DOCUMENT RESUME

06272 - [B1726768]

Are Neighborhood Health Centers Providing Services Efficiently to the Most Needy? HRD-77-124; B-164031(5). June 20, 1978. 33 pp. + 5 appendices (12 pp.).

Report to the Congress; by Robert F. Keller, Acting Comptroller General.

Issue Area: Health Programs: Health Providers (1202); Health Programs: Efficiency and Effectiveness of Grantees and Contractors in Providing Treatment Services (1215).
Contact: Human Resources Div.
Budget Function: Health: Health Care Services (551); Health: Health Planning and Construction (554).
Organization Concerned: Department of Health, Education, and Welfare.
Congressional Relevance: House Committee on Interstate and Foreign Commerce; Senate Committee on Human Resources; Congress.
Authority: Public Health Service Act, as amended (42 U.S.C. 254c ; 42 U.S.C. 300e). Social Security Act (42 U.S.C. 1395; 42 U.S.C. 1396). National Health Planning and Resources Development Act of 1974 (P.L. 93-641). National Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317). Planning and Health Services Amendments of 1966. P.L. 94-63. B-164031(2) (1974).

Federally funded neighborhood health centers provide a wide range of ambulatory health services to residents (primarily the urban poor) of the areas designated as medically underserved. The Department of Health, Education, and Welfare (HEW) funds 112 neighborhood health centers; such centers received most of the $197 million appropriated in fiscal year 1976 for HEW's community health center program.
Findings/Conclusions: There are five basic situations in need of improvement in the neighborhood health center program: (1) centers are understaffed for the number of patients treated, and the underuse of physicians, dentists, support personnel, and services costs more than $1 million annually; (2) demand for health services from neighborhood health centers is not likely to increase beyond present levels and could decline; (3) HEW has not made sure that centers are serving residents of medically underserved areas and does not know the number of percentages of users who live in these areas; (4) HEW no longer requires centers to become financially self-sufficient; and (5) although the Public Health Service Act requires the centers to provide preventive health care, most patients use the health centers to cure illness instead of for prevention. HEW needs to develop and more strongly enforce productivity standards for all health center employees. Recommendations: The Secretary of HEW should: reduce the service capacity at inefficient centers to levels consistent with the demand for services, enforce compliance with

existing productivity and staff-size criteria, develop criteria for measuring the productivity of dentists, assure closer evaluation of the reasonableness of costs at each center in relation to the level of service provided, compile and maintain records to identify center registrants who live in medically underserved areas and identify centers whose registrant workload is not primarily from those areas, stop funding centers which service only or primarily people who do not live in medically underserved areas, continue to encourage and assist centers to bill and collect money when it is due them, and have health centers promote participation in preventive health care serivces. (RRS)

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BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Are Neighborhood Health Centers Providing Services Efficiently And To The Most Needy?

The 112 neighborhood health centers that are funded by the Department of Health, Education, and Welfare are intended to provide outpatient health services to residents of areas that are designated as medically underserved.

Many centers are not operating very efficiently because they are not properly staffed. Some serve residents of areas that are not designated as medically underserved, while most medically underserved areas go without health center services.

Reducing overstaffing at inefficient centers could provide money to reach more of the medically underserved.

HRD-77-124
JUNE 20, 1978

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

B-164031(5)

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

We reviewed neighborhood health centers that are funded as part of the Department of Health, Education, and Welfare's community health center program. Many of the health centers are not operating as efficiently as they could, and some centers primarily serve areas not designated as medically underserved.

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 Secretary of Health, Education, and Welfare and to the Director of the Office of Management and Budget.

ACTING Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

ARE NEIGHBORHOOD HEALTH CENTERS PROVIDING SERVICES EFFICIENTLY AND TO THE MOST NEEDY?

D I G E S T

The Department of Health, Education, and Welfare (HEW) estimates that some 45 million Americans lack adequate access to health care services. In trying to provide outpatient health care services to these people, HEW funds 112 neighborhood health centers primarily in urban areas. In fiscal year 1976 neighborhood health centers received most of the $197 million appropriated for HEW's community health center programs. (See p. 1.)

