greater risks, affiliating with institutions that were our competitors last year. This year I had the great pleasure of walking across the park to the competing hospital on the other side, wandering into the administrator's office to say hello. We had not done that for 70 years. Now it is a function of a partnership, a leap of faith to set new directions and work together.

Our mission directs us to take the lead in our community. We have no other choice. How can we compete when none of us has enough of anything? We do not have enough money, beds, equipment, physicians, outpatient facilities, or time to service community needs. In the health system the only surplus is in sick patients, and the supply-and-demand mechanism is ineffective. In fact, the model is antithetical to the delivery of quality health services.

Mount Sinai's initial partners were our own physicians. The community leadership had three sets of goals—economic, health, and political—and each of those has its own set of needs. Economic goals for the community concern issues of housing, jobs, schools, and shopping, with the empowerment of each individual to gain some economic share as an ultimate aim. In pursuing both health and economic goals, we have to be health care providers and politicians. We have to lobby for compensation or we cannot serve our people. We have to take part in voter registration. We have to host health forums that give people an op-

portunity to hear the issues and to be part of the solutions. We have to encourage formation of community planning groups and provide these groups with the assets they need. We cannot do this alone. We have to enter partnerships to empower the community to function and keep its services intact. We are not just a hospital for inpatients and emergency services, but we also must assure the availability of and access to primary care. We must encourage prenatal care, be active in developing risk-factor interventions, and help obtain outside resources supplemental to those available in the community. We have to encourage the community to plan, to form more partnerships, to provide the answers to risk factors, to go forth into the 1990s.

Our first partnership was easy. We concluded 20 years ago that our primary care was insufficient, our clinics inadequate and outmoded. Moreover, we were losing a lot of money while providing substandard care. In 1970, only four primary care practices were left in our community of 150,000 people. We had two problems that had to be solved together. The solution was a partnership in faith with our teaching faculty to effect a complete reversion to private practice. We closed our clinics and put all 65 faculty physicians into private practice. Private practice provided financial incentives while making the physicians available and accessible to the community. Not only did we save a lot of salary dollars, but the patients in that community had access to quality private care for the first time in years. The faculty group-practices now operate in five different sites surrounding Mount Sinai Hospital.

The medical faculty group sees indigent patients, as well as those with commercial insurance and members of health maintenance organizations. In 1985, to meet increasing difficulties in the community, we acquired a failing hospital on the near north side of Chicago. This hospital had a clinic system which we continued to operate after closing that hospital. In 1985, this clinic system had three sites; by 1990, we managed 12 clinics on the west and south sides of Chicago. The primary care partnerships have been a major success, delivering widely accessible, quality primary care to a large population, while filling a large number of beds at Mount Sinai. With our census high, we can operate with such efficiency that we have the lowest cost per day of any major teaching hospital in the city. Moreover, we break even financially.

The medical partnerships were followed by a series of efforts in community revitalization. We worked with the business community, private foundations, and city and state agencies that fund community development. Most significantly, we entered a partnership with our neighbor, Ryerson Steel, a subsidiary of Inland Steel, the other major employer in Lawndale. Since 1982, the two of us have managed to raise more than \$600,000 to fund a local office of the Neighborhood Housing Service. This agency worked with us to attract more than \$30 million in reinvestment. That money went to develop new and to upgrade old housing in South Lawndale and provided infrastructure improvements—new paving, new sewers, new street lighting, the first in more than a decade. People in our community began to improve the facades of their houses, to put down sod on their small lawns, to make improvements that they did not have the confidence to undertake in previous years.



In May 1991, the mayor's Affordable Housing Program in Chicago committed to build 40 new houses in North Lawndale and 59 new single-family houses in South Lawndale. We are particularly proud to have attracted Lexington Homes (which, although the largest home builder in Illinois, had never built a single home in Chicago) to come into the poorest neighborhood in Illinois and build 40 new single-family homes.

