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REPORT TO THE CONGRESS

Opportunities For Improving The Neighborhood Health Services Program For The Poor Administered By St. Luke's Hospital Center New York City B-130515

Office of Economic Opportunity

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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JUNE 15, 1971

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-130515

To the President of the Senate and the
Speaker of the House of Representatives

This is our report on opportunities for improving the Neighborhood Health Services Program for the poor administered by St. Luke's Hospital Center, New York City. Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget; the Director, Office of Economic Opportunity; and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

OPPORTUNITIES FOR IMPROVING THE NEIGHBORHOOD HEALTH SERVICES PROGRAM FOR THE POOR ADMINISTERED BY ST. LUKE'S HOSPITAL CENTER, NEW YORK CITY
Office of Economic Opportunity B-130515

D I G E S T

WHY THE REVIEW WAS MADE

The Comprehensive Health Services Program is intended to find ways to break the cycle in which sickness and poverty reinforce and perpetuate each other. This is a grant-in-aid program authorized under the Economic Opportunity Act.

Under this program, the Office of Economic Opportunity (OEO) makes grants to public or private nonprofit agencies for projects attempting to demonstrate new ways to provide health services to the poor.

Funding of the program and changes in administrative responsibility since its inception follow.

--For fiscal years 1965 through 1970, OEO had obligated about $220 million. For fiscal year 1971, $99 million additional had been authorized.

--In December 1970 responsibility for 16 of 66 operational projects was transferred from OEO to the Department of Health, Education, and Welfare (HEW) which was to provide up to $30 million in fiscal year 1971 to support those projects.

The General Accounting Office (GAO) is making a series of reviews to determine (1) the extent to which the objectives of this program are being met and (2) how efficiently the program is being administered.

This report presents GAO's findings on the Neighborhood Health Services Program, a project administered by St. Luke's Hospital Center in New York City. The project seeks to demonstrate how the resources and capabilities of a major teaching hospital--St. Luke's--and a large city health department--New York City's--can be combined to provide comprehensive, high-quality, family-oriented health services to a group of approximately 20,000 poor persons.

From June 1967, when the project was approved by OEO, through October 31, 1970, OEO had made grants totaling about $3.8 million for operation of the project. An additional grant of about $1.4 million has been approved by OEO for the project for the year ending October 31, 1971.

Tear Sheet

JUNE 15, 1971

FINDINGS AND CONCLUSIONS

The project began serving patients in December 1967. By March 1970 the project had reached (or enrolled) about 10,000 persons, or about half of its goal. The project had provided health and health-related care to these persons at the project site, at St. Luke's, and in their homes. In interviews with a member from each of 50 enrolled families selected on a systematic basis, GAO found that the individuals generally were satisfied with the project's services. Also the project had succeeded in involving neighborhood residents in its planning and operation.

Because of a number of problems, however, GAO believes that the project has not yet provided a significantly better health care delivery system than that which previously existed. OEO and project officials have already recognized and are working to correct many of these problems. The need to refer many patients to the outpatient clinics at St. Luke's--in essence, returning the patient to the system which project proposals have described as impersonal and institutionalized and which the OEO program is attempting to overcome--is a significant weakness in the project's operation. (See p. 14.)

The amount of space available to the project--about 8,000 square feet on the second floor of a three-story city health department facility--limited the range of services that could be offered at the project site. A formal agreement for use of the space had not been executed with the city. Because there was no formal agreement, OEO denied approval of renovations necessary to accommodate certain equipment. Continued availability of the space is uncertain. (See p. 19.)

The relatively low average number of patients seen by project physicians and dentists--9.5 and 5.7 a day, respectively, during the 8-month period ended February 28, 1970--indicated that the project was not making maximum use of available professional staff members. OEO guidelines suggest that, with adequate space, a physician should treat about 28 patients and a dentist about 14 patients a day. Project officials attributed the problem, in part, to the number of appointments missed by patients and to the inadequate space which limited the number of examining rooms available to each physician. (See p. 23.)

Other improvements are needed if the project is to fully achieve the objectives of the Comprehensive Health Services Program which is designed to overcome the shortcomings of the existing health care system for the poor. The existing system, according to OEO guidelines, offers services widely recognized to be insufficient and often inaccessible, impersonal, fragmented, lacking in continuity, and of poor quality.

Assisted by medical specialists from the U.S. Public Health Service, GAO found that:

--Although patients were generally treated by the same physicians when they visited the project site for medical care, such continuity often was lost when patients were admitted to St. Luke's for inpatient

care. This situation occurred because about half the project's physicians did not have hospital privileges at St. Luke's, the grantee and administering agency of the project. (See p. 25.)

--The project generally provided individually oriented rather than family-oriented health care. OEO guidelines call for a project's staff to attempt to see the patient in his family setting when appropriate and for all members of a family to be seen by the same physician or team of physicians to the extent feasible. (See p. 27.)

--The project made some progress in implementing a program to provide comprehensive health care, including preventive care, but additional efforts need to be made and additional space needs to be acquired if the project is to fully achieve such a program. (See p. 29.)

The project made free medical services available, in some instances, to persons who did not meet OEO-approved eligibility criteria and, in other instances, to persons whose eligibility had not been clearly established. The project needed to strengthen its controls over eligibility determinations to ensure that OEO funds are used to provide care for those persons whom the program is designed to help. (See p. 34.)

Corrective action was taken, or promised, by OEO to improve certain aspects of the management of grant funds which GAO brought to its attention. (See p. 38.)

RECOMMENDATIONS OR SUGGESTIONS

The Director of OEO, through OEO's Office of Health Affairs, should:

--Request St. Luke's and project officials to bring negotiations with the city for additional space to a satisfactory conclusion or, as an alternative, to seek other suitable space. (See p. 21.)

--Review the project's professional staffing organization and determine actions necessary to increase the staff's productivity. (See p. 24.)

--Work with project and St. Luke's officials to obtain hospital privileges for all project physicians. (See p. 32.)

--Stress to project officials the importance of providing family-oriented health care and implementing procedures that will aid such an approach. (See p. 32.)

--Reemphasize to project officials the need to expand preventive health care services and to educate the poor to seek such care. (See p. 32.)

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Tear Sheet

GAO's recommendations should also be of interest to the Secretary of HEW because HEW makes grants for similar projects under section 314(e) of the Public Health Services Act, as amended (42 U.S.C. 246), and because 16 of OEO's projects were transferred to HEW in December 1970.

AGENCY ACTIONS AND UNRESOLVED ISSUES

OEO stated that it was in agreement with each of GAO's recommendations and described actions which had been, or would be, taken to effect the needed improvements. (See app. II.)

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> "*** this report reveals an excellent understanding of the philosophy, purposes, and design of neighborhood health centers. The report's recommendations are well-taken." (See app. III.)

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The matters presented in this report are for consideration by congressional committees having responsibility for federally assisted antipoverty and health services programs. In view of the interest shown by members of the Congress in these programs, GAO is bringing its findings and observations to the attention of the Congress for information purposes.

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
OEO	Office of Economic Opportunity

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CHAPTER 1

INTRODUCTION

We reviewed the operations of the Neighborhood Health Services Program, a project administered by St. Luke's Hospital Center in New York City and financed with grants by the Office of Economic Opportunity under the Comprehensive Health Services Program. OEO's grant for the project's first year was awarded to New York City's Community Development Agency, the city's designated community action agency. Subsequent grants have been made directly to St. Luke's.

Our review was directed toward evaluating the extent to which program objectives had been met and the efficiency of the administration of the project. We were assisted by medical specialists from the U.S. Public Health Service, Department of Health, Education, and Welfare, who evaluated the quality of medical care provided by the project and the adequacy of patient medical records. Our review covered operations of the project from its inception in June 1967 through April 1970 and was supplemented by certain information developed thereafter.

On December 23, 1970, we requested the comments of the Director of OEO, the Secretary of HEW, and the grantee on the matters discussed in this report. By letter dated March 17, 1971, the Deputy Director of OEO provided us with OEO's views. The Deputy Director stated that OEO had received and reviewed the comments of the project and St. Luke's staffs, some of which were incorporated into the OEO comments.

The Assistant Secretary, Comptroller, of HEW, by letter dated February 19, 1971, provided us with HEW's views.

The OEO and HEW letters are included as appendixes II and III, respectively, and comments contained therein or attached thereto have been included in the body of the report where appropriate.

COMPREHENSIVE HEALTH SERVICES PROGRAM

The Comprehensive Health Services Program, which is intended to find ways to break the cycle in which sickness and poverty reinforce and perpetuate each other, is authorized as a specific component of OEO's Community Action Program by the 1966 amendments to the Economic Opportunity Act of 1964 (42 U.S.C. 2701). In authorizing the program the Congress broadened the neighborhood health center concept which had been supported by OEO in 1965 and early in 1966 under its authority to finance demonstration projects designed to test or assist in the development of new approaches or methods to combat poverty through community action.