After reviewing activities of six health centers and HEW records on the others, GAO found five basic situations in need of improvements:

--Centers are overstaffed for the number of patients being treated. This underuse of physicians, dentists, support personnel, and services is costing the six centers more than $1 million annually. HEW records indicate that many other centers have similar costly inefficiencies. Anticipated patient demand on which staff levels were originally based has not materialized, and staffs have not been reduced to levels consistent with demand. (See p. 5.)

--Demand for health services from the neighborhood health centers is not likely to increase beyond present levels and could decline because the population growth of the areas that the centers serve has either stabilized or other sources of health care have become available. (See p. 12.)

--HEW has not made sure that centers are serving residents of medically underserved areas. HEW does not know the

number and percentages of users of the centers who live in these areas. (See p. 18.)

--HEW no longer requires centers to become financially self-sufficient. However, its emphasis on having centers obtain as much revenue as possible from non-Federal sources may be having an adverse impact on the main objective--serving the medically underserved. Some centers have dropped boundary and residency requirements to attract patients who have the means to pay for their services. (See p. 24.)

--The Public Health Service Act requires centers to provide preventive health care services. Patient responsiveness is the basic ingredient necessary for success and is lacking. Most patients use the health centers to cure illness, not for prevention. (See p. 29.)

PROGRAM MANAGEMENT

GAO previously reported on the underuse of health center physicians. Although HEW has acted to improve efficiency, more vigorous steps are needed. HEW has developed productivity standards and staffing ratios for evaluating health center physicians and support personnel. Physician productivity at many centers, however, falls below HEW's minimum standard and the size of the medical support staff often exceeds the allowable ratio. Also, HEW has not developed adequate criteria for evaluating some health center activities.

Because the problem remains, HEW still needs to develop and more strongly enforce productivity standards for all health center employees. It should start reallocating its resources so that individuals in areas without access to outpatient health care services can be served. (See p. 15.)

RECOMMENDATIONS TO THE SECRETARY OF HEW

The Secretary of HEW should:

--Reduce the service capacity at inefficient centers to levels consistent with the demand for services. (See p. 15.)

--Better enforce compliance with existing productivity and staff size criteria. (See p. 16.)

--Develop criteria for measuring the productivity of dentists. (See p. 16.)

--In addition to using cost criteria to control supporting and general service costs, assure closer evaluation of the reasonableness of such costs at each center in relation to the level of service provided. (See p. 16.)

--Compile and maintain records to identify the number of center registrants who live in medically underserved areas and identify centers whose registrant workload is not primarily from those areas (See p. 22.)

--Stop funding centers which serve only or primarily people who do not live in medically underserved areas, particularly where the residents have access to other health care providers. Funds to centers should be reallocated to medically underserved areas whose residents will be the centers' primary workload, so as to achieve the greatest coverage with resources available. See p. 22.)

--Continue to encourage and assist centers to bill and collect money when it is due them and make sure that centers concentrate on serving the medically underserved rather than seek to serve patients in other areas that do not have a shortage of personal health services simply to increase revenue. (See p. 27.)

--Have health centers promote participation of the centers' users in preventive health care services. (See p. 33 .)

--Use some health centers as sites for demonstration projects authorized under the recently enacted National Consumer Health Information and Health Promotion Act of 1976. (See p. 33.)

HEW concurred with GAO recommendations which would result in increased efficiency, allow for resource allocation, and result in increased participation in preventive health care services. Although it revised project funding criteria to include new and revised program indicators as a means of improving project efficiency and effectiveness, GAO believes that this effort needs to be reinforced by more stringent application of funding criteria.

HEW believes that collecting demographic data to identify clinic workload from medically underserved areas would be contrary to current Federal efforts to streamline Federal paperwork requirements and would divert health care delivery funds to administrative recordkeeping uses. Actually, collection of such data would be cost beneficial and provide information on the extent that centers are serving the population base intended by the Congress. HEW stated that decisions on funding clinics must recognize that many users of the clinics have low incomes or are unemployed and medically needy. GAO acknowledges that many registrants have these characteristics but many also have access to other health care providers. Funding decisions should be based on the number of residents in medically underserved areas using the center rather than the number living in the area.

HEW did not concur with GAO's recommendation that centers concentrate on serving target area residents. Centers must serve anyone who seeks their services in HEW's view. However, section 330(a) of the Public Health

Service Act requires only that the centers serve all residents of the target areas. GAO agrees with HEW that centers should not turn away patients solely because they live outside target areas. HEW, however, should not allow centers to seek patients from outside their target areas merely to increase revenue.

