REPORT TO THE CONGRESS

Study Of Programs For Health Services In Outpatient Health Centers In The District Of Columbia B-118638

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JULY 31, 1973

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

B-118638

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

This is our report entitled "Study of Programs for Health Services in Outpatient Health Centers in the District of Columbia."

We made our review 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).

We are sending copies of this report to the Director, Office of Management and Budget; the Secretaries of Commerce and of Health, Education, and Welfare; the Director, Office of Economic Opportunity; and the Commissioner of the District of Columbia.

Comptroller General
of the United States

Contents

ABBREVIATIONS

ADA	American Dental Association
AMA	American Medical Association
C&Y	Children and Youth
DHR	Department of Human Resources
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HPAC	Health Planning Advisory Committee
HSMHA	Health Services and Mental Health Administation
MIC	Maternity and Infant Care
NMAF	National Medical Association Foundation, Inc.
OB-GYN	Obstetrical and Gynecological
OEO	Office of Economic Opportunity

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

STUDY OF PROGRAMS FOR HEALTH SERVICES IN OUTPATIENT HEALTH CENTERS IN THE DISTRICT OF COLUMBIA B-118638

D I G E S T

WHY THE STUDY WAS MADE

Increasing congressional concern with Federal grant-in-aid programs and local government's and private nonprofit organizations' involvement in similar activities prompted GAO to study Federal and District programs providing basic health services (general medicine, pediatrics, obstetrics and gynecology (OB-GYN), and dental) to eligible persons in outpatient health centers in the District.

The District Government, through its Department of Human Resources (DHR), is responsible for providing health care to District residents. DHR and three private nonprofit organizations provide health care in 21 outpatient health centers. Funds for the operation of these health centers are provided by the District under one program and by the Federal Government under seven programs. The Federal programs, because they were usually directed to specific persons and/or persons residing in specific areas, generally did not achieve the District's objective of providing one-stop health care to all members of a family.

In fiscal year 1972, provided funds totaled about $11 million--$7.6 million by the Department of Health, Education, and Welfare and the Office of Economic Opportunity; $2.9 million by the District; and $500,000 by the private nonprofit organizations.

FINDINGS AND CONCLUSIONS

The delivery systems for providing health services in outpatient health centers under these programs were uncoordinated. The individual agency and program approach was used rather than a District-wide coordinated program approach and no one organization had authority over all centers.

The nonprofit organizations and the District, with minimal coordination, individually planned for the location of health centers. This individual planning resulted in (1) an imbalance in the location of outpatient health centers, (2) the capability in some areas to provide more health care than residents were actively seeking, and (3) a lack of capability in other areas to provide sufficient health care. (See p. 7.)

One organization, such as DHR, should have the authority and responsibility to coordinate the planning and development of outpatient health centers on a District-wide basis to insure that centers are located in areas needing services. The District should study health needs and develop a master plan for locating health centers.

Of the 21 outpatient health centers, 14 did not provide comprehensive health care. For example, 9 centers did not provide dental services and 13 centers had either no X-ray equipment or no centralized pharmacy. Some centers served all members of a family, but others served only certain members of the family. (See p. 13.)

Health centers should serve all members of a family and one organization, such as DHR, should have the authority

and responsibility to insure that health centers provide comprehensive health services for all family members.

Underuse of outpatient health services was prevalent, and District-wide reviews of the use of health center services had not been made. (See p. 19.) The average number of daily patient visits per physician by type of service varied widely among the 21 outpatient health centers. For example, patient visits per day per physician for pediatric services ranged from 4 to 34 and averaged 17.

Also, the use of health center services was generally below average compared with use data published by recognized health organizations. (For pediatrics, the average was 26.) The usage rates for the outpatient health centers, by medical specialty, are shown in exhibit C and on the graphs on pages 20 to 23.)

The low use resulted from the location of many centers in the same general area of the District which provided the area with more health care capability than the residents were actively seeking and an inequitable distribution of physicians by medical specialty among the centers in relationship to the age and sex of the population being served.

District-wide usage of health services should be periodically reviewed and compared with acceptable levels of performance as a means of enhancing the delivery of health services.

Health centers followed varying practices for maintaining and retaining patients' medical records. Medical records are essential to providing health services to patients, and therefore the health centers' recordkeeping practices should be uniform. (See p. 25.)

RECOMMENDATIONS

The District Commissioner should prepare a comprehensive action plan, addressing the problems discussed in this report, for delivering outpatient health services and, when necessary, seek authority from Federal agencies to carry out the plan effectively. (See p. 31.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

The Commissioner (see app. I) advised GAO that DHR would appoint task forces to prepare such a comprehensive action plan and to determine what additional authority the District requires to effectively carry out the plan.

MATTERS FOR THE CONSIDERATION BY THE CONGRESS

Categorical Federal grants for health may lessen the opportunity for localities to develop an effective comprehensive action plan for delivering outpatient health services. GAO believes that its study will be useful to the Congress in deliberations on any legislation to consolidate Federal grants for health programs.

CHAPTER 1

INTRODUCTION

Increasing congressional concern with Federal grant-in-aid programs and local government's and private nonprofit organizations' involvement in similar activities prompted us to study Federal and District of Columbia programs for providing health services in outpatient health centers in the District. We previously issued two reports on child-care activities and manpower service programs.[1]

Funds were provided under 7 Federal programs and 1 District program for health services in 21 outpatient health centers. These services include general medical, obstetrical and gynecological (OB-GYN), pediatric, dental, and related support services.

In fiscal year 1972, funds totaling about $11 million were provided for health services--$7.6 million by the Department of Health, Education, and Welfare (HEW) and the Office of Economic Opportunity (OEO); about $2.9 million by the District; and about $500,000 by private nonprofit organizations.

The outpatient health centers have been established in District poverty areas and provide health services generally to disadvantaged District residents. Some centers provide health services only to persons who reside in specific areas; other centers provide health services to all persons.

We examined each of the Federal and District programs involved and interviewed public and private officials responsible for administering and operating these programs. We visited and obtained data for each of the 21 outpatient health centers.

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[1]One report was to the Committee on Education and Labor, House of Representatives, on "Study of Child-Care Activities in the District of Columbia" (B-174875, Jan. 24, 1972), and another was to the Congress on "Study of Federal Programs for Manpower Services for the Disadvantaged in the District of Columbia" (B-146879, Jan. 30, 1973).

We have included, as exhibit A, a map showing the location of the 21 centers and, as exhibit B, a description of the District and Federal programs and how they were organizationally implemented. The Federal and local agencies involved are shown as they existed in fiscal year 1972.

CHAPTER 2

DELIVERY OF OUTPATIENT HEALTH SERVICES

The District's Department of Human Resources (DHR) is responsible for providing health care to eligible District residents. The District determined in 1968 that outpatient health centers providing preventive medical services and treatment of minor health disorders to those in need were an integral part of a District-wide health care program.

At that time the District operated several specialty health centers which provided outpatient services to only certain family members. In lieu of some of these specialty centers, the District established a number of family-oriented neighborhood health centers. The District's goal was to provide one-stop health care at each center to all members of a family and to reduce the large number of outpatient and emergency cases at the District of Columbia General Hospital.

In May 1973 DHR operated eight neighborhood health centers and eight specialty centers. Three private organizations operated two neighborhood health centers and three specialty centers. The specialty centers provided health services only to women and children.

The private nonprofit organizations, which received funds directly under the various Federal programs and which are subject to Federal agency policies and procedures, provided outpatient health services to basically the same District population--the poor and low-income medically indigent--as the DHR did and thus created overlapping responsibilities.

Also, most of the Federal programs are directed to the health needs of only some family members and/or persons residing in specific areas of the District, and, as such, are not consistent with the District's goal of providing one-stop health services to all eligible family members.

In 1966 the Congress allowed State governments to control and coordinate health planning activities at the State and local level by preparing comprehensive State health plans which included (1) designating a single State agency for health planning and (2) establishing a State health planning council.

The District Commissioner (1) designated himself as the sole agency for overseeing comprehensive District health planning, (2) designated the Health Planning Advisory Committee (HPAC) to advise him on such matters, and (3) delegated the responsibility for preparing the District's plan to DHR.

The District's comprehensive health plan was not effectively implemented because the Commissioner lacked the authority to control or coordinate the delivery of all health services; DHR had insufficient staff to review health services activities; and HPAC, whose members serve voluntarily, had little time to make such reviews. As a result, adequate consideration was not given to (1) the imbalance in the location of health centers, (2) the lack of a network of health centers providing comprehensive health services, (3) the underuse of health services, and (4) the lack of uniform policies and procedures for maintaining patients' medical records and transferring them among the centers.

Many of these problems, which are discussed in more detail in the following chapter, resulted from Federal agencies funding outpatient health services on an individual program and agency basis rather than on a comprehensive District-wide basis.

CHAPTER 3

PROBLEMS ASSOCIATED WITH THE INDIVIDUAL AGENCY AND PROGRAM APPROACH

LOCATION OF HEALTH CENTERS

The nonprofit health organizations and the District, with minimal coordination, individually planned the locations for outpatient health centers. This resulted in some District areas having many health centers with the capability to provide more health care than the residents were actively seeking and other areas having very few centers with insufficient health care capability. Unless the planning for locating proposed new health centers is done on a coordinated District-wide basis and includes studies of community health needs, further imbalances could occur.