In its report on the 1966 amendments, the Senate Committee on Labor and Public Welfare indicated its concern for the manner in which health care for the poor had been provided in the past by stating:

> "Differential rates of disease, disability and premature death between the poor and the rest of the population are the result, at least in part, of the inadequate health services received by the poor. We have found that for the poor, health care is emergency care. Health is not a continuous and integral part of their life. Moreover, the care they have received has typically been devoid of a patient-physician relationship. They seldom see the same physician twice and there is little recognition of the total health needs of a family. Health services for the poor are usually rendered in depressing physical surroundings, far from home or place of work, marked by hours of waiting and devoid of concern for the patient's privacy and dignity. This situation is aggravated by the fact that medical care programs for the poor are fragmented and complex and discourage the patient who suffers basic education and cultural impediments."

The Committee, concluding that the neighborhood health centers started by OEO had proven to be highly successful devices in delivering effective health service to the poor, stated:

> "*** Under one roof in one neighborhood a comprehensive health center provides the broadest possible scope of ambulatory health services for the poor. The Neighborhood Health Center is creating an altogether new relationship between the provider and recipient of health services, making services truly responsive to the neighborhood's needs. These centers provide a continuous doctor-patient relationship, in a place that is accessible to those being served by the center, and in a climate of dignity."

The Committee stated that the amendment authorizing the program would enable OEO to build on and expand its early demonstration efforts.

Section 222(a)(4) of the act, as amended, which authorizes the Comprehensive Health Service Program, states that the program is to aid in developing and carrying out projects focused on the needs of urban and rural areas having high concentrations or proportions of poverty and marked inadequacy of health services for the poor. The projects are to be designed to make possible, with maximum feasible use of existing agencies and resources, the provision of comprehensive health services together with necessary related facilities and services.

The act states that comprehensive health services are to include preventive medical, diagnostic, treatment, rehabilitation, family planning, narcotic addiction and alcoholism prevention and rehabilitation, mental health, dental, and follow-up services. In rural areas which lack elemental health services and personnel, less comprehensive services may be established first.

Program services also are to be made readily accessible to low-income residents of the area and are to be furnished in a manner most responsive to their needs and with their participation. Services may be made available to all residents of an area on an emergency basis or pending a determination of eligibility. Wherever possible, the services are to be combined with, or included within, arrangements for providing employment, education, social, or other assistance needed by the families and individuals served.

Before any project is approved, the comments and recommendations of medical associations in the area are required to be solicited and considered and appropriate Federal, State, and local health agencies are to be consulted. Also steps are to be taken to ensure that the projects are carried on under competent professional supervision and that existing agencies providing related services are furnished with all assistance needed to permit them to plan for participation in the program and for the necessary continuation of the related services.

As of December 13, 1970, OEO funded 66 comprehensive health services projects, of which 47 were in urban areas and 19 in rural areas, and provided planning grants for an additional 17 projects. The projects then either fully or partially operational were estimated to have registered over 650,000 persons; when fully operational, the projects are expected to serve over a million persons. Effective December 14, 1970, the responsibility for 16 of OEO's operational projects was transferred from OEO to HEW in accordance with a Presidential directive.

From fiscal year 1965, when the first OEO health services projects were funded as research and demonstration efforts, through June 30, 1970, OEO obligations for the program totaled about $220 million. For fiscal year 1971, $99 million additional has been authorized for the program. HEW is to provide up to $30 million for fiscal year 1971 to support the projects transferred to it.

OEO PROGRAM ADMINISTRATION

The Director of OEO is responsible for the administration and coordination of the activities authorized by the Economic Opportunity Act of 1964, as amended. He is responsible also for the establishment of basic policies governing OEO operations and programs and for the planning, direction, control, and evaluation of OEO programs. The Office of Health Affairs, a part of OEO's headquarters organization, is responsible for directing and coordinating the conduct of all OEO activities concerned with health and medical affairs, including the Comprehensive Health Services Program.

NEIGHBORHOOD HEALTH SERVICES PROGRAM

The project sponsored and administered by St. Luke's Hospital Center is one of seven comprehensive health services projects that have been funded by OEO in New York City. The seven projects, none of which are among the 16 projects transferred from OEO to HEW in December 1970, are listed in appendix I.

The project was funded by OEO to demonstrate how the resources and capabilities of a major teaching hospital--St. Luke's--and a large city health department--New York City's--could be combined to provide comprehensive, high-quality, family-oriented health services to a target population of approximately 20,000 poor persons.

The origin of the project can be traced to 1962 when St. Luke's, which is affiliated with the Columbia University College of Physicians and Surgeons, decided to cooperate with the New York City Health Department to support the then-new clinical programs at the city's Riverside Health Center located about 13 blocks from St. Luke's. These clinical programs, according to the initial proposal for the project, did not offer comprehensive family health services, but rather they offered isolated, individual clinical services.

With the passage of 1966 amendments to the Economic Opportunity Act which first authorized the Comprehensive Health Services Program, the city health department invited St. Luke's to participate in expanding the clinical programs at the Riverside Health Center into a comprehensive family program. A neighborhood health council, formed early in 1967, aided St. Luke's in preparing the initial project proposal.

During the early-1967 period, OEO dealt with three city organizations--the Health Services Administration, the Council Against Poverty, and the Human Resources Administration's Community Development Agency--in launching its health services program in New York City. The Health Services Administration is responsible for health-related activities in the city.

The Council Against Poverty, a 51-member board appointed by the mayor, determines the priorities of the various antipoverty programs in the city and gives overall policy direction to these programs. The Council consists of 17 public officials; nine representatives of citywide education, social service, religious, labor, and business organizations; and 25 representatives from the city's designated poverty areas.

The Human Resources Administration is responsible for the city's efforts to help welfare recipients, unemployed persons, drug addicts, youths, and communities solve problems in education, health, and welfare. The Administration's Community Development Agency, the city's officially designated community action agency, is authorized to receive funds from OEO and to carry out the Council Against Poverty's policy decisions.

Early in 1967, the proposals for OEO-funded health services projects, which were submitted by interested sponsors, were reviewed by the Health Services Administration to evaluate the level of medical service proposed and by the Community Development Agency and the Council Against Poverty to evaluate the extent of poverty in the area designated by each proposal, the expressed interest of the community in participating in the program, and the availability of hospital services in the area. The proposals were then submitted to OEO which approved those that it found acceptable. This project was one of those approved by OEO.

During the project's initial program period--June 1967 to November 1968--the Community Development Agency was the grantee for the project and St. Luke's, which had sponsored the project, administered it as a delegate agency. Subsequent grants for the project have been made by OEO directly to St. Luke's.

The following schedule shows the amounts approved and funded by OEO for the project's first 4 program years.

Program year	Period covered	Amount Approved	Amount Funded by OEO (note a)
1	6-16-67 to 6-15-68[b]	$1,139,403	$ 939,403
2	11- 1-68 to 10-31-69	1,802,239	1,552,239
3	11- 1-69 to 10-31-70	1,657,085	1,346,085[c]
4	11- 1-70 to 10-31-71	2,165,524	1,365,524[d]

[a]Differences between the OEO-approved and OEO-funded amounts result from anticipated program revenue, such as Medicare and Medicaid reimbursements.