Contents

ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
MUA	medically underserved area
OEO	Office of Economic Opportunity

CHAPTER 1

INTRODUCTION

An estimated 45 million Americans live in areas which have no or few private practice health care providers. To help meet the medical needs of these Americans, the Department of Health, Education, and Welfare (HEW) funds neighborhood health centers, community health networks, and family health centers. These three types of centers are administered through HEW's community health center program.

Federally funded neighborhood health centers, the oldest of the three types, provide a wide range of ambulatory health services to residents (primarily the urban poor) of areas designated as medically underserved.

Neighborhood health centers received most of the $197 million appropriated in fiscal year 1976 for the Department's community health center program. HEW funds 112 neighborhood health centers through grants authorized under section 330 of the Public Health Service Act, as amended (42 U.S.C. 254c.).

Neighborhood health centers were first funded under the Office of Economic Opportunity (OEO) Comprehensive Health Service Program, authorized by the Planning and Public Health Services Amendments of 1966. In 1973, the program was transferred from OEO to HEW, and the centers were funded under section 314(e) of the Public Health Service Act. Section 314(e) was repealed in July 1975 and replaced by section 330.

Centers authorized under section 330 are required to provide

--primary health services, such as physician, laboratory, X-ray, preventive health and dental, and transportation services; and

--educational health services.

The centers may provide supplemental health services such as hospitalization, vision, pharmaceutical, and social services when needed to support the primary health services. Supplemental services can be provided either through the center's staff and supporting resources or through contracts or cooperative arrangements with other public or private entities. When appropriate, centers may refer patients to providers of supplemental health services and pay the providers for services rendered and provide environmental health services.

In addition to grant funds, financial support for the centers may come from such sources as State or local governments and public or private nonprofit agencies. Furthermore, centers are required under section 330 to seek reimbursement for medical services from such sources as titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act (42 U.S.C. 1395, 1396), private insurance, State and local welfare programs, and patients. Centers charge patients according to their ability to pay, as determined by a sliding fee schedule based on income and family size.

About 1.4 million people are registered at the 112 neighborhood health centers. Patient registration averages about 13,000 per center, but ranges from less than 1,000 to over 36,000. About 75 percent of the centers are in urban areas. The average center has been operational about 5 years.

The Bureau of Community Health Services, Health Services Administration, in Rockville, Maryland, is responsible for providing national leadership and support to the community health center grant program, which is administered on a decentralized basis by HEW's regional offices. The regional offices are responsible for monitoring centers' activities and providing needed technical assistance. Each regional health administrator has authority to approve and fund grants to centers within regional boundaries.

OUR PRIOR REVIEWS OF NEIGHBORHOOD HEALTH CENTERS

We previously reviewed aspects of neighborhood health center activities. In a report: "Implementation of a Policy of Self-Support by Neighborhood Health Centers" (B-164031(2), May 2, 1973) to the Chairman, Subcommittee on Health, Senate Committee on Labor and Public Welfare, we concluded that health center operating practices and the limited or lack of coverage of some services severely limited the prospect of improving the centers' level of self support.

In a report: "Better Use Should Be Made of Physicians and Dentists in Health Centers" (B-164031(2), Apr. 9, 1974) to the Congress, we stated that physicians and dentists were underused and recommended several corrective actions to HEW. Since our report, HEW has issued various criteria for measuring health center efficiency, identifying unacceptable health center management, and determining appropriate levels of grant support. These efforts have resulted in some improvements in the management of the centers, but, as discussed in this report, more improvements are needed.

SCOPE OF REVIEW

In this review, we reevaluated issues discussed in both of the above reports, giving recognition to the HEW productivity criteria and HEW management initiatives. In addition, we evaluated the size of health center clinic support staff (e.g., laboratory, X-ray, and pharmacy personnel) and the need for certain supporting services such as social and transportation services. We also reviewed centers' efforts to provide preventive health care services and patient responsiveness to such services. We made our reviews at six centers (see app. I), four HEW regional offices, and the headquarters of the Health Services Administration in Rockville, Maryland. In addition, we discussed our findings in various meetings with Department representatives and gave them a draft of this report for comment in July 1977. The Department's comments, received in February 1978, are recognized in this report.