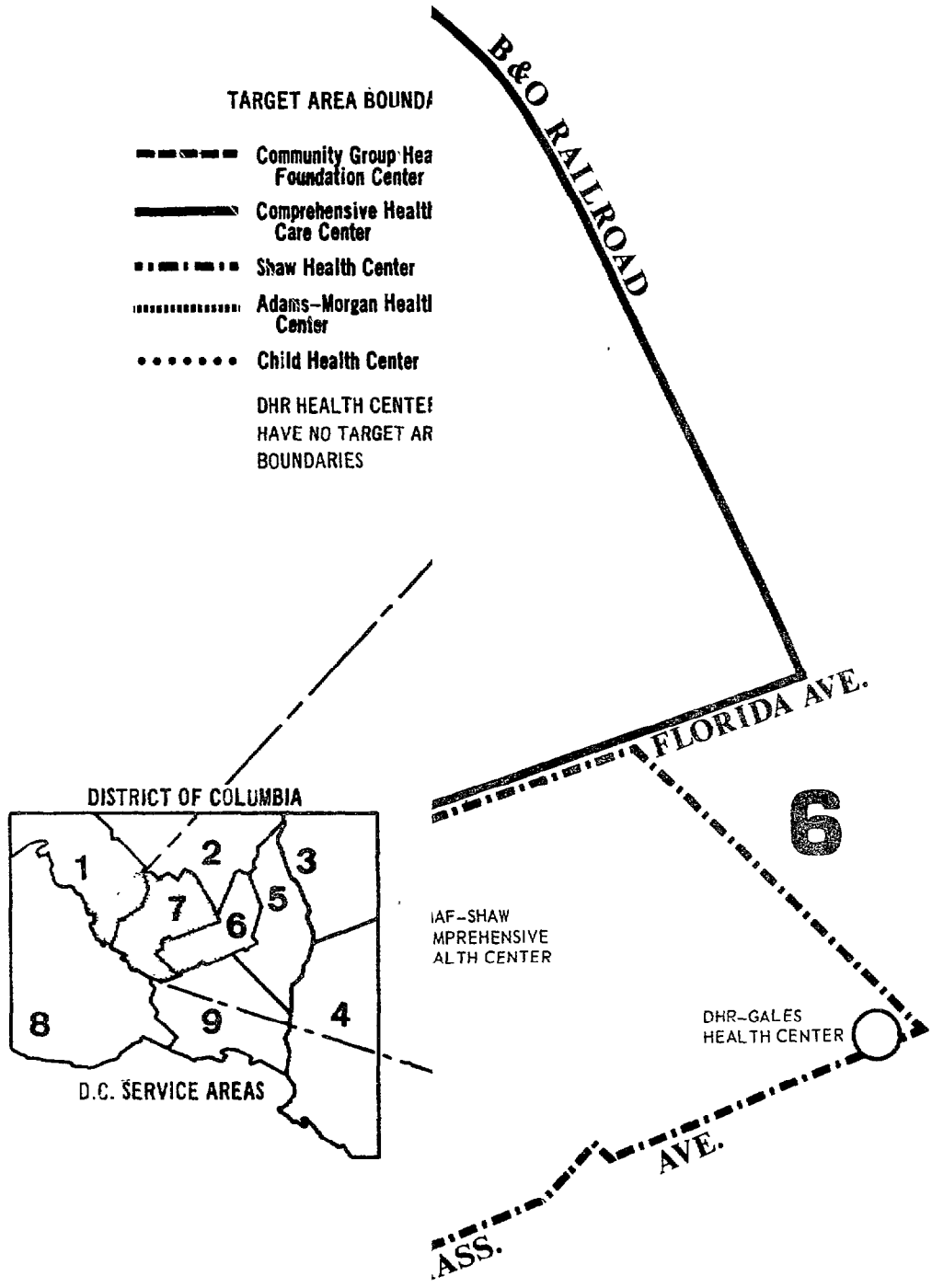
Two outpatient health centers are located in the Anacostia area (service area 4 on exhibit A) which had a population in 1970 of about 126,200, or approximately 17 percent of the total District population. These health centers, funded and operated by DHR, provide health care to all family members.

Eight health centers are located in the Cardozo-Shaw area (see map below) which had a 1970 population of 174,000, or about 23 percent of the total District poulation. Of these eight health centers, five are operated by three private nonprofit organizations which depend almost entirely on Federal funds and three are funded and operated by DHR.

Each of the privately operated centers has a designated service area and provides outpatient health services only to persons residing in the designated area. In some instances, as shown on the map, the designated areas overlap, indicating uncoordinated planning in locating the centers and in establishing the service areas.

For example, a child residing in the vicinity of point A on the map (an overlapping area) is eligible for and can obtain pediatric services at three health centers--the Shaw Community Comprehensive Health Center, operated by the National Medical Association Foundation, Inc. (NMAF); the Child Health Center, operated by Children's Hospital; and the Mothers and Children Center No. 2, operated by DHR.

REA


TARGET AREA BOUNDA
Community Group Hea
Foundation Center
Comprehensive Health
Care Center
Shaw Health Center
Adams-Morgan Health
Center
Child Health Center
DHR HEALTH CENTE
HAVE NO TARGET AR
BOUNDARIES
B&O RAILROAD
FLORIDA AVE.
6
DISTRICT OF COLUMBIA
1
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D.C. SERVICE AREAS
AF-SHAW
MPREHENSIVE
ALTH CENTER
DHR-GALES
HEALTH CENTER
AVE.
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The Shaw center, which began operating in October 1971 and which was the most recent center to be located in the area, was justified to and funded by HEW on the basis that there were not enough health centers in the area. Service area boundaries were drawn to coincide with the boundaries of the Shaw Community area, and a health center was established of sufficient size, according to HEW standards, to serve the persons residing in the area.

Shaw officials told us that, when the health center's boundaries were being established, they considered the health services available in three other health centers in the Shaw service area but that they did not study the need for health services in the area. The three existing health centers, operated by two different groups, provided OB-GYN and/or pediatric services to mothers and children in the general area and thus reduced the population from which the Shaw center could draw its patients. Such reduction may have contributed to the Shaw center experiencing less-than-average use of such services when compared with use data published by recognized health organizations. (See exhibit C.)

Persons residing in various other locations in the Cardozo-Shaw area can obtain OB-GYN and pediatric services at two, and in some cases three, health centers. For example, persons in the designated area of the Community Group Health Foundation's health center can obtain services at one or two other centers.

The Foundation's proposal to OEO for funds to operate the center mentioned only one of the two health centers that were providing health services to residents of the area. The extent to which these centers reduced the population from which the Foundation's center could draw its patients may have contributed to the less-than-average use of such services when compared with use data published by recognized health organizations. (See exhibit C.)

The Economic Development Administration, Department of Commerce, awarded the Foundation a grant of about $1.44 million in June 1969 and a supplemental grant of about $710,000 in June 1971 to finance the construction of a replacement center. The Foundation awarded the construction contract in September 1972.

The Foundation's new health center will be about four times larger than the existing one and is expected to serve the persons residing in the same area served by the existing center.

According to officials of the Economic Development Administration, the grants were awarded to the Foundation to stimulate economic growth in the Cardozo-Shaw area but the use of the existing center and other outpatient health centers in the area had not been considered. They also advised us that District officials fully supported the project.

Because our Cardozo-Shaw study, which included an analysis of patient visits, showed that (1) there was a concentration of health centers, (2) most of these centers served only designated areas, parts of which overlapped resulting in possible duplication of services, and (3) these centers experienced less-than-average use of such services, we suggested to DHR officials that they meet with the Community Group Health Foundation, Children's Hospital, and NMAF to develop a coordinated health services plan, considering existing and planned health centers.

DHR officials later advised us that they had met with the Director of the Community Group Health Foundation to discuss possible health service delivery arrangements for the Cardozo-Shaw area and had reached a tentative agreement which provided that the designated area of the Foundation's new center would gradually be increased to replace two DHR health centers. The officials advised us further that, when the Foundation assumes this responsibility, the District plans to use the freed resources elsewhere in the District.

The proposed action would reduce the number of health centers and enhance the delivery of area health services; however, because Children's Hospital and NMAF, which operate health centers in the area, were not included in the discussion, the total health needs in the area were not considered. Children's Hospital is constructing a new hospital 14 blocks from its present location with financing of about $27 million from HEW. The new hospital will contain an outpatient health clinic to provide health services to persons in need.

We suggested to DHR officials that they meet with these two organizations to explore further arrangements for

coordinating and providing health services in the Cardozo-Shaw area and to discuss with NMAF the possible expansion of its service area. DHR officials advised us later that such discussions had started.

In April 1972 another private group, the East of the River Health Association, Inc., proposed establishing one, or possibly two, new outpatient health centers in the Anacostia and far northeast areas of the District, to be funded directly by OEO. HPAC, which reviewed the proposal, recommended that the Director, DHR, recommend to OEO that the project be funded even though HPAC stated that it was not entirely satisfied because it had not had sufficient time to complete its analysis.

HPAC also recommended that the Association consider various items pertinent to successfully developing and operating the proposed outpatient health centers, including (1) a stated policy that high-quality care at reasonable cost is the paramount objective of the Association, (2) an early, intensive effort by the Association to recruit the highest quality personnel available so that health services could be provided within 3 or 4 months, rather than 12 months as indicated in the proposal, and (3) a need for all parties involved, including HPAC, to closely monitor, monthly, the centers' development.