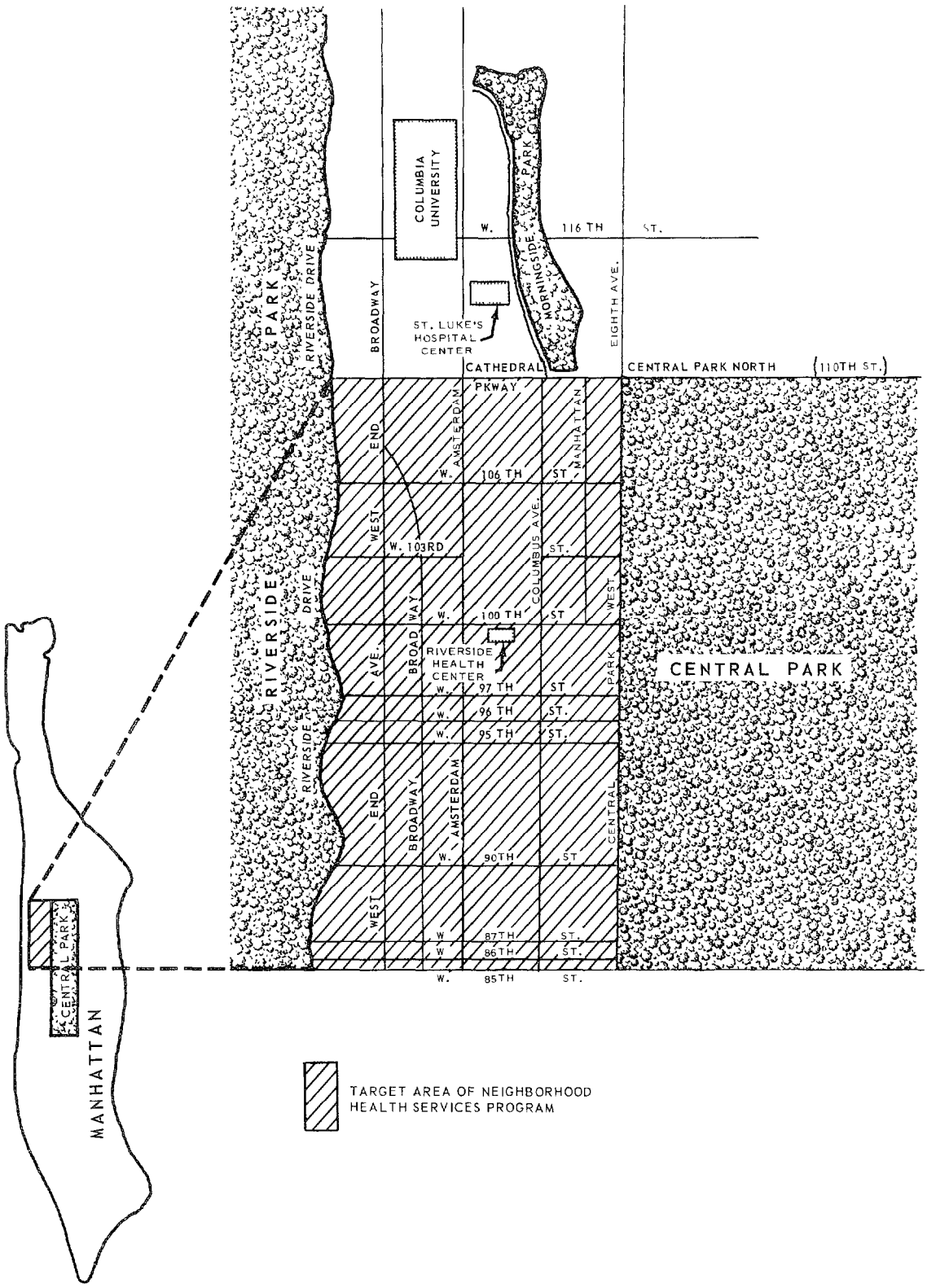
[b]Extended to November 30, 1968. For the month of November 1968, the first and second grants overlapped and ran concurrently.

[c]Includes $478,019 available from prior program year.

[d]Includes $65,929 available from prior program year.

The project's target area is in the West Side of Manhattan (see map on the following page) bounded by West 85th Street, Central Park West, West 110th Street, and the Hudson River. The project's offices are located on the second floor of the three-floor Riverside Health Center which is approximately in the center of the target area. The remainder of the building is used by the city health department to provide various city-sponsored health services, such as chest X-rays, family planning services, public health nursing services, school dental services, child health examinations, immunizations, and social hygiene services.

St. Luke's initial project proposal stated that in 1960 approximately 140,000 persons lived within the target area in economic and social situations which ranged from abject, grinding poverty to relative affluence and moderate wealth. The proposal stated also that 60,000 of these persons constituted the poverty population to which the project would be directed and that a patient enrollment of approximately 20,000 persons from this group was anticipated when the project was fully operational.


RIVERSIDE PARK
RIVERSIDE DRIVE
COLUMBIA UNIVERSITY
MORNINGSIDE PARK
W. 116 TH ST.
BROADWAY
ST. LUKE'S HOSPITAL CENTER
EIGHTH AVE.
CATHEDRAL PKWAY
CENTRAL PARK NORTH (110TH ST.)
AMSTERDAM
MANHATTAN
END
W. 106 TH ST.
WEST
W. 103RD ST.
COLUMBUS AVE.
BROAD WAY
W. 100 TH ST
RIVERSIDE HEALTH CENTER
W. 97 TH ST
W. 96 TH ST.
W. 95 TH ST.
CENTRAL PARK
BROADWAY
AMSTERDAM
W. 90TH ST
W. 87TH ST.
W. 86TH ST.
W. 85TH ST.
MANHATTAN
TARGET AREA OF NEIGHBORHOOD HEALTH SERVICES PROGRAM

Data obtained from city health department records showed that, from 1960, the total population of the target area had decreased. Also, project officials have informed us and we have observed that portions of the target area have undergone, or are scheduled to undergo, redevelopment as part of an urban renewal program.

As of September 30, 1969, the project had 108 full-time employees including seven physicians. An additional 10 physicians and three dentists worked on a part-time basis at the project at that time. As of September 30, 1970, the project's staff had been increased to 130 full-time employees, including 10 physicians and one dentist, and 12 part-time employees, of whom nine were physicians and three were dentists.

CHAPTER 2

IMPROVEMENTS NEEDED TO HAVE THE PROJECT FULLY MEET PROGRAM OBJECTIVES

During its first 3 program years, the project had

--enrolled about half of its intended target population;

--permitted low-income persons needing medical and other health care to be served at the project site, at the sponsoring hospital, and in their homes;

--provided medical services that generally satisfied its enrollees; and

--generally succeeded in involving target-area residents in its planning and operation.

Because of a number of problems, however, which OEO and project officials have recognized and are working to correct, we believe that the project has not yet provided a significantly better health services delivery system than that which previously existed. The Public Health Service medical specialists who assisted us in our review concluded that, on the basis of their visit to the project site and their review of 63 systematically selected patient medical charts, "The program was merely an extension of St. Luke's Hospital Center Emergency-Outpatient Clinic."

Also an OEO evaluation team, which visited the project for 2 days in February 1970 to evaluate the quality of the medical care provided by the project and to review other project operations, noted in its June 1970 report that the project needed to provide more comprehensive, unfragmented services to its patients. The report stated:

> "There appears to be a lack of a concentrated multidisciplinary approach in the delivery of health care services at the Center. The total patient handling system gives the feeling of a traditional charity outpatient department."

Inadequate space and the need to refer many patients to the outpatient clinics of St. Luke's--in essence, returning the patient to the system which project proposals submitted by St. Luke's have described as impersonal and institutionalized--are significant weaknesses in the project's operation.

Other project operations and program components also need to be improved if the project is to fully meet its goals and those of the Comprehensive Health Services Program. Some of the improvements needed were disclosed in the OEO evaluation team's report and in a report of an evaluation of the project made by its own staff in June 1969.

IMPACT OF THE PROJECT

The project, initially funded in June 1967, began providing services in December 1967. As of March 1970 the project had enrolled about 10,000 persons. The project did not have information readily available to show how many of those enrolled had actually been treated after inception of the project, but the project's records did show that many low-income persons needing health and health-related care had been served at the project site, at the sponsoring hospital, and in their homes. For example, during the 8-month period ended February 28, 1970, the project reported the following number of patient encounters with project personnel.

Internist	7,211
Pediatrician	6,770
Other physician specialist	565
Dentist	872
Nurse	1,092
Social worker	820
Community worker	5,020
Other project personnel or not classified	686
Total	23,036

The project's records showed that, of the above encounters, 16,954 had occurred at the project site, 256 had occurred at the hospital, and 5,299 had occurred in the patients' homes. A specific place was not shown for the

remaining 527 encounters, and the total does not include encounters at the hospital with nonproject personnel.

Services provided to enrollees

At the time of our fieldwork, the project offered basic medical services at the Riverside Health Center, the project site, on 5 weekdays and on two weekday evenings; and specialists in gynecology, dermatology, and surgery were on duty one-half day a week. In December 1970 the project extended its hours to include two additional weekday evenings, and in April 1971 Saturday morning hours were added on a trial basis. Following our discussions with project officials about the absence of an after-hours answering service, the project also established an answering service at the Center on a 24-hour basis.

For specialty clinic services and inpatient care, enrollees are generally referred by the project to St. Luke's Hospital Center. The project also has made arrangements with St. Luke's to make emergency room services available to project enrollees after hours and on weekends.

Certain laboratory services were available at the project site during 5 weekdays, and chest X-rays, using city health department equipment, were available on 4-1/2 weekdays. The more difficult laboratory work and all X-rays except chest X-rays were provided at St. Luke's. Because the project did not have sufficient space to provide pharmacy services, most of the enrollees' prescriptions were filled at a nearby private pharmacy with which the project had made special pricing arrangements.