CHAPTER 2

HEALTH CENTERS CAN REACH MORE PEOPLE BY ELIMINATING UNNECESSARY COSTS

The need is great. HEW estimates that 45 million Americans are medically underserved (i.e., lacking adequate access to personal health care services).

The cost is high. Efforts to provide such services to the estimated 1 million people who were served by neighborhood health centers in fiscal year 1975 1/ cost an average of $201 per registrant.

The resources are limited. About $259 million (including nongrant funds) was available for neighborhood health center support in fiscal year 1975 1/; about $10 billion annually would be required to reach the remaining medically underserved at the annual cost of $201 per registrant.

The limited resources need to be used more efficiently. Neighborhood health centers employ more physicians, dentists, and support staff than are needed by the number of people using the centers. As a result, some employees are underused. For example, over $1 million a year was being spent on unnecessary personnel at the six centers we reviewed. (See app. II.) By eliminating such unnecessary costs, centers could still give the same level of health care and could use the savings to reach even more of the medically underserved. The overstaffing and resulting underuse of employees stems from several factors, including less than anticipated demand for services, a high rate of broken appointments, and health center management weaknesses. In addition, over half of the centers exceed allowable limits for general service costs which include administration, management information, and maintenance services.

1/In FY 1976, HEW combined the neighborhood health center program with the rural health initiative, community health network, and family health centers programs, into the community health center program. HEW's program data does not allow for readily compiling more current cost data on the neighborhood health center segment of the program.

OVERSTAFFING AND OTHER INEFFICIENCIES

Eliminating overstaffing and other inefficiencies at the neighborhood health centers would result in large savings in three main categories: (1) physician and dentist staffing, (2) medical support personnel, and (3) supplemental support services.

Physicians

According to productivity standards developed by HEW to evaluate health center efficiency, primary care physicians 1/ should treat at least 2.7 patients an hour. Program consultants to HEW recommend that primary physicians treat between 2.85 and 3.57 patients an hour. In evaluating the centers, we used 2.7 (HEW's standard) and 3.57 (consultant's standard) as the limits of reasonable productivity.

We found that four of the six centers visited performed below HEW's standard, and all six were below the consultant's standard. At four centers, the same number of patients treated during a typical several-months period could have been treated by 4.4 fewer full-time equivalent 2/ physicians if HEW's standard had been achieved. Had the consultant's standard been achieved, 12.9 fewer full-time equivalent physicians would have been needed. Salary costs for the excess physicians were $137,000 annually using HEW's standard and $421,000 annually using the consultant's standard, as shown in appendix III.

HEW records show similar costly underuse of physicians nationally. Seventy-two 3/ of the 112 centers reported productivity data for the first quarter of calendar year 1976. Physician productivity was below HEW's standard at 42, or 58 percent of these centers. Only 10 percent of them achieved the consultant's standard, which follows.

1/Primary care physicians include internists, pediatricians, and general practice and family practice doctors who provide primary health services to adults and children.

2/Full-time equivalent positions are used to measure productivity because centers employ both full-time and part-time staff.

3/Excludes six centers because of data inconsistencies.

Average Number of Patients Treated by Physicians Per Hour in 72 Reporting Centers During First Quarter of 1976

Range of average no. of patients treated	No. of centers	Cumulative no. of centers	Average no. of patients treated	Percent of centers	Cumulative percentage	
Less than 0.9	1	1	0.6	1	1	
0.9 to 1.4	2	3	1.4	3	4	
1.5 to 2.0	12	15	1.8	17	21	Below HEW
2.1 to 2.6	27	42	2.3	37	58	standard
2.7 to 3.56	23	65	3.0	32	90	
3.57 and over	7	72	4.7	10	100	
Total	72		2.6	10[illegible]		

For the 42 centers below HEW's standard, we estimated that annual salary costs for excess primary care physicians were $1.8 million. Sixty-five centers were below the consultant's standard, thereby increasing our estimates of annual salary costs for excess primary care physicians to $4.2 million. (Salary costs for excess primary physicians may have been higher if data from all 112 centers had been available.)

Dentists

HEW has not developed criteria for measuring the productivity of health center dentists. Since the reporting centers 1/ employed 204 dentists at an annual cost of $5.6 million, we believe that HEW needs to develop criteria to properly manage and evaluate dental efficiency.