One HPAC member considered parts of the Association's proposal to be ambiguous, namely (1) the rationale for locating the proposed centers in areas that did not have the greatest health needs and (2) the initial provision of health services to only 14,000 persons for the amount of money involved.

In a June 28, 1972, letter to OEO, the Director, DHR, concurred in HPAC's comments and recommendations. OEO subsequently funded an outpatient health center for 16 months beginning July 1, 1972, at a cost of about $1 million.

District officials advised us that, as of April 1973, the Association had not acted on HPAC's recommendations.

We believe that one organization, such as DHR, should have the authority and responsibility to coordinate the District-wide planning and development of health centers to insure that centers are located in areas according to needs. As an initial step, the District should study health needs

and develop a master plan for locating health centers, adjusting the present outpatient health care delivery arrangements of the various health centers, and establishing new health care capability where needs exist.

COMPREHENSIVE HEALTH CARE

DHR health officials generally agree that an outpatient health center should provide at least basic general medical, pediatric, OB-GYN, dental, and laboratory services and that, to provide comprehensive health care, a center would need to furnish additional services, such as X-ray, emergency, and specialty consultations. DHR officials further believe that each outpatient health center should provide services to all family members.

Health services

The District has an uncoordinated network of outpatient health centers furnishing comprehensive or less-than-comprehensive health services to either all family members or only some family members, as follows:

	Number of outpatient health centers serving		
Type of health care	All family members	Some family members	Total
Comprehensive	3	4	7
Less than comprehensive	7	7	14
Total	10	11	21

Of the seven health centers providing comprehensive health care, six were almost entirely federally funded; most of the centers offering less-than-comprehensive health care were District funded. The federally funded health centers were superior to the District-funded centers in physical lay-out, equipment, and staff size. However, health services provided in the federally funded centers were generally limited to certain family members and/or persons residing in specific areas.

Persons needing services unavailable in some outpatient health centers must go to other centers or hospital clinics. For example, of the 14 centers that provided less-than-comprehensive health services, 9 did not provide dental services and 13 had either no X-ray equipment or no centralized pharmacy.

A January 1972 report by the District's Bureau of Dental Health Task Force Committee stated that all health centers should provide dental services. The task force recommended:

> "* * * one-stop health care facilities establishing comprehensive dental care specializing in family care attractive to poor families, who are more likely to seek preventive services for the whole family under such arrangements than they would under the present system of health care for the District of Columbia."

If a health center does not have X-ray equipment, persons needing this service usually go to the D.C. General Hospital's outpatient clinic. If a center does not have a centralized pharmacy, persons needing special prescription drugs must go to either District Government pharmacies, the D.C. General Hospital's pharmacy, or commercial drugstores to get prescriptions filled. It is reasonable to expect that some persons having to go to many different places to receive needed outpatient health services may become disillusioned and may refrain from seeking further health services.

As of June 1972 the District's Parkside, Anacostia, and Congress Heights neighborhood health centers did not have full-time general medical physicians; Parkside did not have one for 13 months. Lacking full-time general medical physicians, these centers referred their general medical patients to the D.C. General Hospital outpatient clinic which, for example, is located about 2 miles from the Parkside center. This disrupted general medical services for patients regularly using the three centers and added to the workload at D.C. General Hospital's outpatient clinics. The District had hoped to reduce this workload when it established the family-oriented neighborhood health centers.

Individual-oriented versus family-oriented health care

Eleven outpatient health centers provide health services to only some family members. A list of these centers and the family members they serve follows.

Children's Hospital:

Child Health Center--children up to 12 years of age.

Comprehensive Health Care Center--children up to 12 years of age.

Adams-Morgan Health Center--children up to 18 years of age and limited general medical services for adults.

DHR:

Center No. 2--children up to 12 years of age and family planning services for females.

Center No. 10--children up to 12 years of age and family planning services for females.

Center No. 16--children up to 12 years of age and family planning services for females.

Gales Health Center--children up to 5 years of age and maternity patients.

Center No. 17 (C&Y)[1]--children up to 13 years of age.

Center No. 17 (MIC)[2]--females for OB-GYN and family planning services.

Center No. 18 (C&Y)--children up to 13 years of age.

Center No. 18 (MIC)--females for OB-GYN and family planning services.

The Mayor's Task Force on Public Health Goals reported in 1970 on providing only some family members with health services. A section of the report dealing with the fragmentation of services to a family reported the following case.

"Mrs. Jones was advised by a nurse friend to take her acting-out 15 year old son to a psychiatric

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[1]Children and Youth program.

[2]Maternity and Infant Care program.

day clinic. On the day of appointment, she accidently twisted her ankle and felt an urgent need for medical attention herself. By coincidence, her other three children were feverish and congested. One of them also had a severe toothache.

"She thought it best to have everyone visit the doctor that day, thinking to herself that one trip with everyone could save time, effort and money. Mrs. Jones, however, was greatly disappointed for she was shuttled back and forth: she took her son to the psychiatric clinic; had to go to the pediatric clinic for the childrens' [sic] check-ups, had to run to the adult health clinic only to be told to go somewhere else for an X-ray. Things just didn't work out the way she thought they would. Not only did she go from one end of the city to the other - she had to wait for hours and had to answer the same questions at every clinic. In fact, she didn't even have the time to take her child with the toothache to the dentist.

"At the end of the day, Mrs. Jones was completely drained, so much so that she vowed she'd never visit the clinics again if she were to be subjected to such difficulties."

The task force concluded:

"Why no system is being devised to make it easier for the residents of the city to obtain medical services is beyond one's comprehension. Why is it that one has to go to A Clinic for immunization; to B Clinic for X-rays and laboratory tests; to C Clinic for prenatal services, and to D Clinic for psychiatric help? Why is it that one has to fill out the same forms and answer the same questions at every clinic? Why is it that no referral system is in existence, thus, subjecting the consumer to a cumbersome, frustrating and anxiety provoking intake process? Why are preventive and educative services not linked up to treatment-oriented services?

"Why are services planned and implemented in a fragmented way - separating one service from

another - as if part of the human body can be separated and treated in isolation?"

Although situations similar to the above may not occur every day, we believe the example points out that providing services to only selected family members can result in (1) some confusion and frustration among residents as to the services available and (2) a fragmentation of services to a family.

Also, health care was disrupted because of changes in designated service areas and in age eligibility criteria. For example, to stay within the scope of a Federal program for children and youth health services, District officials, three times during fiscal years 1969-72, changed the age eligibility criteria for children who could receive services at two District centers--No. 17 (C&Y) and No. 18 (C&Y).

In fiscal year 1969 children up to 5 years of age were eligible for pediatric and related support services. In fiscal year 1970 the eligibility criteria were changed to include only infants up to 2 months old and siblings less than 3 years old. The eligibility criteria were broadened somewhat in fiscal year 1971 to include infants up to 4 months old and siblings less than 3 years old and were expanded in fiscal year 1972 to include all children up to 13 years of age. During the same period, designated service areas were also changed.

These changes interrupted the continuity of health services for certain children. Some of the children between the ages of 3 and 5 years who were eligible to receive services at these centers under the initial eligibility criteria became ineligible with the first change and then became eligible again with the most recent change. DHR health officials told us that community residents were confused as to when and if their children could receive services at the two centers.

Continuity of health services is likely also to be interrupted in those centers which provide services to children only up to a certain age and which are not staffed and equipped to provide services beyond that age. DHR health officials told us that a shortcoming of this situation is the loss of the physicians' knowledge of the children's health problems and the children's and their parents' confidence in the

physicians acquired over the years. This shortcoming is compounded by the lack of a uniform system for maintaining, referring, and storing patient records, as discussed later in this report.

We believe one organization, such as DHR, should have the authority and responsibility to insure that outpatient health centers provide comprehensive health services for all family members.

UNDERUSE OF OUTPATIENT HEALTH SERVICES

Outpatient health center operators have periodically accumulated statistics on the number of patient visits and the number of available physician hours by medical specialty for each of their health centers, but no one organization has analyzed this information District-wide. As a result, no one organization had data on the use of the individual medical services for all health centers or on whether the use was above or below average compared with published data on the average use of these types of services.