Dental services at the project site were available to enrollees three evenings a week when the city-owned dental facilities used by project dentists were not being used by the city health department for its dental program. For dental services during the day, enrollees were referred to St. Luke's dental clinic. In March 1970 we were informed by the project director that OEO had approved the project's plans for a three-chair dental clinic. According to the OEO-approved grant for the project's fourth program year, the expanded dental services are expected to be operational in August 1971.

At the time of our review, a psychiatrist was available at the project site 20 hours a week to provide mental health services. Social services were provided at the project site but were somewhat limited after the fall of 1969 when most of the personnel in the project's social service department resigned because of a difference of opinion as to their proper functions. In March 1971 OEO informed us that the project staff then included one full-time and one part-time psychiatrist and one psychiatric nurse and that three social workers and two social work aides were then providing social services.

The project provided transportation to the project site and to St. Luke's during weekdays for those enrollees needing it, and its neighborhood health aides visited enrollees in their homes. The project's public health nurses also made some home visits.

The project pays St. Luke's for all services provided by St. Luke's to project enrollees who are not eligible to have their health care paid for by other programs, such as the State title XIX (Medicaid) program. For those patients enrolled in programs such as Medicaid, St. Luke's bills the programs directly.

Acceptance of the project by low-income individuals was evidenced by information we received from interviewing a member from each of 50 enrolled families who, after being systematically selected, consented to an interview. For example, 44 of the 50 persons informed us that they were satisfied with the medical service provided by the project.

Participation of target-area residents

As provided for by OEO guidelines and approved project proposals, the project employed and provided training to residents of the target area and provided them with opportunities to become involved in the policymaking and conduct of the project through membership in a neighborhood health council.

Of the project's 108 employees as of September 1969, 64 occupied nonprofessional positions, such as neighborhood health aides, social service assistants, junior secretaries, and messengers. Of the 64 nonprofessionals, 62 were

residents of the project's target area. Also, of the 39 members of the project's neighborhood health council in the fall of 1969, 19 were eligible to receive project services.

The target-area residents generally filled lower paying positions, and, consistent with general conditions in the health services field, opportunities for their career advancement were somewhat limited. The jobs, however, according to project officials, offered certain advantages to the residents, such as comparatively good salaries[1] and proximity to their homes. Also, with the employment of a new training director in the fall of 1969, emphasis was placed on providing basic education to the nonprofessionals to enhance their basic skills and to assist some of them in obtaining high school equivalency certificates.

The neighborhood health council, whose membership includes representatives of organizations dealing with the poor in the target area as well as persons eligible for project services, participates in decisions on such matters as eligibility criteria, program priorities, and criteria for hiring nonprofessional employees. Of the 20 project enrollees who were asked during our interviews whether they knew of the council, only four stated that they did. Project officials informed us, however, that the council intended to increase its membership of persons eligible for project services and to make itself more widely known to targe -area residents

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[1]The staff salaries are based on (1) salaries paid for similar positions at St. Luke's, (2) salaries paid by other OEO-supported health services projects in New York City, or (3) in cases where the above bases cannot be used, salaries paid for other jobs within the project.

NEED FOR ADDITIONAL PROJECT SPACE AND ASSURANCE THAT IT WILL CONTINUE TO BE AVAILABLE

The project needs more space if it is to achieve its goal of providing comprehensive health services to approximately 20,000 individuals. Moreover, a formal agreement should be executed for the space to ensure its continued availability.

The lack of a formal agreement for the space caused OEO to deny approval of renovations to the facility, which the project had requested to accommodate certain equipment and program services, and might affect the project's ability to achieve its anticipated benefits. The inadequate amount of space has limited the services that can be offered at the project site and seriously affects the possibility of the project's serving its entire target population.

In the initial project proposal to OEO, St. Luke's and the Community Development Agency stressed the availability of space at the city's Riverside Health Center. We were told by the former project director that the project's goal to provide health care to approximately 20,000 persons was predicated on the use of the entire Riverside Health Center facility, which consists of approximately 25,000 square feet. He informed us that use of the entire facility was orally promised to St. Luke's in December 1966 by the city health commissioner who corroborated this information in our discussions with him.

OEO officials informed us that, in approving the project, they considered one of its strengths to be the availability of the city facility, which indicated that health services could be initiated rapidly. OEO funding was initially approved in June 1967, but it was not until mid-October 1967 that the project was provided with half of the second floor of the Center. In November 1967 OEO released the grant funds, and in mid-December 1967 the project started to provide health services. In June 1968, or a year after the OEO grant was approved, the Center's entire second floor, consisting of about 8,000 square feet, was made available by the city health department. Because a contract for the space has not been executed between the city and

St. Luke's, however, the project has no legal rights to the space it occupies.

Although the city submitted several proposed agreements for the space, OEO did not approve them because OEO officials believed that the agreements would not provide the project with sufficient autonomy to operate in accordance with OEO policy. The proposed agreements specified that St. Luke's would assume all responsibilities in providing services, whereas the city's health commissioner would retain final authority over such matters as general policy, procedures, and hours of operation. Under the city's proposed agreements, in effect, the city would not relinquish any control of its facility to the project.

OEO considers the 8,000 square feet available to the project to be entirely inadequate for the comprehensive health program called for under the OEO grant. In its site visit appraisal report dated June 1970, the OEO evaluation team stated that "Without question, the present space available to the program is woefully inadequate." Further, in its guidelines for the development of space allocations for neighborhood health centers, OEO suggests as a general guide that about 38,000 square feet be provided for centers serving a target population of 20,000 persons.

Project officials have also expressed the need for additional space in their proposals to OEO. The proposal for the second program year stated:

> "*** by July 1, 1969, some steps will have to be taken to obtain additional space for the Neighborhood Health Services program."

The proposal for the third program year stated:

> "Space limitations lend to operating inefficiency, staff morale problems, and curtailment of number of patients served."
>
> "A building of some 30,000 - 35,000 square feet is needed if the program is ever to service the 20,000 - 25,000 patients envisioned at the outset."

The proposal for the fourth program year which began on November 1, 1970, stated that registration of new patients would be suspended after 12,500 persons were enrolled due to the lack of space to adequately serve a larger number of patients.

In addition to not having adequate space to serve the intended target population, renovations needed to install pharmacy and X-ray equipment purchased with grant funds were not approved by OEO because a contract for the space did not exist. The project was able to transfer the X-ray equipment, which cost $27,895, to another OEO health services project, but the pharmacy equipment, which cost about $16,600, was being held in storage, at the project's expense, at the close of our fieldwork.

Recommendation to the Director of OEO

If the project is to provide the broad range of services contemplated by the Congress and OEO for comprehensive health services projects, OEO, through the Office of Health Affairs, should request St. Luke's and project officials to bring negotiations with the city for necessary space to a satisfactory conclusion or, as an alternative, to seek other suitable space.

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The Deputy Director of OEO informed us in his letter of March 17, 1971, that OEO was in agreement with the recommendation and that negotiations with the city's Health and Hospital Corporation were then under way. The Deputy Director also stated:

> "A major problem encountered by the project has been adequate space. It was originally anticipated that the total health department facility would be made available to the project early in its development. There have been many unanticipated problems in achieving this step.
>
> "The slow progress the project has made in solving these problems must be viewed in the context of the complexities involved in dealing with many institutions in the City of New York. Negotiations

for an acceptable contract have involved numerous parties, including the Commissioner and Deputy Commissioner of the Health Services Administration, the City Health Office and District Health Officer of the Health Department, the City's Office of Legal Counsel, the Mayor's Office, St. Luke's Hospital, several labor unions, the Midwestside Neighborhood Health Council, and others.

"A further factor was the establishment in 1969 of the Health and Hospital Corporation. HHC was formally organized in July 1970 and on July 1, 1971 the Health Department is to transfer its health clinic facilities to HHC. It is hoped that recent negotiations with HHC will provide a new opportunity for ensuring additional space for the project."

PRODUCTIVITY OF PROJECT'S PROFESSIONAL STAFF SHOULD BE REVIEWED

The relatively low average number of patients seen by project physicians and dentists during the period covered by our review indicated that the project was not making maximum use of available professional health manpower. Project officials acknowledged the problem but attributed it, in part, to the number of appointments missed by patients and to the inadequate space which limited the number of examining rooms available to each physician. OEO informed us in March 1971 that the professional staff's productivity had improved, but we believe that OEO needs to periodically review such productivity to ensure the maximum use of its professional staff members.