In an earlier review of HEW's community health center program, we found general agreement among dentists that a reasonably productive dentist should be able to treat about 1.8 patients per hour. This productivity factor is still current according to data supplied by the American Dental Association. Applying this standard at the six centers, we found some centers were overstaffed and dentists underused, though on a more limited scale than physicians. Had the patients at three of the six centers been treated at the rate of 1.8 per hour, 6.9 full-time equivalent dentists, rather than the nine dentists employed, would have been needed. The salary costs for the excess dentists amounted to $58,000 annually.

1/Only 74 of the 112 centers reported data on the number of dentists employed for the first quarter of calendar year 1976.

Medical support

HEW criteria allows centers to employ up to four medical support staff for each physician. Medical support personnel include laboratory, X-ray, pharmacy, and medical records staff and all medical staff except physicians. At five of the six centers visited, medical support staffing exceeded this criteria. When evaluated on the basis of the number of physicians needed, using the productivity standards discussed on page 5, the total cost of this overstaffing was $718,000 using the HEW productivity standard and $1,088,000 using the consultant's standard.

For example, if the Hough Norwood Family Health Care Center, Cleveland, had treated 2.7 patients an hour, 13.8 physicians and 55 medical support staff would have been needed at the 4 to 1 ratio. However, the center employed 99.5 medical support staff--44.5, or 81 percent, more people than needed. If the center had treated 3.57 patients an hour, it would be overstaffed by 55.5 persons at the 4 to 1 ratio. Hough Norwood pays these people an average of $8,200 a year plus 19 percent fringe benefits. At that rate, overstaffing for medical support staff costs the center from $432,000 to $539,000 annually.

HEW records show a similar picture nationally. Sixty-eight 1/ of the 112 centers reported medical support staff data for the first quarter of 1976. Forty-eight, or 71 percent, of the 68 centers exceeded HEW's 4 to 1 staffing ratio, as shown below.

Average Number of Medical Support Personnel for Each Physician in 68 Reporting Centers During First Quarter of 1976

Range of average no. of medical support personnel	No. of centers	Cumulative no. of centers	Ratio of medical support personnel	Percent of centers	Cumulative percentage	
10.0 and over	3	3	11.7 to 1	4	4	
8.1 to 10.0	3	6	9.0 to 1	5	9	Exceed
6.1 to 8.0	11	17	7.1 to 1	16	26	HEW
4.1 to 6.0	31	48	5.1 to 1	46	71	standard
2.1 to 4.0	13	61	3.5 to 1	19	90	
2.0 or less	7	68	1.8 to 1	10	100	
Total	68		5.2 to 1	100		

1/Excludes 14 centers because of data inconsistencies.

The 48 centers employed an average of 5.8 medical support staff for each of 362 physicians--or 652 people too many. Medical support staff are paid an average of about $9,700 a year at the 48 centers, excluding fringe benefits. At that rate, we estimate that excess salary costs at the 48 centers amount to $6.3 million annually. The estimated excess salary costs are even larger if the number of physicians on which the estimate is based is reduced to recognize the previously discussed physician productivity standards.

Supplemental support

Besides medical support staff, health centers employ people for supplemental support services, such as transportation and social and community services. These services are intended to support but not relate directly to medical, dental, or mental health services. Social and community services include social workers, outreach workers, and family health workers who help patients solve family, community, or health care problems. Transportation service is authorized under the law for patients who have special difficulties getting to and from the health center.

HEW data shows that such supporting service costs nationwide amount to at least $12 million annually and were about 6 percent of total health center costs. According to HEW guidelines, such costs should be no more than 15 percent of total costs.

This criterion alone, however, does not assure efficient management of supporting services. A health center's costs can be within the 15-percent limit, but excess staff can still exist and unnecessary services can still be provided.

At three of the six centers visited, we identified unnecessary supporting services, the cost of which totaled $210,000 annually. In each instance, the supporting service cost was less than 15 percent of total costs.

Hough Norwood Center

In 1975, the supporting service costs at Hough Norwood were $256,000, or 3.5 percent of total costs--well within the 15-percent limit. However, 9 of the 12 family health workers which the center employed in 1976 were performing tasks previously done by other employees. Center officials agreed that the task--helping patients fill out forms and directing patients to various laboratory test areas in the center--could again be performed by other members of the medical team.