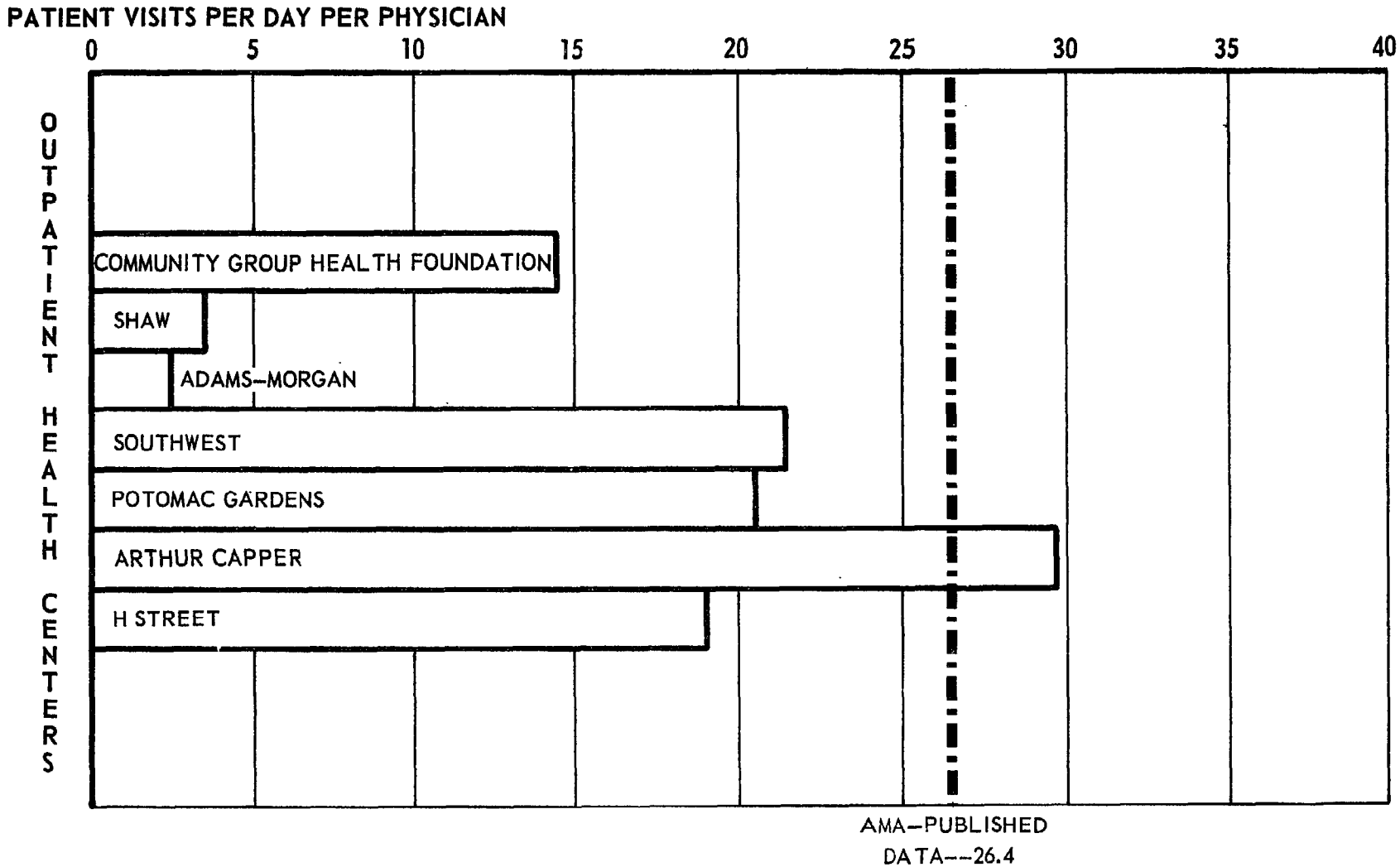
Each center gave us information on the number of patient visits and the number of full-time equivalent physicians by medical specialty for all or a part of the period April 1, 1971, to March 31, 1972. We computed, for each of the medical specialties, the daily average number of patient visits and the number of full-time equivalent physicians available each day for each center and divided the number of patient visits by the number of equivalent physicians to arrive at a daily usage rate. Health center officials agreed with this approach for calculating usage rates.

Our analysis showed wide variances among the centers in the average number of daily patient visits per physician. When comparing American Medical Association (AMA) published data and American Dental Association (ADA) survey data on the average number of patient visits an hour that each physician should be able to handle with health center data, our analysis showed that the use of health center services was generally below average. We used the AMA and ADA data on physicians in an office practice because standards had not been established specifically for outpatient health centers. (See charts on pp. 20 to 23.)

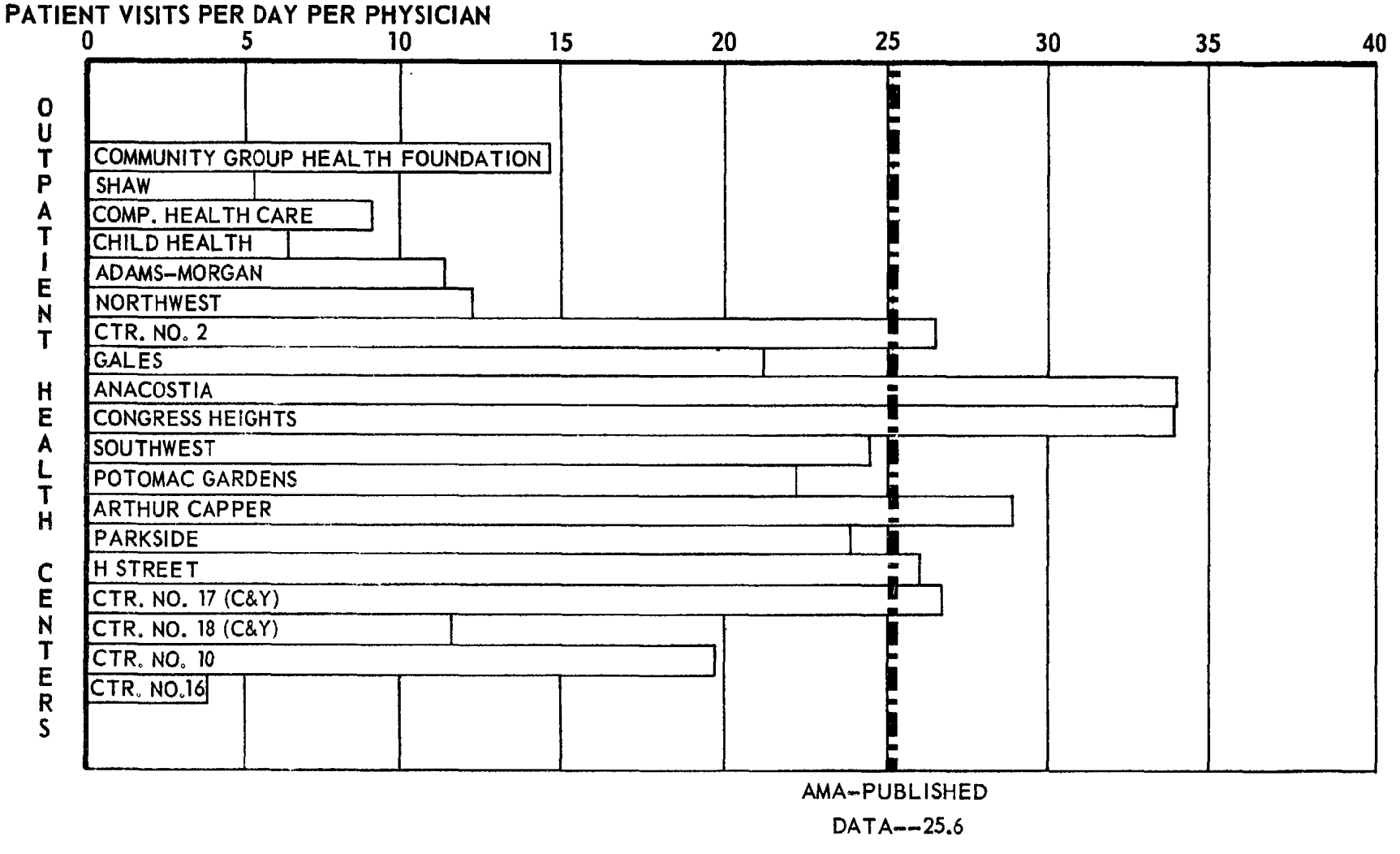
A list of the centers and their usage rates is included as exhibit C.

Two of the principal factors contributing to the below-average usage rates experienced by several of the centers were (1) the location of many centers in the same general area of the District which centers, in total, provided more health care capability than the residents were actively seeking and (2) an inequitable distribution of physicians by medical specialty among the centers in relationship to the age and sex of the population being served.