In its guidelines for space allocations for neighborhood health centers, OEO suggests that, with adequate space, a physician could be expected to treat four patients an hour, or 28 in a 7-hour day, and that a dentist could be expected to treat two patients an hour, or 14 a day. Further, an OEO evaluation team, in a report on its evaluation of another OEO health services project, stated that a patient load of 14 to 16 patients a day treated by physicians at that project was much less than one would expect.

Our analysis of the project's reported statistics for an 8-month period ended February 28, 1970, showed that, on the average, a project physician treated 9.5 patients a day and a project dentist treated 5.7 patients a day.

In regard to the project's staff-to-patient ratio, the Public Health Service medical specialists who assisted us in our review stated that "Staff-patient ratio appeared unrealistic; staff top-heavy." In its June 1970 report on its appraisal of the project, the OEO evaluation team commented that the physicians were averaging only six or seven patients a day and stated "Clearly there is room for large productivity improvement by the medical staff."

OEO, St. Luke's, and project officials informed us that they agreed generally that the above data indicated that the project was not making maximum use of its professional staff. The officials stated, however, that appointments missed by project patients and inadequate office

space to permit the physicians to have more than one room available for treating patients hampered productivity.

Recommendation to the Director of OEO

OEO, through the Office of Health Affairs, should review the project's professional staffing organization and determine actions necessary to increase the professional staff's productivity.

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The Deputy Director of OEO stated that OEO was in agreement with the recommendation and that progress had been made. The project reported to OEO in February 1971 that, during November and December 1970, its staff physicians treated, on the average, 17.8 patients in a 7-hour day and that the project dentist treated an average 9.1 patients in a 7-hour day.

IMPROVEMENTS NEEDED IN CERTAIN SERVICES AND PROGRAM ELEMENTS

Our review, in which we were assisted by Public Health Service medical specialists, and the findings reported by the project staff and the OEO evaluation team show that improvements are needed in certain of the project's services and program elements if the project is to fully achieve program objectives.

OEO's guidelines in effect when the project initially was proposed stated that the health services then being offered to the poor were insufficient and often inaccessible, impersonal, fragmented, lacking in continuity, and of poor quality. To overcome these problems, the guidelines called for OEO projects to:

--Provide a broad range of comprehensive outpatient health and health-related services--including preventive health services, such as physical checkups, screening, immunization, and health education; diagnostic services; treatment; dental care; and mental health services--at a single conveniently located setting.

--Arrange for specialized services that could not be provided directly, such as highly specialized diagnostic procedures, to be provided elsewhere.

--Arrange for hospital inpatient care with the patient's health center physician maintaining continuity of care.

--Deal effectively with barriers usually encountered by the poor, including hours during which services are available.

--Enable an individual patient to see the same health professionals over continuing periods and all members of a family to be seen by the same physician to the extent that the physician's training makes this feasible. The staff also was to attempt to see the patient in his family setting when appropriate.

In seeking OEO funds to undertake the project, project sponsors stated that the health care provided by the project, among other things, would be continuous, accessible, family oriented, and comprehensive.

Continuity of care for hospitalized patients

Patients were generally treated by their assigned physicians when they visited the project site for medical care, but such continuity was often lost when patients were admitted to St. Luke's for inpatient care. This situation occurred because about half the project's physicians did not have hospital privileges at St. Luke's.

One of the key elements of the project proposed by St. Luke's and approved by OEO was that a single physician would be assigned to provide or supervise the medical care rendered to a patient and his family. Further, whenever a patient was hospitalized, the assigned physician was to follow his progress in St. Luke's, because the physician would be a member of the Department of Medicine at St. Luke's.

For patients visiting the Center, the project made every effort to maintain continuity of care. These efforts were generally successful for patients with appointments, as

evidenced by a study made by two medical students during the summer of 1969 under the guidance of the former project director. The study showed that, in 377 appointment visits to the Center by 75 patients in the sample,[1] the patients were seen by their regular physicians 350 times. Of these 75 patients, 50 were seen by their regular physicians at all of their appointment visits.

When a patient was hospitalized, however, continuity of care by his assigned physician was not ensured because six internists and one of the six pediatricians on the project's medical staff at the time of our fieldwork did not have privileges at St. Luke's.

To determine the extent to which project physicians had maintained contact with patients during the time that the patients were hospitalized, we asked the 50 persons whom we interviewed whether they had been hospitalized after enrolling in the project and, if so, whether they had been seen by a project physician during their hospital stay. Of the 17 persons who had been hospitalized, one informed us that he had been seen by a project physician during his hospitalization. Project records also showed that one project physician visit was made to St. Luke's in the 6-month period ended December 31, 1969, during which time 35 patients were referred to St. Luke's for inpatient care.

Some coordination of treatment during hospitalization was provided in that the project generally forwarded patients' charts to St. Luke's when patients were hospitalized there. Also, if a project patient went to St. Luke's emergency room for service when the project was not open, St. Luke's forwarded an emergency room record to the Center to be placed in the patient's chart.

Project and OEO officials informed us in April and May 1970, respectively, that they recognized that the lack

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[1]The sample consisted of 75 internal medicine patients over the age of 30 who had registered in the months of November and December 1968 and who had been seen by a project physician at least three times.

of hospital privileges for some of the project physicians affected the project's ability to fully achieve its objective of providing continuity of care to project patients. OEO officials stated that, although major hospitals such as St. Luke's did not easily grant hospital privileges, they were attempting to work out a solution with St. Luke's and the project.

Family-oriented health care

The project generally provided individually oriented rather than family-oriented health care to its target population, partially because the project had not fully implemented two operational features which were intended to contribute to family-oriented care--medical care units, or teams, and a family unit health record system.

To provide family-oriented care as called for by OEO guidelines, the project's initial proposal stated:

> "The key element of the proposed Neighborhood Health Services Program is that entire families will be taken on as a single unit, will be assigned to the continuing care and supervision of a single physician, and will receive a comprehensive and well-integrated program of services to handle all their health problems through one source of care."

As an approach to treating the whole family with good medical and other health care, the proposal stated that the project would utilize a medical care unit, or team, consisting basically of two physicians--an internist or general practitioner and a pediatrician--a nurse, a health aide, and a social worker. The proposal stated also that each family would be assigned to a team with the hope that a bond of identity would be established between the patient's family and the team. The proposal stated further that the project's medical records would include certain family data, such as names and medical problems of family members.

Initially, the project attempted to operate on the basis of the team concept. Project officials informed us that the attempt was largely unsuccessful, however, because of missed appointments, a large number of persons walking

in without appointments, patient care requirements differing from those anticipated, inadequate personnel training to adapt to the team concept, and shortages of certain types of team members.

The project's June 1969 self-evaluation report indicated that the inability to carry out the team concept resulted in uncoordinated care's being provided to project families. In this regard, the OEO evaluation team, in its June 1970 report on its site visit appraisal, stated:

> "The problems of the total family have not been viewed at all. Services have been rendered only to the individual patient without consideration or knowledge of the total family picture."

In regard to patient records, the project maintained a unit health record which identified medical care given to an individual, but a family unit health record system had not been implemented. The Public Health Service medical specialists who assisted us stated that their review of patient medical records had shown that:

> "The health care rendered was individual centered. It was not family centered.
>
> "There were no treatment plans to reflect a full assessment of either the individual or the family care needs."

The study made in the summer of 1969 by the two medical students under the guidance of the former project director also disclosed deficiencies in patient records, including an absence of social and family data. The study report stated:

> "The absence of any real social history for 55% of the patients is especially disturbing in view of the fact that Neighborhood Health Services Program serves a low-income population where a high level of social and environmental problems could be expected. The absence of family histories and review of systems could seriously compromise the quality of subsequent diagnoses."

During discussions of this matter, project officials agreed that the project had not made much progress in providing family-oriented care but told us that consideration was being given to reintroducing the team concept.

Comprehensive health care

The initial proposal stated that enrollees would receive a comprehensive and well-integrated program of services to handle all their health problems through one source of care. The proposal stated also that a basic range of preventive, diagnostic, and therapeutic services would be carried out at the project site with the patient's family physician having available to him the specialized facilities and services of St. Luke's or the city health department for problems he could not handle himself.

Because the project's space is limited, however, the services offered at the project site are limited and many patients have to be referred elsewhere, particularly to the specialty and dental clinics at St. Luke's, for needed services. Our analysis of project records for a 5-month period ended October 31, 1969, for example, showed that the number of appointments of project patients at St. Luke's specialty and dental clinics averaged about 1,180 a month and the number of patient encounters with physicians and dentists at the project site averaged 1,675 a month.