Program consultants tc HEW reached a similar conclusion after reviewing the efforts of family health workers in 1975. By eliminating the nine family health worker positions, the center could save $92,000 a year.

Hough Norwood also spent more than was necessary on transportation service. The center employed seven transportation workers and operated eight vehicles (three minibuses, three station wagons, and two cars) at a total annual cost of about $110,000. The minibuses made hourly runs through the target area. The station wagons and cars transported patients to and from the center and area hospitals. This service cost the center an average of $6 for each patient roundtrip.

Public bus fare, which the center will reimburse, was only 25 cents. The public bus system runs bus routes through the center's target area. A bus stop is one block away from the main building. The center transportation supervisor told us that 55 percent of the patients transported from their homes to the center could use public transportation. However, the center transports anyone requesting the service, regardless of whether they could use public transportation.

We believe that Hough Norwood should transport only patients who have special problems in getting to the center. By so doing, the center could eliminate the minibus service, which duplicates the public bus service, and reduce its transportation staff and vehicles by one-half. This would save about $44,000 a year and still provide the service needed and intended under the Public Health Service Act.

South Brooklyn center

The director of the South Brooklyn Health Center in New York, New York, concurred with our finding that his transportation service could be reduced from four vehicles and four drivers to one vehicle and one driver--at a savings of $44,000 a year. Because the service area is quite small geographically, adequate transportation service could still be provided to those in need using fewer vehicles.

Mission center

In October 1975, a consulting firm at the Mission Neighborhood Health Center in San Francisco, identified about $70,000 in excess costs for community health workers and about $30,000 in excess costs for transportation personnel. According to the consulting firm, community health workers'

responsibilities were unclear, and their contribution to center operations was questionable. Center officials subsequently eliminated the unnecessary community health workers and said they planned to cut unnecessary transportation costs.

Similar unnecessary supporting services could exist at many other centers and not be noticed by HEW when it limits its review to the 15-percent criterion as a means of identifying services that may not be needed.

General services

General services include administration, management information, and maintenance services. HEW data indicates over half the centers exceed the allowable limit for such costs.

According to HEW criteria, costs for general services should not exceed 25 percent of a center's total ambulatory health care costs. For the quarter ended March 31, 1976, cost data reported by 83 of the 112 centers showed that general service costs represented 28 percent of total ambulatory care costs. General service costs for 58 of the 83 centers exceeded the 25-percent limit and ranged from 26 percent to 66 percent of total costs at each center. The 83 centers employed 2,835 people in the general service category.

We noted that centers employ a large number of highly paid administrative personnel. For example, in his review of one health center, an HEW regional office official concluded that it was questionable whether a project with 11,000 registrants needed a director-level administrative staff of the following size and cost.

Position	Annual salary
1. Center director	$ 42,204
2. Administrator	27,500
3. Director of health services	24,200
4. Director of operations	20,350
5. Director of nursing	18,150
6. Director of internal service	12,312
7. Chief fiscal officer	16,500
8. Director of social services	17,600
9. Director of dentistry	36,300
	$215,116

We found similar costs at the centers we visited. For example, Mission center's director-level administrative staff included:

Position	Annual salary (note a)
1. Executive director	$ 28,000
2. Associate director	17,500
3. Assistant director	16,500
4. Medical director	9,800
5. Dental director	18,150
6. Community health services director	36,300
7. Assistant director for ancillary services	16,000
8. Pharmacy director	19,800
9. Operations manager	15,500
10. Fiscal manager	16,000
11. Data processing manager	16,000
	$209,550

a/Excludes salary for time spent treating patients.

Director-level administrative salaries averaged $208,000 at each of the remaining five centers.

We did not make an indepth review of the use of general service staff. However, because of (1) the number of centers whose costs for general services exceeded HEW's criteria and (2) the number of people employed in general service positions, we believe that the potential for cost savings also exists in this personnel category.

CAUSES OF UNDERUSE AND OVERSTAFFING

Centers established under the OEO Comprehensive Health Service Program were to provide jobs as well as health care to neighborhood residents. Often the jobs provided were of the supporting service type--transportation personnel and social or family health workers--which required minimal skill or training. To some degree, this employment objective contributed to overstaffing. HEW has since eliminated this objective, but many centers still employ community people in supporting-activity-type jobs in excess of the number needed to serve patient workloads.