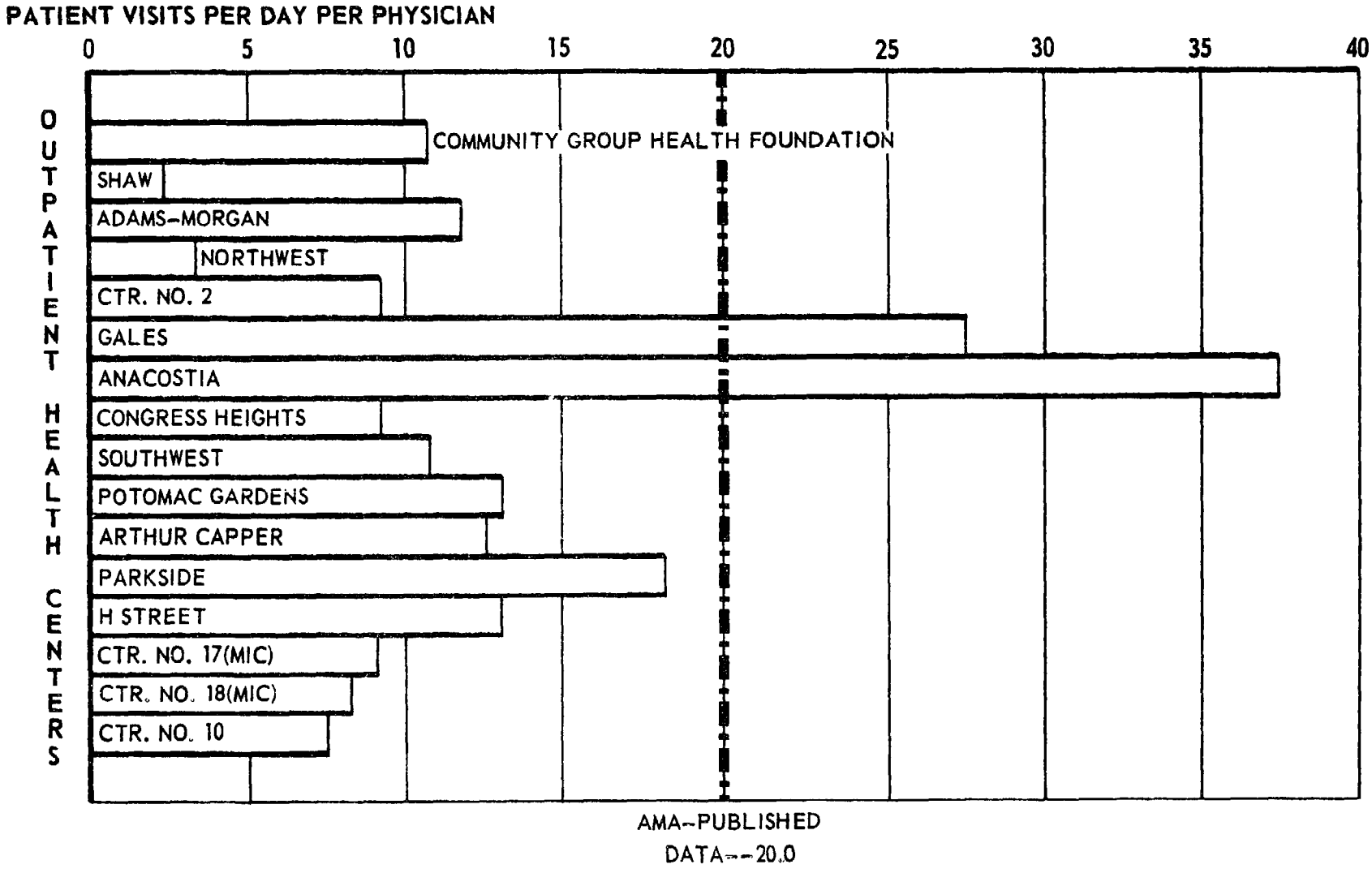
GENERAL MEDICAL SERVICE DATA
COMPARED WITH AMA–PUBLISHED DATA



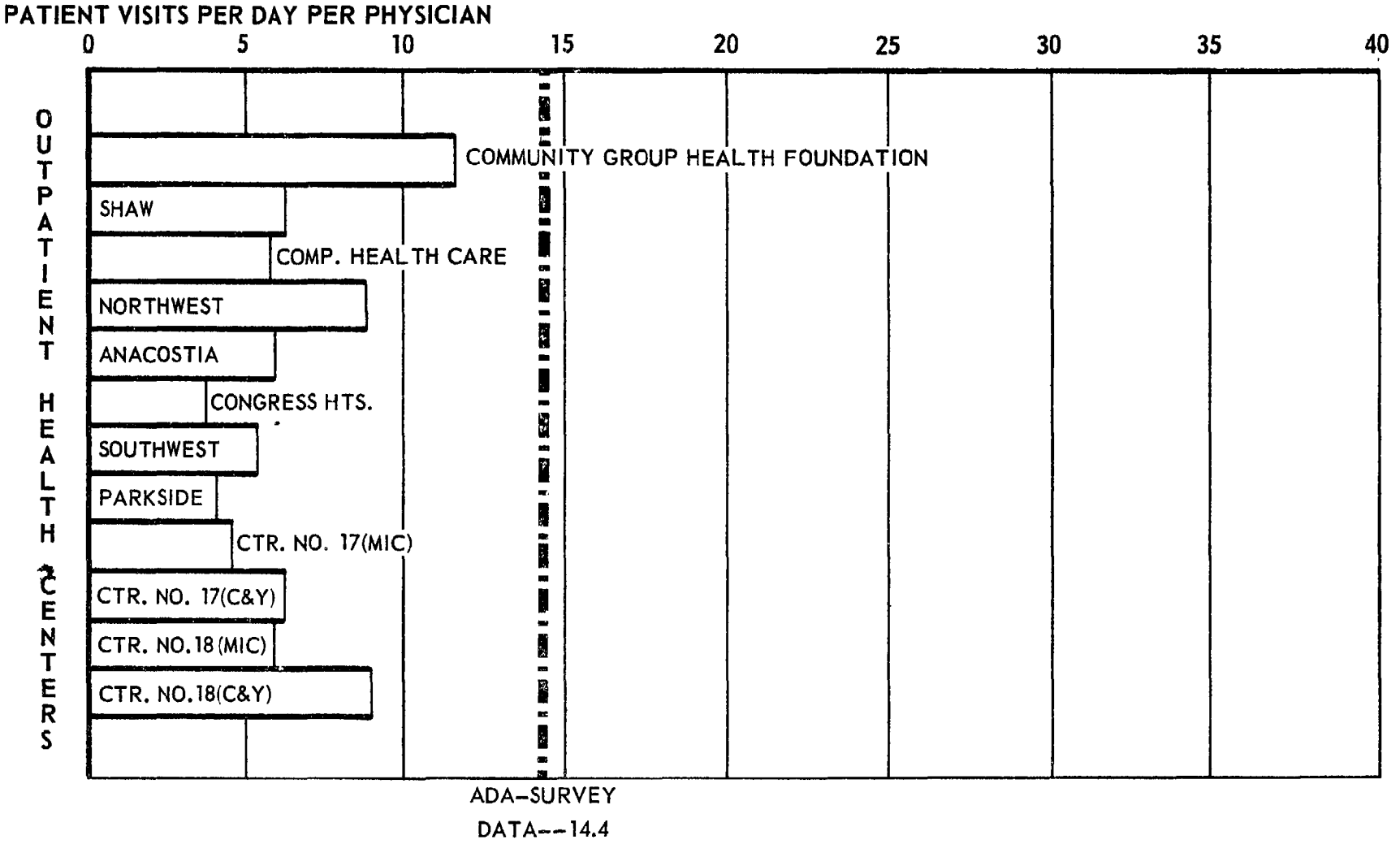
PEDIATRIC SERVICE DATA
COMPARED WITH AMA-PUBLISHED DATA



OB–GYN SERVICE DATA
COMPARED WITH AMA–PUBLISHED DATA



DENTAL SERVICE DATA
COMPARED WITH ADA SURVEY DATA



Our examination of the use of health services provided in two poverty areas showed that the usage rates for the many Cardozo-Shaw health centers were less than the average rates for such services and that the rates for the few Anacostia centers were generally higher than those for the Cardozo-Shaw centers. (See exhibit C.)

According to our examination, the two areas also had imbalanced distribution of physicians by medical specialty in relationship to the age and sex of the population being served.

For example, 15.4 full-time equivalent pediatricians, or about one-half of all pediatricians in the 21 centers, were employed in the 8 Cardozo-Shaw centers. This area has about 33,000 children up to age 12 representing about 19 percent of the area's population. The ratio of pediatricians to children in the area is about 1 to 2,100.

The two Anacostia centers employed 2.4 full-time equivalent pediatricians, less than one-tenth of all pediatricians employed in the 21 centers. This area has about 40,000 children up to age 12 representing about 32 percent of the area's population. The ratio of pediatricians to children in the Anacostia area is about 1 to 16,600, or almost 8 times that of the Cardozo-Shaw area. We also noted imbalances in the distribution of general practitioners and dentists between these two areas.

Although population data by itself is not representative of the need for health care, we believe that a comparison of poverty areas on the basis of number of physicians and population indicates imbalance of health services in those areas. Furthermore, the heavier pediatrician workload in the Anacostia area, as shown in exhibit C, indicates an imbalance in the distribution of pediatricians.

One organization, such as DHR, should periodically review patient use of health center services District-wide and compare usage rates with acceptable levels of performance to assess and improve health center performance and to identify and adjust imbalances in the distribution of professional personnel, by medical specialty, among the health centers.

MEDICAL RECORDS

Health officials agree that patients' medical records are important because (1) physicians refer to them when providing medical care or consultation to patients, (2) they evidence the medical services that have been provided, and (3) they provide data for medical research and/or education.

A uniform system for maintaining these records and for transferring them to other centers when patients move to other areas is an important element in providing outpatient health services. The District does not have such a system, however, because no one organization has the authority or responsibility for this common activity.

Maintenance

Centers providing outpatient health services to similar groups of persons use different systems for maintaining medical records. For example, some centers providing health services to all family members maintain medical records by family, whereas similar centers maintain records by individual patient. Some centers providing health services only to children maintain the medical records of all children of the same family in one folder, whereas other such centers maintain a separate folder for each child with no system for relating one child's folder to his siblings' folders.

A health center physician told us that many health problems of persons may result from either their below standard socioeconomic background and/or environment or their heredity. Studies show that persons who reside in poor areas of a city are more susceptible to certain diseases and illnesses, experience a greater incidence of health problems, and need more health services than those in other environments. A medical record system which does not consolidate the environmental and heredity health problems of a family could prevent the physician from readily identifying the health problem of family members.

We believe that all outpatient health centers should maintain patients' medical records on the same basis to enhance the provision of health care. Maintaining medical records by family seems logical because it would (1) permit detection and treatment of health problems stemming from environmental

and heredity factors, (2) maintain identity of the family unit, particularly when all family members do not have the same surname, and (3) enable the health centers' social workers and neighborhood aides to identify and deal with health-related problems by family--the District's health goal--and to encourage a family approach to better health.

Retention and storage

The health centers' medical record retention policies and practices differed.

One federally funded, privately operated health center, which provides services to all family members, destroys records 11 years after the last visit by a family member. A similar health center had not established any retention policy; however, it planned to retain medical records for 10 years after the last visit by a family member.