Although referrals to other health care sources are appropriate when services are not available at a project site, we believe that a system of frequent referrals of large numbers of patients to other health care sources where they encounter long waits and receive impersonal care is little improvement over the prevailing health care system which the poor would otherwise encounter and which the Comprehensive Health Services Program is designed to change.

Project proposals submitted by St. Luke's have stated that it is the opinion of most objective observers that neither St. Luke's emergency room nor its outpatient clinics provide the type of comprehensive health services considered to be "good medical care" by generally accepted standards--that they are "distant" in a geographical sense from the target area and in a personal sense in the type of institutionalized, impersonal medical care which they offer to patients.

We were informed by project officials that, unless a patient was accompanied to St. Luke's by a project aide, he generally had to wait for a long period of time to obtain medical care even if an appointment had been made for him. The OEO evaluation team also noted this situation and, in its site visit appraisal report, stated:

> "It appears that the procedure is for each patient to be given a referral at the Center and to then confront the St. Luke's clinic system on his own."

The project also appeared to have fallen short in fully achieving its objective of providing preventive health services. For example, the Public Health Service medical specialists who assisted us concluded from their review of patient records that:

- --The health care rendered was primarily episodic. It was not preventive or comprehensive.
- --Physical examinations did not routinely include dental examinations.
- --There were no treatment plans to reflect a full assessment of either the individual or the family care needs.
- --The health care that was rendered was done almost exclusively by either a physician or a dentist. Except on rare occasions, the record documentation did not substantiate nursing evaluation, diet and nutrition services, environmental health services, or community worker involvement.

In its June 1969 self-evaluation report, project personnel stated in regard to preventive medicine:

> "That there is presently no well thought out and organized approach to this extremely important concept is of great concern. Again, it should become a basic component of NHSP's [Neighborhood Health Services Program's] present and future goals."

* * * * *

"Many patients have been seen as walk-ins several times but have never had a full workup [complete physical examination]."

The report recommended that:

"1. Systems be instituted to provide yearly X-rays, pap tests, checks for lead poisoning in children.

"2. Greater emphasis be placed on the education for project employees in regard to preventive care."

The project subsequently initiated a campaign for detection of lead poisoning in children.

Project and OEO officials stated that they were aware that many patients were being referred to St. Luke's clinics but that the lack of space made it necessary. The project director stated that plans were under way to increase the services offered at the project site. The officials stated also that they recognized that improvements were needed in preventive health services but that part of the problem lay with the attitude of project patients who generally were not familiar with the benefits of preventive medicine and therefore were not inclined to seek it.

Conclusion

Improvements are needed in certain services and program elements if the project is to make comprehensive health services available to its target population in the manner contemplated by the Congress and called for by OEO guidelines and approved project proposals. Some of these improvements would be facilitated if adequate space was available. Others will require changes in the project's approaches to and methods of organizing and delivering health services, cooperation of the sponsoring hospital, and increased efforts to provide and encourage the poor to seek preventive care.

Recommendations to the Director of OEO

OEO, through the Office of Health Affairs, should:

--Work with project and St. Luke's officials to obtain hospital privileges for all project physicians.

--Stress to project officials the importance of providing family-oriented health care and implementing procedures and a records system that will aid in such an approach.

--Following arrangements for suitable space, as already recommended, ensure that services will be available to the maximum feasible extent at the project site.

--Reemphasize to project officials the need to expand preventive health care services and to educate the poor to seek such care.

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The Deputy Director of OEO, in his letter of March 17, 1971, informed us that OEO was in agreement with these recommendations, and he indicated actions that had been or would be taken to implement them.

In regard to hospital privileges, the Deputy Director informed us that a series of discussions with St. Luke's to overcome the long-standing problems of hospital privileges had resulted in some progress. The project informed OEO in January 1971 that all project physicians had clinical appointments at St. Luke's and that all pediatricians had attending status. The project stated that it did not have a problem in getting its patients admitted to the hospital, despite the fact that the physicians did not have an attending status, but that the problem occurred in attempting to coordinate patient health care management during hospitalization.

In February 1971 the project informed OEO that it had formalized a mechanism whereby its physicians, on a rotating basis, were attending hospital rounds and that such attendance provided the project with a direct relationship to the patient while hospitalized. The project also stated

that its patients would be seen by the project's nursing staff during their stay.

In regard to family-oriented care, the Deputy Director stated that the team approach was being initiated on a trial basis. The project informed OEO in January 1971 that one team had been established as a pilot project to enable project officials to evaluate properly the goals of a team and to determine, in fact, a team's impact on a specific patient population. The project stated that the pilot project was intended to avoid the pitfalls that had occurred in the past when the teams were quickly implemented without the necessary training and without the teams' goals, objectives, and evaluation procedures having been worked out.

In regard to family records, the project informed OEO in January 1971 that basic changes would have to be worked out with St. Luke's since project records were tied to the St. Luke's system. In the meantime, the project stated, a face sheet summarizing social and medical facts relating to the family was being made a part of each project patient's record.

In regard to increased services at the project site, the Deputy Director stated that, as we had indicated, improvements depended, in large part, on the availability of additional space.

In regard to preventive health services, the Deputy Director stated that some progress had already been made but that changes in health care practices to give greater emphasis to preventive care required substantial and continuing educational efforts among both providers and consumers.

CHAPTER 3

IMPROVEMENTS NEEDED IN PROJECT ADMINISTRATION

CONTROLS OVER ELIGIBILITY DETERMINATIONS SHOULD BE STRENGTHENED

The project made free medical services available, in some instances, to persons who did not meet OEO-approved eligibility criteria and, in other instances, to persons whose eligibility had not been clearly established. The project needs to strengthen its controls over eligibility determinations to ensure that OEO funds are not diverted from the intended target population.

OEO guidelines specify that all persons receiving OEO-assisted health services must meet a test of need by reason of circumstances of poverty and that only persons residing within the designated target area may receive regular care. The guidelines specify, however, that no such determinations are to be made in a circumstance when the need for medical services is acute but that determinations of eligibility for continued services are to be made as soon as possible after the initial services.

In accordance with OEO guidelines and with OEO's approval, the project chose to use the family income standards of New York State's Medicaid Program in determining a person's eligibility for project services by reason of circumstances of poverty. The project proposals also stated that it would enroll only persons residing within its target area.

The project enrolled some persons, however, and used OEO funds to provide services to them, without regard to their family incomes or places of residence. For example, participants in a program for unwed pregnant teenagers, carried out at a private clinic located in the target area, were enrolled in the project, prior to September 1969, along with members of their families, regardless of family income and whether or not they resided in the target area. In October 1969 there were 75 participants in the program. A project official informed us that most participants

resided in the target area but that those residing outside the target area were not refused services.

On September 1, 1969, the project's neighborhood health council directed the project to continue serving those participants then in the program and their families regardless of residence but stated that, thereafter, although no regard was to be given to family income, new participants and their families would be eligible for enrollment in the project only if they lived in the target area.

In another instance, a community organization operating in the general geographic area of the project established a program in the summer of 1968 to train mothers and aid them in finding jobs; day care for their children was to be provided in nearby homes. The trainees and all adult members of the families who were to provide day-care services were required to have physical examinations. The then-project director instructed the project staff to consider all persons referred from this program as eligible for project services and to enroll them in the project for regular care.

On September 1, 1969, the neighborhood health council informed the project's department heads that all participants in this program and their families then enrolled in the project would remain eligible for project services but that new participants would not be enrolled unless they qualified on the basis of the project's income and residency criteria. The council stated, however, that those participants not qualifying for regular care would be given initial physical examinations at the project without charge.

The project generally did not verify enrollees' reported family incomes and places of residence. Aside from verbal statements made by the enrollees or the showing of Medicaid cards at the time of initial application or reregistration, no verification was made in regard to incomes or places or residence. We did not seek to verify the addresses of all enrollees; but, in attempting to contact 136 systematically selected enrollees to interview them about the services they and their families had received from the project,

we found that 39 did not reside at the addresses shown for them in project records.[1]

To reduce the number of ineligible patients, the project adopted a policy late in August 1969 which provided that persons without appointments, who were not otherwise eligible for services, would be treated only if they were considered medical emergencies; otherwise, they would be referred elsewhere. If persons had been registered at the project, however, they would continue to be served.

When we questioned project officials about the problems of eligibility during our review, we were told that the project was formulating policies and procedures by which ineligible persons could be removed from the registration roles.

Project, St. Luke's, and OEO officials acknowledged that some ineligible persons may have been served by the project. They stated, however, that eligibility determinations were not always easily or expeditiously made because of the transient nature of the target population and the need to follow OEO's policy that eligibility determinations be made in ways consistent with the objective of eliminating financial, administrative, and other barriers to needed health services.