Other factors contributing to underuse and overstaffing include

--less than anticipated demand for services, due partly to the availability of other forms of health services such as hospital outpatient departments;

--the traditionally high rate of broken appointments in neighborhood health centers; and

--health center organizational and management weaknesses.

Patient demand

Health center physicians and dentists are underused primarily because demand for their services is low. The Mission center, for example, had enough primary physicians to treat 34,600 patients annually, but only 27,000 patients came in for service. Since the staffing ratio for clinic support personnel is based on the physician staff size, physician overstaffing naturally leads to clinic support overstaffing. The anticipated patient demand, upon which staff levels were originally based, has not materialized, and the staff levels have not been appropriately reduced.

Patient demand--as indicated by patient-use levels--appears to have stabilized in at least three of the six centers reviewed. 1/ For example, the number of patients using the Homewood-Brushton Neighborhood Health Center in Pittsburgh, in recent years was as follows.

Year	Average monthly visits
1972	3,102
1973	3,627
1974	3,966
1975	3,469
1976 (first 5 months)	3,650

Also, census data indicates the population of Homewood-Brushton's target area declined 16 percent between 1960 and 1970 and another 16 percent between 1970 and 1975. Four of the other five centers' target areas showed similar population losses in recent years.

1/Accurate patient-use data was not available at one of the remaining centers, and the other two showed some increase.

Another factor contributing to the leveling of patient demand is the transient nature of the target population and the eligiblity of the residents for health services under other programs. For example, about 40 percent of Homewood-Brushton's target group changed residency within 5 years. Also, an estimated one-third of the center's target population were welfare recipients with Medicaid coverage and, therefore, had more flexibility in choosing a health care provider.

The availability and competition of other health care resources draw many target area residents away from the health center and also hampers increases in center-use levels.

For example, about 6,000 of Hough Norwood's target area residents had used the outpatient department of a distant county-operated hospital for their ambulatory health care. Several nearby hospital outpatient departments also drew heavily from the center's target area population; one of the larger hospitals drew 23.5 percent of its patient visits from much of the center's target area. A nearby State and federally funded mental health clinic also competed for patients with Hough Norwood. In addition, the county constructed an ambulatory care facility, about 1-1/2 miles from the Hough Norwood center, which offers the same services provided by Hough Norwood.

As part of another review on aging, we interviewed a random sample of the 6,391 elderly persons (age 65 and older) living in Hough Norwood's target area. Fifty-six percent of those interviewed said that they were aware of the center. However, only 18 percent of the sample had used it. Many of the sample obtained their health care at various places other than Hough Norwood. Thirty-six percent went to a physician's office, while 48 percent went to a hospital. Seventy percent of the sample received regular physical examinations at a physician's office, hospital, or other provider location. Obviously, Hough Norwood faces stiff competition for patients.

As pointed out in our April 1974 report on this program (see p. 2). although the number of patients using the center is not static, it is unlikely that most of the centers reviewed will experience such a substantial increase in demand for services that the overstaffed conditions would be materially affected. As of June 1976, the centers we reviewed had been operating for 7 to 9 years. The average age of all centers in the program was about 5 years. Therefore, the

centers have been operating long enough for the vast majority of community residents to be aware of them and to take advantage of services if they so desired.

Broken appointments

The high broken appointment rate--ranging from about 30 to 40 percent at most centers--was frequently cited by center officials as hindering productivity. A study by one center of a typical day showed 124 of 236 patients failed to keep their appointments. Unless an unscheduled patient shows up for treatment, the physician remains idle during the broken appointment time. On the date of the above study, only 32 unscheduled patients came in for treatment.

This has been a longstanding, difficult problem at health centers. The above study showed that such factors as weather, distance from center, transportation availability, or number of health problems had little impact on the broken appointment rate. The center had tried a number of remedies, but to no avail.