DHR-operated health centers that provide services to all family members are subject to District policy which provides for the destruction of records 6 years after the last visit by a family member. However, some DHR centers have not followed this policy. Some of the operators told us that they were not aware of the policy or did not agree with it and that they retained medical records indefinitely.

Those health centers that provided services to only women and/or children generally had no retention policy. One DHR health center retains children's records until the children reach age 13, then transfers the records to a record storage center and destroys them 3 years later. A similar DHR health center neither transfers nor destroys children's records. Officials of two other DHR health centers said that they had no written policies regarding the retention of children's medical records and that they retain all medical records indefinitely. Three health centers operated by a private organization retain children's medical records until the children reach either the age of 12 or 18; the records are then transferred to the organization's central storage center and kept indefinitely.

Record transfer among centers

The District has no system for transferring patients' medical records among centers when the patients move to other areas of the District or use other health centers. Without such a system, physicians treating persons who had received prior health services have usually been at a disadvantage and medical records have not been available when needed.

One physician told us that she had to use valuable time and effort to reconstruct a patient's medical record--a time-consuming and unreliable procedure--and that, in some cases, she had to delay medical treatment until after she had given the patient a complete medical examination to determine his health problem. Officials at some health centers advised us that one of their major problems was trying to locate a patient's medical record. They stated that in several cases they knew that the patient had been to another outpatient health center but they could not locate his medical records.

District health center operators told us that a record transfer system is needed to better serve District residents and to get a better count of the number of persons provided medical services.

We believe the District should adopt policies for all outpatient health centers operated by DHR and private organizations to maintain, retain, and transfer patients' medical records.

CHAPTER 4

ATTEMPTS TO COORDINATE HEALTH SERVICE PROGRAMS

To assist the States in planning for their current and future health needs, the Congress enacted the Comprehensive Health Planning and Public Health Services Amendments of 1966 (42 U.S.C. 246) which provided for each State to prepare plans for comprehensive State health planning, including (1) the designation of a single State agency to oversee health planning functions and (2) the establishment of a health planning council to advise the State agency in carrying out its functions.

In February 1967 the Board of Commissioners of the District designated the Department of Public Health as the agency for overseeing the District's health planning functions. In September 1968 the Commissioner of the District established HPAC to advise the Director of the Department of Public Health.

In May 1970 the Commissioner designated himself as the sole agency for overseeing comprehensive health planning and delegated the responsibility for preparing the District's plan for comprehensive health planning to DHR. In June 1970 he designated HPAC to advise him on comprehensive health planning, construction and regulation of hospitals and medical and related facilities, public health programs, and other matters affecting the health of District residents. The members of HPAC, appointed by the Commissioner, include representatives from agencies of the District Government, nongovernmental organizations and groups concerned with health, and consumers of health services.

DHR's Office of Planning, assisted by HPAC, prepares the District's annual plan for comprehensive health planning. The plan includes information on (1) the current year's planning and program priorities, (2) program results of the past year, and (3) expected future accomplishments.

The fiscal year 1972 plan suggested many priority items, covering all types of health and health-related activities, to focus immediate and long-range attention on the health problems in the District. Many of these items, such as those below, dealt with outpatient health centers.

1. Undertaking a District-wide consumer health survey to measure the status of health services as perceived by District residents and to provide information on use patterns of existing health facilities.

2. Coordinating District health and health-related programs.

3. Planning for a comprehensive health services delivery system emphasizing the needs of poor and underserviced residents, especially those of the Anacostia and far northeast areas of the District but giving careful attention to achieving an equitable distribution of health services throughout the District.

4. Providing comprehensive health services and reducing fragmentation of health services by promoting facility-sharing and improving access to facilities and services.

5. Reducing unnecessary duplication of health services among the various local health agencies.

Our review of the fiscal year 1972 District plan and our discussions with DHR's Office of Planning staff revealed that the 1972 priority items were essentially restatements of priority items included in the fiscal year 1971 plan with some additional suggestions by the Office, HPAC, other District health committees, and prior task force studies relating to health. We noted that many of the problems given priority for solution in fiscal year 1972 still remain unresolved and that little progress has been made toward correcting them.

An official of the Office of Planning advised us that many of the plan's priority items are long range and that the Office generally has not evaluated program operations because of its small staff, its preoccupation with DHR's other health planning responsibilities, and its assistance to HPAC in discharging its responsibilities.

HPAC's responsibilities include consulting and advising the Commissioner on the delivery of health services to

District residents. HPAC also has been designated as the State Advisory Board under the 1970 Economic Stabilization Act (12 U.S.C. 1904 nt (Supp. I, 1971)) and is responsible for overseeing and regulating price controls applying to hospitals and nursing homes.

Two HPAC subcommittees have some responsibilities for reviewing the delivery of outpatient health services, the location of health centers, and the actions taken on the priority items included in the District plan. The Subcommittee on Delivery of Health Services is responsible for reviewing the health care delivery system and for recommending to HPAC improvements in the system. The Subcommittee on Health Facilities is responsible for evaluating all projects for the construction of health care facilities in the District and for making recommendations to HPAC.

Because HPAC, whose members serve voluntarily, had many other health-planning responsibilities and was responsible for administering price controls, it has had little time to evaluate the operations of all health centers providing outpatient health services or to consider problems common to all centers. Furthermore, HPAC is only an advisory committee and therefore does not have any authority or responsibility for seeing that any recommendations it makes are carried out.

For DHR to plan effectively for the delivery of outpatient health services to District residents, information on ongoing District-wide health operations must be gathered, reviewed, and evaluated. Authority to review operations and to effect changes District-wide should be vested with the Commissioner so that DHR and HPAC can discharge their responsibilities for planning, reviewing, and evaluating health services in the District.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The District's problems in providing outpatient health services to needy persons have resulted from the uncoordinated implementation of Federal and District health programs and the lack of reviews of ongoing operations. No one organization has (1) determined health needs to serve as a basis for locating outpatient health centers, (2) taken action to insure that outpatient health centers provide comprehensive health care to all family members, (3) evaluated the use of the health centers' medical services District-wide, compared use to acceptable levels of performance, or taken action to increase the level of performance, and (4) identified and proposed solutions for District-wide health care operational problems, such as the need for a uniform system for maintaining and transferring patients' medical records.

To provide for an effective outpatient health care delivery system, DHR should prepare a comprehensive action plan. To effectively carry out this plan, the Commissioner will need to have financial accountability of all District and Federal funds for outpatient health center services.

RECOMMENDATIONS TO THE COMMISSIONER OF THE DISTRICT OF COLUMBIA

We recommend that the District Government prepare a comprehensive action plan, addressing the problems discussed in this report, for delivering outpatient health services, and, when necessary, seek authority from the Federal agencies to enable it to carry out the plan effectively.

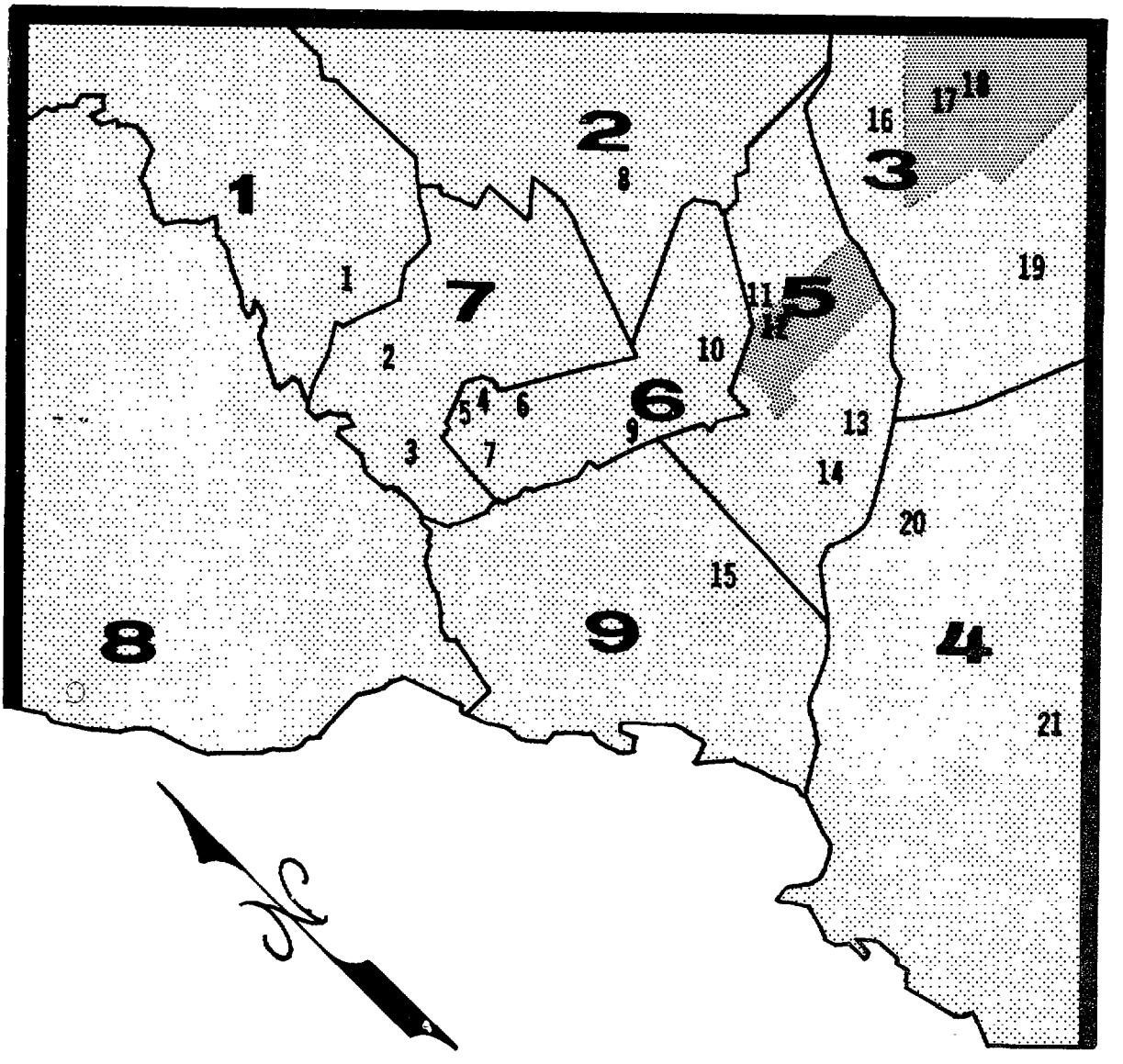
MATTERS FOR CONSIDERATION BY THE CONGRESS