Recommendation to the Director of OEO

To preclude the use of OEO funds to provide services to ineligible persons, which diverts those funds from the intended target population, OEO, through the Office of Health Affairs, should require the project to strengthen its controls over eligibility determinations.

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[1] In addition to the 50 successful interviews and 39 cases of erroneous address, there were 36 prospective interviewees who were not at home, nine who were not willing to be interviewed, and two who had not made medical visits to the project.

The Deputy Director of OEO informed us that OEO agreed with the recommendation and that considerable progress had been made in this area since the close of our fieldwork. In this connection, the project informed OEO in February 1971 that it had embarked on and was continuing a reregistration campaign intended to (1) screen out patients no longer eligible for the project and (2) maintain the records of patients who were eligible and who were still utilizing the project.

NEEDED IMPROVEMENTS MADE OR PROMISED IN MANAGEMENT OF GRANT FUNDS

A number of matters needing improvement came to our attention in our review of selected aspects of the management of grant funds. We brought these matters to the attention of OEO in a draft of this report in December 1970 and proposed actions necessary to effect the improvements. By letter dated March 17, 1971, the Deputy Director of OEO informed us that OEO agreed with our proposals, and he cited actions that had been or would be taken to implement them. The matters and the actions cited by the Deputy Director are discussed below.

Audit of indirect cost rate needed

OEO had not made or arranged for an audit of the rate used by St. Luke's for charging indirect costs to the project during the project's first 2 program years which ended October 31, 1969. On the basis of St. Luke's acknowledgment in the proposal for the project's third program year that the rate used during the first 2 program years was too high, it appears that the amounts paid by the project to St. Luke's for indirect costs during that time may have been excessive.

St. Luke's was paid $94,094 and $131,692 for the first and second program years, respectively, for providing certain administrative services, such as personnel and payroll services, to the project. These payments were computed on the basis of an indirect cost rate of 15 percent of project salaries and wages including fringe benefits. This arrangement was accepted by OEO, subject to audit. Through October 1970, however, no audit had been made.

St. Luke's acknowledged in its proposal for the project's third program year that the 15-percent rate was too high. Therefore, OEO tentatively approved $50,000, rather than a percentage, for indirect costs for the third program year, subject to the following special condition.

> "The amounts budgeted for indirect costs shall not be expended until an auditing agency or an auditor designated by OEO identifies the direct and indirect costs incurred in conducting the

approved work program of this grant and arrives at an indirect cost allocation for the work undertaken pursuant to this grant***."

In November 1970, OEO officials informed us that OEO was planning to review the St. Luke's indirect cost rate.

We proposed in our December 1970 draft report that OEO arrange for an audit to be made. In response, the Deputy Director informed us that OEO, on several occasions, had requested St. Luke's to submit indirect cost proposals for the first 3 program years so that OEO could arrive at an overhead rate. He stated that an indirect cost proposal for the third program year, submitted on January 29, 1971, had been deemed to be inadequate and that, as a result, no funds for indirect costs had been approved for the fourth program year. He stated also that further discussions were under way between the OEO staff and St. Luke's personnel on this matter.

Project should seek reimbursement for services provided to St. Luke's

Although the project pays their entire salaries, full-time project physicians who have hospital privileges at St. Luke's are required to spend 10 percent of their working time at St. Luke's clinics. St. Luke's has not reimbursed the project for these physicians' services. As of February 1970, five project physicians, receiving annual salaries totaling about $131,000, were working on a part-time basis at St. Luke's.

St. Luke's associate director informed us that some Medicaid payments had been received by St. Luke's for services provided at the clinics by project physicians. He also told us that St. Luke's was planning to reimburse the project in some manner for these physicians' services.

We proposed in our December 1970 draft report that OEO determine whether the project had taken action to obtain reimbursements from St. Luke's for services provided at St. Luke's by project employees. The Deputy Director of OEO informed us in March 1971 that such action had been taken. The project informed OEO in January 1971 that it had set up a system whereby all hours spent by project physicians at

St. Luke's clinics would be reimbursed to the project at the rate that St. Luke's is reimbursed from Medicaid.

Internal controls over payroll procedures need strengthening

The project needs to strengthen certain internal controls over its payroll procedures to ensure that duties and responsibilities for preparing and disbursing the payroll are separated appropriately and that payroll expenditures are appropriate and are supported by adequate documentation.

Our review of the project's payroll procedures showed the following weaknesses.

1. Time cards of employees working at the main project site were not certified by supervisory personnel.

2. Employees working at places other than the main project site certified their own time and attendance.

3. The individual responsible for payroll preparation also distributed the payroll checks.

4. Some project physicians were paid for substantial periods which were not recorded on their time cards.

Project officials informed us in April 1970 that action would be taken to provide the necessary internal controls. In March 1971, the Deputy Director of OEO stated that all four weaknesses concerning payroll procedures had been corrected.

Questionable project expenditures

Through mid-December 1969, the project had paid about $65,200 in salaries and related fringe benefits and overhead charges which we questioned because the employees' positions either were not needed for project operations or had not been authorized by OEO. Such expenditures might have been avoided through closer monitoring of the project by OEO. Details follow.

1. A pharmacist was initially employed with OEO's approval on March 24, 1968, but her employment was terminated on September 30, 1969, because the project had not established its own pharmacy. During the first 6 months of her employment, her efforts in helping to formulate pharmaceutical requirements for the planned project pharmacy were applicable to the project. The planned pharmacy was not established, however, and the salary and related charges of about $13,700 applicable to the remainder of her employment period, when she worked at St. Luke's pharmacy, were of questionable benefit to the project.

2. A public health nurse and a secretary were employed, without OEO approval, at a private clinic in the target area which operated an educational program for unwed pregnant teenagers. The former project director informed us that he had decided to fund the positions from project funds even though the clinic's operation was not mentioned in project proposals and the clinic did not require that participants reside in the target area. Through December 13, 1969, salary and related charges for these two persons totaled about $30,550. The project discontinued funding these positions on March 6, 1970.

3. The project employed a person to supervise students who were enrolled at Columbia University and who were assigned to the project's neighborhood health council to meet a requirement of their master's programs in social work. The students were not required for project operations. The project director informed us that this position, for which salary and related charges totaled about $18,610 through mid-December 1969, would be eliminated at the end of the 1969-70 academic year.

4. The project used grant funds to pay one third of the salary of an employee working in St. Luke's personnel department. Personnel costs incurred by St. Luke's for project business were to be covered by St. Luke's indirect cost charges and, therefore, direct payment by the project of part of the salary of this employee was not appropriate. Salary and

related charges for this employee totaled about $2,340 through mid-December 1969.

- - - -

In our December 1970 draft report, we proposed that OEO determine whether the project had taken appropriate action to adjust the charges to OEO grant funds for items which were not authorized under grant provisions and stated that OEO should monitor the project's financial controls and procedures more closely to ensure that grant funds would be expended in accordance with prudent business practices and OEO requirements.

In March 1971, the Deputy Director informed us that OEO agreed with our proposals and that

--the OEO account had been reimbursed by St. Luke's for the full amount of $13,700 of the pharmacist's salary,

--the program for teenagers was discontinued promptly after OEO became aware of it,

--the position of supervisor of the social work students was eliminated in May 1970, and

--the OEO account was reimbursed by St. Luke's in the full amount of $2,340 for the employee working in St. Luke's personnel department.

CHAPTER 4

SCOPE OF REVIEW

Our review was concerned primarily with the policies, procedures, and practices followed in the administration of the Neighborhood Health Services Program by St. Luke's Hospital Center in New York City and the extent to which Comprehensive Health Services Program objectives had been met. We were assisted in our review by Public Health Service medical specialists who evaluated the quality of medical care provided by the project and the adequacy of patient medical records.

We reviewed the basic legislation authorizing the Comprehensive Health Services Program, OEO policy and guidance publications and documents, and the grant agreements approved by OEO. We examined pertinent records and documents and interviewed officials of OEO, the project, St. Luke's, and the Community Development Agency. We also interviewed 50 program beneficiaries to obtain their views on services furnished by the project.

Our review was performed primarily at the project site, at St. Luke's Hospital Center in New York City, and at OEO's headquarters offices in Washington, D.C.