We have also attempted partnership approaches to the problems facing local public housing developments. For example, we sponsored and helped to organize the Ogden Courts Women's Organization which trains the women of that housing unit and three nearby public buildings in tenant empowerment skills to help improve conditions in public housing. We put these women in contact with tenant leaders of public housing units in other cities. We helped them obtain grant money so that they could have leadership training in places like St. Louis and meet with people like Bertha Gilkie, who had started similar programs 10 years earlier. Soon, the tenants of those buildings will assume management responsibility for the property. They not only have jobs but control over what happens in their building.

Although not all of our initiatives have been this successful, they all were valuable in providing the experience we needed to learn how to succeed.

The key element in the success of our partnerships is control by a small core of committed leaders. The partnership must make its decisions in an open environment to allay the fears that reside in the community, and the partners must not assume that they have all the expertise. We must facilitate decision-making, and we must bring expert counsel into the process. When we involve ourselves in areas in which we are not the professionals, we must seek all the help we can afford. Our failures sometimes resulted from not consulting outside experts in housing and economic redevelopment.

We also have been involved in issues of business and new sources of employment. Commercial development is essential. Without convenient shopping, people with lower and middle incomes will not move into a community. Even more importantly, the absence of good schools severely discourages families from settling in a community. We effected an agreement with Corporate Classrooms, a Chicago firm, to use Mount Sinai's facilities for workshops in language skills and in obtaining employment. The courses were offered to residents of the three public housing buildings. We have helped bring to our community the state's Project Chance, which provided incentives for public aid recipients to become employable. We also are an employer through Project Chance. And we benefit from our involvement, because if community residents are employed, their health care purchases will be made with commercial insurance.

As a partner in local ventures, we have become involved with every local Chamber of Commerce and community development corporation. Hospital personnel are on the boards of the YMCAs and the Boys and Girls clubs. In one interesting venture, we are joined with four churches in South Lawndale. Some of our staff (who had previously developed several successful thrift shops benefiting the hospital) helped them start and operate a new resale shop, providing community residents with inex-

pensive recycled goods, everything from furniture to clothing. The profits are divided among the four needy churches. In turn, we have reaped bountiful goodwill from the community and a harvest of volunteer pastoral counselors and chaplains.

Several successful partnerships are with government agencies. Ten years ago, we gave up railing at the government for inadequate funding. We decided that we had the same mission as the social-service arms of the federal, state, county, and city governments and we might as well work with them. In 1982, with the help of the police department, we initiated a rape victim and crime victim counseling program. The Attorney General's office funded and provided training for a corps of volunteers for the program. We have the most effective such effort in the state. Most of the volunteers are hospital employees who use their off time to assist victims brought into Mount Sinai's emergency room. In keeping with the policy of equal opportunity, we trained a class of male volunteers, primarily to assist the growing number of male rape victims. The corps of nearly 100 volunteers also handles the social needs of trauma victims, freeing our clinicians to meet these patients' serious medical needs.

In 1985, in cooperation with the Department of Children and Family Services and the Department of Public Aid, we opened the nation's first inpatient center for treatment and prevention of child abuse. Emphasizing rebuilding family units, the team of physicians, nurses, social workers, psychiatrists, and psychologists supports the clients through their initial crises. After assessing the abusive situation, the center provides inpatient therapeutic intervention and outpatient follow-up for an average of 18 months. Such partnerships serve community needs and augment our resources to help meet those needs.

Working with the Illinois Department of Public Health, our family and community health services program sponsors one of the largest Women, Infants, and Children's Nutrition Program in Illinois; a Parent-Too-Soon program with more than 3,500 clients; and a Subsequent Pregnancy program. We train case managers for community, state, and social service agencies as well as for the schools. We provide education about the acquired immunodeficiency syndrome; train teenagers to counsel other teens; and foster an initiative for drug-free pregnancy that focuses on women at risk. We provide on-site physician services in Chicago's senior-citizen buildings as well as for the three clinics in public high schools. These programs promote healthy life-styles, emphasizing disease prevention while providing primary care to teenagers, with the consent of their parents.

In 1989, Mount Sinai acquired an unprofitable outpatient ambulatory care site of another local hospital. By contract, Mount Sinai provides laboratory and other tertiary referral services for that hospital, saving it several hundred thousands of dollars each year.

