



**UNITED STATES GENERAL ACCOUNTING OFFICE**

**WASHINGTON, D. C. 20548**

**CIVIL DIVISION**

**October 29, 1971**

**Dear Mr. Hjornevik:**

We have reviewed the operations of the Neighborhood Health Services Program, a project operating in Rochester, New York, funded by the Office of Economic Opportunity under the Comprehensive Health Services Program. During this review--which covered the period from November 1967 through March 1970--we observed that although the project was serving a substantial number of persons, the project had several shortcomings which have precluded it from fully meeting its goals and the program's objectives.

We were assisted by medical specialists from the U. S. Public Health Service, HEW, who evaluated the quality of medical care provided by the project and the adequacy of patient medical records.

The purpose of this letter is to bring our findings and observations to your attention so that appropriate corrective action can be taken. Some of the findings are similar to those included in two recent reports to the Congress on our review of the Neighborhood Health Services Program for the poor administered by St. Luke's Hospital Center, New York City (B-130515, June 15, 1971), and the Southern Monterey County Rural Health Project, King City, California (B-130515, July 6, 1971).

From June 1967 when the project was initially approved by OEO through July 31, 1971, OEO had made grants totaling about \$6.1 million for project operations. An additional grant of about \$1.1 million was approved by OEO for the year ending July 31, 1972. The project seeks to demonstrate how the resources and capabilities of a major medical school--University of Rochester--and a large county health department--Monroe County--can be combined to deliver comprehensive, high quality, family-oriented health services to a target population of approximately 12,000 poor persons.

During its first 3 program years, the project generally succeeded in involving target-area residents in its planning and operation. It

enrolled about three quarters of its intended target population of 12,000 persons and provided medical services that generally satisfied these enrollees.

Improvements are needed, however, in providing preventive health care and in medical recordkeeping 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.

## IMPACT OF PROJECT

### SERVICES PROVIDED TO ENROLLEES

The project began providing services in July 1968, and as of March 31, 1970, had enrolled about 9,080 persons. Although it did not have information readily available to show how many of those enrolled had actually been treated since inception of the project, its 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 (Strong Memorial), and in their homes. For example, during the 9-month period ended March 31, 1970, the project reported 24,733 patient encounters, of which 21,085 occurred at the project site, 2,196 occurred in the patients' home and 1,452 occurred at the hospital and other sites.

The project uses the health team concept for family-oriented care and in June 1970 there were five such teams consisting of a pediatrician, an obstetrician, internists, a dentist, public health nurses, and family health assistants. All health care given to an individual and his family at the project, at home, or in the hospital is the responsibility of the assigned team. Patients were generally treated by the same physician or by another medical person from their health team.

We interviewed 53 enrollees of the project to obtain their views on several aspects of the project's operations. One of our questions dealt with continuity of care, and 45 of the 53 indicated that they were generally treated by the same physician each time they visited the project. Such continuity often prevailed also when a patient was admitted to Strong Memorial Hospital for inpatient care. Of the 53 persons interviewed, 19 were hospitalized while enrolled in the project, and 13 of them said that a project physician treated them while in the hospital.

The project also seems to have improved the general health of children in the project target area. An evaluation of the impact of

the project indicated a 38-percent reduction in visits by children from the project area to emergency departments of local hospitals between 1967 and 1970. The report on the study, made by three doctors from the Department of Pediatrics of the University of Rochester, stated that this reduction compared with no change in the number of similar visits from other areas in Rochester and a 29-percent increase in emergency visits by suburban children.

#### ACCEPTANCE AND PARTICIPATION BY TARGET-AREA RESIDENTS

The project seemed to have gained the acceptance of most of the low-income individuals that it serves. Forty-four of the 53 persons we talked to said they were satisfied with the medical services provided by the project; and in a similar survey by the project in September 1970, 163 of the 176 persons interviewed said they were satisfied with the project's medical care.

The Neighborhood Health Council, comprised of 28 representatives of organizations dealing with the poor in the target-area as well as persons eligible for project services, participated in decisions on such matters as eligibility, program priorities, and criteria for hiring nonprofessional employees. Only 10 of the 53 project enrollees whom we asked during our interviews whether they attended council meetings stated that they did. Project officials informed us that the council intended to increase its membership of persons eligible for project services--only 7 of the 28 members were project enrollees in February 1970--and to make itself more widely known to target-area residents.