APPENDIXES

OEO-FUNDED COMPREHENSIVE HEALTH SERVICES PROJECTS IN NEW YORK CITY

Project	Administrating agency	Grantee
Neighborhood Health Services Program 160 West 100th Street New York, New York	St. Luke's Hospital Center	St. Luke's Hospital Center
Neighborhood Health Center of Provident Clinical Society, Inc. 476 Nostrand Avenue Brooklyn, New York	Provident Clinical Society of Brooklyn, Inc.	Community Development Agency
Charles Drew Neighborhood Health Center 425 Howard Avenue Brooklyn, New York	Catholic Medical Center of Brooklyn and Queens	Community Development Agency
Red Hook Neighborhood Health Center 70 Atlantic Avenue Brooklyn, New York	Long Island College Hospital	Community Development Agency
Sunset Park Health Center 514 49th Street Brooklyn, New York	The Lutheran Medical Center	The Lutheran Medical Center
Gouverneur Health Services Program 9 Gouverneur Slip New York, New York	Beth Israel Medical Center	Beth Israel Medical Center
Dr. Martin Luther King, Jr. Health Center 3674 3rd Avenue Bronx, New York	Montefiore Hospital and Medical Center	Montefiore Hospital and Medical Center

OFFICE OF ECONOMIC
OPPORTUNITY

EXECUTIVE OFFICE OF THE PRESIDENT
WASHINGTON, D.C. 20506

MAR 17 1971

Mr. Henry Eschwege
Associate Director
United States General Accounting
Office
Washington, D.C. 20543

Dear Mr. Eschwege:

As requested in your letter of December 29, 1970, we have reviewed in detail the draft report on the Neighborhood Health Services Program of St. Luke's Hospital Center, New York, New York. We have also provided copies to the Project and Hospital staff and have received and reviewed their comments.

Comments on the draft report are enclosed. These statements include both general observations and comments on particular points.

We would be pleased to discuss any of these comments further with G.A.O. staff.

Thank you for your assistance.

Sincerely,

Wesley L. Hjornevik
Deputy Director

Enclosure

Comments on GAO Draft Report, "Opportunities for Improving the Neighborhood Health Services Program for the Poor Administered by St. Luke's Hospital Center, New York, New York.

GENERAL COMMENTS

The O.E.O. Comprehensive Health Services Program assists local agencies and groups that are committed to participate in the development of more effective ways of providing ambulatory health care to low-income populations. The Program Guidelines indicate the goals and general approaches of these efforts. Local institutions and personnel plan and implement their own special ways of working towards these goals.

A key aspect of the O.E.O. - supported experiments has been the variety of local approaches that have been undertaken. In this way, the opportunities for new learning and demonstrations under diverse conditions and circumstances have been furthered. Special features of the project administered by the St. Luke's Hospital Center are the participation of a major teaching hospital and a health department facility, along with concerned community groups on the west side of Manhattan Island.

A major problem encountered by the project has been adequate space. It was originally anticipated that the total health department facility would be made available to the project early in its development. There have been many unanticipated problems in achieving this step.

The slow progress the project has made in solving these problems must be viewed in the context of the complexities involved in dealing with many institutions in the City of New York. Negotiations for an acceptable contract have involved numerous parties, including the Commissioner and Deputy Commissioner of the Health Services Administration, the City Health Office and District Health Officer of the Health Department, the City's Office of Legal Counsel, the Mayor's Office, St. Luke's Hospital, several labor unions, the Midwestside Neighborhood Health Council, and others.

A further factor was the establishment in 1969 of the Health and Hospital Corporation. HHC was formally organized in July 1970 and on July 1, 1971 the Health Department is to transfer its health clinic facilities to HHC. It is hoped that recent negotiations with HHC will provide a new opportunity for ensuring additional space for the project. Many of the problems of the project have been and are directly or indirectly related to the space problems. Their experience has demonstrated and documented the extraordinary difficulties in trying to implement a Comprehensive Health Services Program under these conditions.

The comments of the Project Director and the St. Luke's Hospital staff are attached as Exhibit 1. [See GAO note.]

GAO note: The exhibit was considered in the preparation of our final report but has not been included here.

SPECIFIC COMMENTS

GAO note: Following are excerpts from the specific comments accompanying the Deputy Director's letter, which refer to the recommendations made in our final report or to proposals made in our draft report and to actions taken thereon. The page numbers refer to the pages of this report.

We did not include here those portions of the specific comments which referred to particular points in our draft report or to the project's views, as these comments were either included in, or considered by us in the preparation of, our final report.

"We are in agreement with this recommendation. Substantial efforts have been made by OEO staff as well as local project officials to obtain needed space. *** negotiations with the Health and Hospital Corporation are now underway; staff of the Office of Health Affairs, project officials, and St. Luke's personnel are actively involved." (Page 21.)

"We are in agreement with the recommendations on staffing patterns and productivity. Much progress has already been made in this area." (Page 24.)

"We are in agreement with these recommendations:

"Hospital privileges for physicians--Considerable progress has already been made in this area."

"It should be noted that OEO consultant staff have had a series of discussions with the St. Luke's staff to overcome the long-standing problems of hospital privileges. Significant progress has been made."

"Family-oriented health care--Some progress has already been made in this area ***."

"The team approach is being initiated on a trial basis."

"Fragmented Services--As indicated, improvements depend in large part on the availability of additional space."

"Preventive Health Services--Some progress has already been made." (Page 32.)

"We are in agreement with the recommendation regarding eligibility. Considerable progress has been made in this area since the close of GAO's field work." (Page 37.)

"OEO has, on several occasions, requested St. Luke's Hospital to submit indirect cost proposals for the three program years so that OEO can arrive at an overhead rate. OEO, as well as other applicable Federal agencies, does not normally compute or otherwise develop a grantee's overhead costs. An indirect cost proposal for the third program year, submitted on January 29, 1971, has been deemed to be inadequate. As a result, no funds for indirect costs have been approved for the fourth program year. Further discussions are underway between the OEO staff and St. Luke's personnel on this matter." (Page 39.)

"Action has been taken on reimbursements for services provided at St. Luke's." (Page 39.)

"All four weaknesses concerning payroll procedures have been corrected." (Page 40.)

"The OEO account has been reimbursed by St. Luke's for the full amount of $13,700, of the pharmacist's salary." (Page 42.)

"This program for teenagers was discontinued promptly after OEO became aware of it." (Page 42.)

"Five social work students were assigned to the Midwestside Neighborhood Health Council, free of charge, by Columbia University. The students

were involved in assisting and training health council members, a valuable service to facilitate program development. However, since the position of supervisor was not specifically approved by OEO, the position was eliminated in May 1970." (Page 42.)

"The OEO account has been reimbursed by St. Luke's in the full amount of $2,340." (Page 42.)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

FEB 19 1971

Mr. Philip Charam
Associate Director, Civil Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Charam:

Reference is made to your letter of December 23, 1970 in which you requested that we review GAO's draft report on their audit of the operations of the Neighborhood Health Services Program for the Poor administered by the St. Luke's Hospital Center, New York, N.Y., and funded by the Office of Economic Opportunity.

We believe that this report reveals an excellent understanding of the philosophy, purposes, and design of neighborhood health centers. The report's recommendations are well-taken.

We appreciate the opportunity afforded us to review the draft report, and would like to receive a copy of the final report when it is released.

Sincerely yours,

James B. Cardwell
Assistant Secretary, Comptroller

APPENDIX IV

PRINCIPAL OFFICIALS OF THE OFFICE OF ECONOMIC OPPORTUNITY RESPONSIBLE FOR THE ADMINISTRATION OF ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
DIRECTOR:		
Frank C. Carlucci	Dec. 1970	Present
Donald Rumsfeld	May 1969	Dec. 1970
Bertrand M. Harding (acting)	Mar. 1968	May 1969
R. Sargent Shriver	Oct. 1964	Mar. 1968
ASSOCIATE DIRECTOR, OFFICE OF HEALTH AFFAIRS:		
Carl A. Smith, M.D.	May 1971	Present
Thomas E. Bryant, M.D.	Sept. 1969	Apr. 1971
ASSISTANT DIRECTOR, OFFICE OF HEALTH AFFAIRS (note a):		
Thomas E. Bryant, M.D. (acting)	Jan. 1969	Sept. 1969
Joseph T. English, M.D.	Mar. 1968	Jan. 1969
Julius B. Richmond, M.D.	July 1966	Mar. 1968
ASSISTANT DIRECTOR FOR COMMUNITY ACTION PROGRAMS (note a):		
Theodore M. Berry	Apr. 1965	Sept. 1969
PROJECT MANAGER, HEALTH SERVICES, COMMUNITY ACTION PROGRAM (note a):		
Gary D. London, M.D.	Apr. 1968	Aug. 1969
John Frankel, D.D.S.	July 1966	Apr. 1968

[a]In September 1969 these offices were terminated as organizational entities in a major reorganization of OEO. At that time the various health activities of OEO, including the Comprehensive Health Services Program, were combined in a new Office of Health Affairs while the majority of other Community Action Program activities were shifted to a newly created Office of Operations.

U.S. GAO, Wash., D.C.