With yet another hospital and Chicago's Health Department, we provide follow-up maternity care. More than 1,000 pregnant women receive prenatal care in city clinics, but there had been no coordinated hospital delivery or postnatal services. Now that hospital and Mount Sinai together provide these services.

Those two ventures with other hospitals set the stage for our most ambitious venture, the West Side Health Partnership. This new corporation brings together many health providers serving



low-income and minority residents on the west side of Chicago. All professional and community constituencies are represented in the governance of this joint venture. After a year of work and hundreds of meetings, we established a partnership that includes Mount Sinai, Schwab Rehabilitation Hospital and Care Network, Bethany Hospital, St. Anthony Hospital, four community health centers, two city-run clinics, 11 hospital-affiliated primary care facilities, and more than 100 private-practice physicians. This amazing project is a unique model of cooperation in providing coordinated health services for the indigent. In addition to the providers, our partners in this venture include the State Department of Public Health and the State Department of Public Aid. The Department of Public Aid provides \$2.5 million a year for management of the partnership, with a 10% incentive payment for the care of patients. Important goals of the partnership are to decrease the use of hospital emergency rooms as a source of primary care, to emphasize health promotion and disease prevention, and to deliver health care to all who need it. In recent years, lacking such cooperation, several community hospitals closed. Cooperation among the providers, as opposed to competition, is a highly significant achievement.

Other models of cooperation have emerged as well. Political lobbying is now being pursued jointly by four west side hospitals seeking to improve our compensation. (Note: In mid 1992, 19 Illinois hospitals formed a "disproportionate-share coalition" to lobby for adequate Medicaid funding.) The West Side Health Authority has been set up by the community to empower west side residents regarding issues of health care. The Illinois Primary Health Care Association runs the remarkable Linkage Project which links the City Health Department clinics with other primary providers, community health centers, and, in our case, hospital-sponsored primary care sites. We also work with the Austin People's Action Council (a local health care and social service agency), church groups by the score, the Chicago Department of Health (for whom we served on a local development council to open the Health Department's newest comprehensive primary care center), the Jewish Council on Urban Affairs, and the Jewish Federation of Metropolitan Chicago. In the interest of our large Mexican community, we work with *Mujeres Latinas en Accion* (Latin Women in Action), an agency concerned with such problems as domestic abuse and the difficulties facing single working mothers.

We do not always succeed. Hospitals should be involved in many partnerships, but some fail. In 1986, in an attempt to open primary care centers where they could not otherwise be open at night for security reasons, we became partners with the Zayre Corporation which operated discount stores. Two sites inside inner-city Zayre stores were failures within four years. People would not buy primary medical care in a Zayre store.

We remain a financially troubled institution. We don't always make the right decisions. However, many of our decisions have been right for us and for the community. Throughout this period of social change in Chicago, our original community has honored its commitment to the mission. Millions of dollars raised every year go directly to our operating deficits. We know that our mission lies in our community and that problems in fulfilling our mission do not necessarily come from within us. They reflect the economic problems of this nation and the ambivalence of our leaders about their commitment to provide equal access to health care.

Mount Sinai has survived in a community that hit bottom in the late 1960s during the aftermath of the riots that followed the assassination of Dr. Martin Luther King. Situated in one of the poorest areas of a nation, a nation that has chosen not to meet the needs of those whose needs are most urgent, we are working to revitalize our community and to improve the lives of its residents. We have had important successes and convinced many other institutions to join us. Moreover, we have benefited from our commitment to the community. Community support of the hospital has improved dramatically. We have been able to bring back and retain physicians who previously left the community in large numbers. We have had assistance from the community in recruiting nursing staff. Community activities demonstrate tangibly that the services of the nursing staff are greatly appreciated. This support improves our ability to recruit and improves security around the hospital. It improves the payer mix and will improve our long-term economic viability. Community support produces an immediate, welcome sense of stability. Our admissions in the last few years have increased 28%, while the average of all Chicago hospitals has declined 19%. Mount Sinai has demonstrated that hospitals can be involved in ensuring the vitality of their community, that this is in their own self-interest, and, more importantly, that this is the right thing to do.