As called for by OEO guidelines and approved project proposals, the project employed and provided training to residents of the target-area. Of the project's 134 employees as of July 30, 1969, 57 occupied nonprofessional positions such as family health aide, medical social receptionist, dental assistant, and medical records clerk; 23 of the nonprofessionals were residents of the project's target-area.

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 and proximity to their homes.

## PROJECT SERVICES IN NEED OF IMPROVEMENT

### PROFESSIONAL STAFF PRODUCTIVITY NEEDS TO BE INCREASED

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. Our analysis of the project's reported statistics for a 3-month period ended December 31, 1969, showed that, on the average, a project physician treated an equivalent of 12.4 patients a day and a project dentist treated an equivalent of 4.6 patients a day. 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 a dentist could be expected to treat two patients an hour, or 14 a day.

Project officials acknowledge the problem but attributed it, in part, to the number of appointments missed by patients, to the inadequate space, and to the additional time required for hospital visits.

We recommend that the Director, Office of Health Affairs, review the project's professional staffing pattern and take whatever actions can reasonably be taken to increase the professional staff's productivity.

### OVERALL HEALTH CARE PROVIDED NOT ACHIEVING PROJECT OBJECTIVES

Improvements are needed in preventive health care and medical recordkeeping 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.

Public Health Service medical specialists reviewed patient medical and dental records and concluded:

- The health care rendered was primarily episodic. In general, documentation did not indicate that care was preventive-oriented.
- There were no treatment plans for a full assessment of either the individual or the family care needs.
- The history and physical findings recorded related primarily to the episodic visit. In only a small percentage of records was a meaningful, complete workup (complete physical examination) available.

--Except on occasion, the dental documentation did not show evidence of routine semiannual examinations. Visits to the Center seemed to be in response to specific dental need such as filling and extraction.

--Documentation of the diagnostic results was fragmented.

Project officials told us they were aware that some patients come to the Center only when they are ill and do not return for scheduled medical checkups. They said that they are striving to improve this situation by having the doctors, nurses, and family aides impress on their patients the importance of medical checkups and follow-ups. The project director said that a committee of project doctors had been established to review the patients' medical records and documentation to ascertain where improvements are needed.

We recommend that OEO, through the Office of Health Affairs, stress to project officials the need to improve its recordkeeping and expand preventive health care and dental services and to educate the poor to seek such care.

#### ADMINISTRATIVE MATTERS NEEDING IMPROVEMENT

##### NEED FOR FEE SCHEDULE

OEO guidelines provide that whenever a project proposes to serve individuals who have income above the standard for free care, the application should include a schedule of the amounts to be charged for services to such individuals. The schedule should also indicate at what income levels the full costs of services are to be billed and how these costs are to be determined.

The June 10, 1969, proposal for the third year of operation mentioned for the first time services to individuals whose income was above the standard for free care. About 13 percent of the patients treated during the period July 1, 1969, through September 30, 1969, were charged \$3.00 for the clinic visit. The proposal had stated that the project and the Neighborhood Health Council would develop a sliding fee scale for these patients.

In the grant for the third year, OEO required that the project obtain advance approval from the OEO Office of Health Affairs of the proposed sliding fee schedule.

The council, which had been working on a fee schedule since June 1969, submitted one to OEO during March 1971. OEO did not approve it and returned it for revision. As of September 1971, a revised schedule had not been submitted to OEO for approval.

We recommend that the Director, Office of Health Affairs, take the necessary action to have the project expedite the submission of the required fee schedule.

AUDIT OF INDIRECT COST RATE NEEDED

OEO had not audited the tentative indirect cost rate of 20 percent of project direct costs (excluding renovations) charged by the University of Rochester during the project's first three program years ended July 31, 1970.

Under this arrangement, which was accepted by OEO subject to audit, the University of Rochester was paid \$37,288, \$172,721, and \$134,479 for the first, second, and third program years, respectively, for providing administrative, personnel, and payroll services.

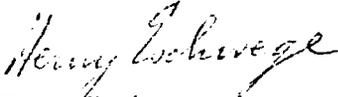
Although OEO officials informed us in September 1970, that OEO was planning to review the University of Rochester indirect cost rate, no such audit had been made as of September 1971.

We recommend that the Director, Office of Health Affairs, arrange for an early audit of the indirect costs.

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We would appreciate being advised of any actions taken on our recommendations. Our staff is available to meet with you or your representatives to discuss them further should you so desire. We wish to acknowledge the courtesies extended to us during this review.

Sincerely yours,

  
Henry Eschwege  
Associate Director

Mr. Wesley L. Hjernevik  
Deputy Director  
Office of Economic Opportunity