Categorical Federal grants for health may lessen the opportunity for localities to develop an effective comprehensive action plan for delivering outpatient health services. We believe that our study will be useful to the Congress in deliberations on any legislation to consolidate Federal grants for health programs.

AGENCY COMMENTS

The Commissioner, in response to our findings and recommendations (see app. I), said that DHR would appoint task forces to prepare the recommended action plan and to determine what additional authority the District will require to effectively carry out the plan.

LOCATION OF OUTPATIENT HEALTH CENTERS IN THE DISTRICT OF COLUMBIA



LARGE NUMBERS REFER TO D.C. SERVICE AREAS
SMALL NUMBERS REFER TO LOCATION OF OUTPATIENT HEALTH CENTERS

EXHIBIT A

OUTPATIENT HEALTH CENTERS

IN THE DISTRICT OF COLUMBIA (note a)

COMMUNITY GROUP HEALTH FOUNDATION, INC.:

2. Community Group Health Foundation Center
   14th and Park Road NW.

CHILDREN'S HOSPITAL:

3. Adams Morgan Health Center
   2320 17th Street NW.
4. Comprehensive Health Care Center
   1116 W Street NW.
5. Child Health Center
   1307 W Street NW.

NATIONAL MEDICAL ASSOCIATION FOUNDATION:

6. Shaw Community Comprehensive Health Center
   1701 7th Street NW.

DEPARTMENT OF HUMAN RESOURCES:

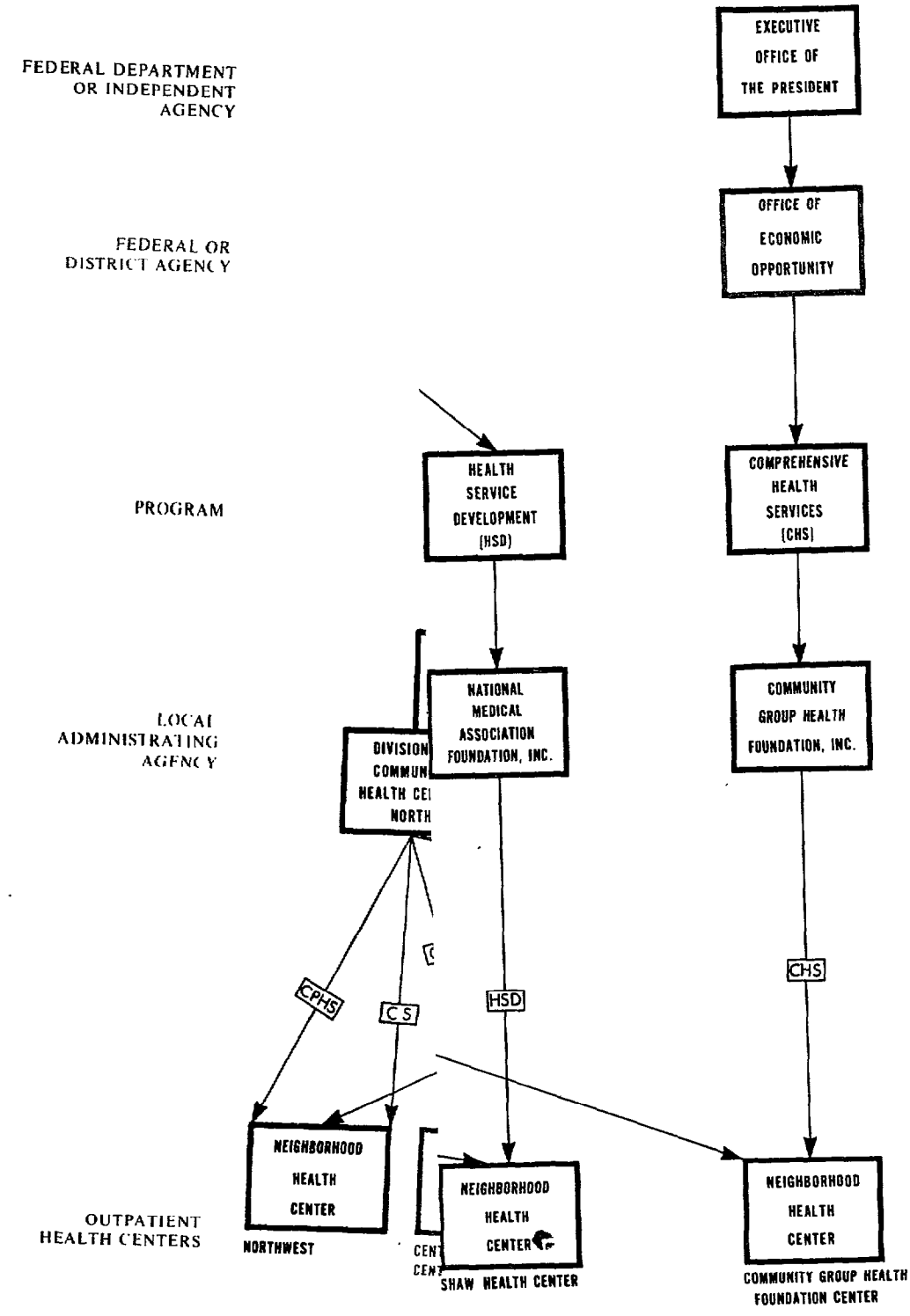
1. Northwest Central Health Center
   1325 Upshur Street NW.
7. Center No. 2 for Mothers and Children
   1801 14th Street NW.
8. Center No. 10 for Mothers and Children
   1300 Rhode Island Avenue, NE.
9. Gales Health Center
   65 Massachusetts Avenue NW.
10. H Street
    635 H Street NE.
11. Center No. 17 (MIC)
    702 15th Street NE.
12. Center No. 17 (C&Y)
    702 15th Street NE. (target area shaded)
13. Potomac Gardens
    1227 G Street SE.
14. Authur Capper
    1011 7th Street SE.
15. Southwest
    850 Delaware Avenue SW.
16. Parkside
    701 Kenilworth Terrace NE.

DEPARTMENT OF HUMAN RESOURCES: (continued)

17. Center No. 18 (MIC)
    4130 Hunt Place NE.
18. Center No. 18 (C&Y)
    4130 Hunt Place NE. (target area shaded)
19. Center No. 16
    330 Ridge Road SE.
20. Anacostia
    Between 13th and 14th on W Street SE.
21. Congress Heights
    8th and Xenia Streets SE.

[a]Numbers are keyed to exhibit A map.

EXHIBIT B


FEDERAL DEPARTMENT OR INDEPENDENT AGENCY
FEDERAL OR DISTRICT AGENCY
PROGRAM
LOCAL ADMINISTRATING AGENCY
OUTPATIENT HEALTH CENTERS
EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF ECONOMIC OPPORTUNITY
HEALTH SERVICE DEVELOPMENT (HSD)
COMPREHENSIVE HEALTH SERVICES (CHS)
NATIONAL MEDICAL ASSOCIATION FOUNDATION, INC.
COMMUNITY GROUP HEALTH FOUNDATION, INC.
CPHS
CS
HSD
CHS
NEIGHBORHOOD HEALTH CENTER
NORTHWEST
NEIGHBORHOOD HEALTH CENTER
SHAW HEALTH CENTER
NEIGHBORHOOD HEALTH CENTER
COMMUNITY GROUP HEALTH FOUNDATION CENTER

DISTRICT AND FEDERAL HEALTH PROGRAMS IN THE DISTRICT

Funding for the 21 outpatient health centers in the District is provided under 1 District program and 7 Federal programs. The chart on page 36 shows the District and Federal programs and how they were organizationally implemented. The Federal and local agencies involved are shown as they existed in fiscal year 1972.

District-funded programs

Clinical Services--Under the District's Clinical Services program, outpatient health services are provided to all family members through eight neighborhood health centers and to only women and children through three specialty centers. The medical services provided at the neighborhood health centers generally included general medical, pediatric, and OB-GYN services. Dental services were provided at five of the centers. The specialty centers provided pediatric, prenatal and postnatal, and family planning services.

The objective of the Clinical Services program is to provide one-stop health services to all eligible family members. The eight neighborhood health centers--some new and some converted from specialty centers--were established to accomplish this objective. The three specialty centers do not provide services to all family members. District officials advised us that they intend either to phase out the specialty centers after they have reviewed the current and future needs for health centers or to convert them to neighborhood health centers when funding becomes available.

Clinical Services program funds for operating the District's outpatient health centers are channeled through DHR and the Community Health and Hospitals Administration to two Divisions of the Bureau of Clinical Services. The Division of Community Health Services North is responsible for overseeing the operation of one neighborhood health center and two specialty health centers. The Division of Community Health Centers South is responsible for overseeing the operation of seven neighborhood health centers and one specialty center. The locations of these outpatient centers are shown in exhibit A.

Federally funded programs

Medicaid--Under Medicaid, authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396), HEW, through its Social and Rehabilitation Service, and the District, through DHR's Payments Assistance Administration, provide funds for medical assistance to low-income persons of all ages who need care and cannot pay for it. Persons eligible for Medicaid may obtain medical care from either private or public sources. DHR officials estimate that about 70 percent of the Medicaid payment in 1973 was for services provided by the private health sector.

DHR's Bureau of Payments Processing administers Medicaid. Local participating physicians and health organizations providing services to eligible persons are reimbursed for health services rendered under the program. According to a Bureau official, the five privately operated outpatient health centers received reimbursements under the program.

Comprehensive Public Health Services--Under this program, as authorized by section 314(d) of the Public Health Services Act, as amended (42 U.S.C. 246(d)), HEW, through HSMHA, provides grants to assist States in making significant contributions toward providing and strengthening public health services. The program is to provide services for high-risk populations, including the poor, and to improve the health services delivery system.

The Comprehensive Health Services program grant to the District is administered, in part, by DHR's Bureau of Clinical Services through its Divisions of Community Health Centers North and South. Part of these program funds were used to provide District residents with outpatient health and health-related services in three DHR-operated health centers--Northwest, Arthur Capper, and Anacostia.

Maternal and Child Health Services--Under title V of the Social Security Act, as amended (42 U.S.C. 701), HEW, through HSMHA, funds this program, which is intended to extend and improve services for reducing infant mortality and to improve the health of mothers and children.

This program, operated by DHR's Bureau of Clinical Services through its Division of Maternal and Child Health,

provides health services to infants and pre-school-age children. The District's Gales Health Center operated under the program in fiscal year 1972 and served eligible persons residing anywhere in the District.

Maternity and Infant Care--This is another program authorized by title V of the Social Security Act, as amended, and administered by HEW's HSMHA. The purposes of this program are to (1) provide prenatal and postnatal care to mothers and their infants, including care to high-risk infants up to age 1 and (2) promote and provide family planning services.

The MIC program is operated by DHR's Bureau of Clinical Services through its Division of Maternal and Child Health. MIC program funds were used to provide persons from low-income families with OB-GYN and family planning services at several District-operated health centers--primarily at Center No. 17 (MIC) and Center No. 18 (MIC). The MIC program serves all eligible persons residing anywhere in the District.

Children and Youth--This is a third program authorized by title V of the Social Security Act, as amended, and administered by HEW's HSMHA. The purpose of this program is to promote health care and services for children and youth of school and preschool age in areas with a concentration of low-income families. Children's Hospital, a nonprofit organization, and DHR operate the C&Y program in the District.

The Children's Hospital C&Y program began operating in September 1967. Children's Hospital operates an outpatient clinic in its hospital and three outpatient health centers. These centers, located in the northwest area of the District, are the (1) Comprehensive Health Care Center, which provides pediatric and dental services to children to age 12, (2) Child Health Center, which provides pediatric services to children to age 12, and (3) Adams-Morgan Health Center which provides pediatric services to children to age 18, OB-GYN services to females to age 18, and limited general medical services to adults using DHR Clinical Services program physicians. These centers serve residents in specific areas in the Cardozo-Shaw area, as shown on the map on page 8.

The DHR C&Y program, operated by its Bureau of Clinical Services through its Division of Maternal and Child Health, also began operating in September 1967. Children and youth to age 13 who reside in or attend public schools in specific northeast areas of the city (see exhibit A) are provided pediatric and dental services at Center No. 17 (C&Y) and Center No. 18 (C&Y).

Health Services Development--Under the Health Services Development program, authorized by section 314(e) of the Public Health Services Act, as amended (42 U.S.C. 246(e)), HEW, through HSMHA, provides funds to public and/or private nonprofit agencies and organizations for comprehensive health services. The program is intended to promote, improve, and maintain the health of persons in the community and to promote accessibility of health care to the poor, with the highest priority given to establishing and developing comprehensive health centers.

The National Medical Association Foundation, Inc., a nonprofit organization, administers this program. In October 1971 NMAF opened the Shaw Community Comprehensive Health Center in the northwest section of the District. The center provides general medical, pediatric, OB-GYN, dental, and support services. NMAF also received, under DHR's Clinical Services program, personnel to augment the center in fiscal year 1972. The center serves residents of the Shaw area in the northwest section of the District, as shown on the map on page 8.

Comprehensive Health Services--Under this program, authorized by the Economic Opportunity Act of 1964, as amended (42 U.S.C. 2809), OEO provides funds to public and/or nonprofit agencies and organizations to operate comprehensive health centers. The purpose of this program is to provide comprehensive health care to low-income persons in a designated area served by the center.

This program is administered by the Community Group Health Foundation, Inc., a nonprofit organization. Its center, the Community Group Health Foundation Center, is located in the northwest section of the District and was opened in

December 1969. The center provides general medical, pediatric, OB-GYN, dental and support services. The center serves residents of the Cardozo area in the northwest section of the District, as shown on the map on page 8.

EXHIBIT C

AVERAGE PATIENT VISITS PER DAY PER EQUIVALENT PHYSICIAN BY CENTER AND MEDICAL SPECIALTY

	General medicine	Medical specialty		
		Pediatrics	OB-GYN	Dental
Cardozo-Shaw area:				
Community Group Health Foundation	14.6	4.7	10.7	11.6
Shaw	3.7	5.2	2.3	6.3
Comprehensive Health Care	(b)	9.5	(b)	5.9
Child Health	(b)	6.4	(b)	(b)
Adams-Morgan	2.7	11.4	11.9	(b)
Northwest Central	(a)	12.3	3.3	8.8
Center No. 2	(b)	26.5	9.4	(b)
Gales	(b)	21.2	27.5	(b)
Total	9.7	12.7	6.2	8.1
Anacostia area:				
Anacostia	(a)	33.9	37.4	6.0
Congress Heights	(a)	33.8	9.3	3.7
Total	(a)	33.8	15.6	4.9
Other areas:				
Southwest	21.6	24.7	10.7	5.4
Potomac Gardens	20.8	22.3	13.2	(b)
Arthur Capper	29.9	28.9	12.6	(b)
Parkside	(a)	23.8	18.3	4.1
H St.	19.2	26.1	13.1	(b)
Center No. 17 (MIC)	(b)	(b)	9.2	4.5
Center No. 17 (C&Y)	(b)	26.7	(b)	6.3
Center No. 18 (MIC)	(b)	(b)	8.3	5.9
Center No. 18 (C&Y)	(b)	11.6	(b)	9.0
Center No. 10	(b)	19.7	7.7	(b)
Center No. 16	(b)	3.7	(b)	(b)
Total--all centers	11.7	17.5	9.4	6.9
AMA published data	26.4	25.6	20.0	(c)
ADA survey data	(c)	(c)	(c)	14.4

[a]General medical service was offered at these centers but sufficient information was not available to ascertain usage rate.

[b]Medical service not available.

[c]Not applicable.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
EXECUTIVE OFFICE
WASHINGTON, D. C. 20004

WALTER E. WASHINGTON
MAYOR-COMMISSIONER

May 25, 1973

Mr. Frank Medico
Assistant Director
General Accounting Office
Washington, D. C. 20548

Dear Mr. Medico:

I appreciate the opportunity to comment on the draft report on health services in outpatient health centers in the District of Columbia.

The Department of Human Resources will within the next 60 days appoint task forces to prepare a comprehensive action plan for the delivery of outpatient health services, and to determine what additional authority the District of Columbia requires to effectively carry out the plan.

The report is a major contribution toward an understanding of the complex issues which need to be resolved before a fully coordinated comprehensive ambulatory care delivery system can become a reality in the District.

Sincerely,

Walter E. Washington
Mayor-Commissioner

APPENDIX II

CURRENT PRINCIPAL OFFICIALS OF THE DISTRICT

GOVERNMENT CONCERNED WITH ACTIVITIES

DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
COMMISSIONER:		
Walter E. Washington	Nov. 1967	Present
DIRECTOR, DEPARTMENT OF HUMAN RESOURCES:		
Joseph P. Yeldell	Dec. 1971	Present
DEPUTY DIRECTOR, DEPARTMENT OF HUMAN RESOURCES:		
Joseph L. Douglas, Jr.	Jan. 1973	Present
DIRECTOR, COMMUNITY HEALTH AND HOSPITAL ADMINISTRATION:		
Raymond L. Standard, M.D.	July 1972	Present
ASSOCIATE DIRECTOR, OFFICE OF INSPECTION AND PROGRAM ANALYSIS:		
Joseph L. Douglas, Jr.	Jan. 1972	Present
ASSISTANT DIRECTOR FOR PLANNING:		
William H. Whitehurst, Jr.	Apr. 1973	Present
William H. Whitehurst, Jr. (acting)	July 1972	Apr. 1973

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