Health center management weaknesses

HEW consultant reviews of various health centers have found numerous and continuing weaknesses in the management and operation of centers. For example, reports on the Mission center in 1975 by two consulting groups stated that the (1) organizational structure is ill-defined, inefficient, and inadequate; (2) lack of communication among departments results in duplication and underuse of services; (3) allocation of personnel is inefficient and wasteful; and (4) severe administrative deficiencies are the result of several years of inexperienced and inept management. At the Hough Norwood center, HEW's consulting review group reported that

--the center's control of costs was a result of circumstances rather than planning;

--such techniques as job analysis, performance standards, or cost-effective appraisal of procedures had not been used to control personnel costs;

--staffing ratios had occurred rather than having been planned; and

--no personnel staffing level guidelines were found based on population ratios, growth expectancy, or on any other basis.

CONCLUSIONS

Since our prior report on health centers, HEW has taken various steps to improve program management and efficiency. HEW has established criteria for measuring physician productivity and evaluating medical support staff size and general services costs. However, HEW has not adequately enforced compliance with its criteria and has not required centers to maintain staffing levels consistent with demands for service. Also, HEW has not developed criteria for measuring dentist productivity.

HEW has not developed adequate criteria for assuring that health center supporting and general services costs are reasonable for the level of service provided. The percent of total cost limitation is inadequate by itself. Total costs may be inflated due to overstaffing of physicians, dentists, and medical support personnel. Even without inflated total costs, however, a center's supporting and general services costs can be within the limit and still be unnecessary. Also, HEW has not adequately enforced compliance with the 25-percent limit on general services costs, as evidenced by the many centers which exceed it. In our opinion, controlling these costs requires closer evaluation of their reasonableness at each center than is provided by the current criteria.

Health center costs can be cut significantly by reducing service capacity to levels consistent with patient demand for service. Such reductions would save millions of dollars annually which could be used to reach more of the estimated millions of medically underserved Americans.

In some cases, centers' efforts to increase patient demand might result in registering more patients. We believe that the result would be minimal, however, because (1) most centers have been operating long enough to have attracted most of those who can be expected to use the service and (2) other health care resources are available to target area residents. In view of the steadily increasing cost of health care and the large unmet need for health care services, we believe that HEW must take more aggressive steps to eliminate unnecessary costs at health centers.

RECOMMENDATIONS

We recommend that the Secretary of HEW

--reduce the service capacity at inefficient centers to levels consistent with the demand for services;

--better enforce compliance with existing productivity and staff size criteria;

--develop criteria for measuring the productivity of dentists; and

--in addition to using cost criteria to control supporting and general service costs, assure closer evaluation of the reasonableness of such costs at each center in relation to the level of service provided.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on a draft of this report, HEW concurred with each of the above recommendations. It expects improved project efficiency and effectiveness through implementation of new, revised, and more stringent program indicators and criteria which it published as funding criteria for various grant programs administered by the Bureau of Community Health Services. We have noted, however, that the new or revised program indicators may not result in increased project efficiency and effectiveness.

The funding criteria include four indicators for measuring project efficiency. Two of the indicators address physicians and midlevel medical practitioners. HEW formerly expressed desired physician productivity as 2.7 patient encounters per hour. The new criteria expresses the productivity on an annual basis--4,200 encounters per year. Under the former criteria a physician working 7 hours per day, treating 2.7 patients per hour, and working only 220 days a year (365 days minus Saturdays and Sundays, 8 holidays, and 33 leave or training days) would have about 4,200 encounters per year. Therefore, the new criteria is not more stringent and does not provide for increasing efficiency.

The third criteria for increasing efficiency provides that the sum of administrative housekeeping and maintenance costs should not exceed 20 percent of total operating costs. The former criteria was 25 percent. The fourth criteria concerns the ratio of medical support staff to the number of physicians. Formerly a 4 to 1 ratio was desired and the new ratio is 3 to 1. Although both of these new criteria imply a closer scrutiny to accomplish increased efficiency, we noted that (1) in regard to the third criteria, certain cost elements previously included in calculating the 25-percent factor were also excluded from consideration (for the new lower standard, HEW lowered the percent but also lowered the pool of cost elements to be considered in calculating the percent);

and (2) in regard to the medical support staff to physician ratio, HEW similarly removed certain categories of staff from consideration in determining the number of medical support staff.

As stated in this chapter, more stringent application of the prior criteria would have resulted in increased efficiency. Therefore, we believe that HEW needs stronger enforcement of its criteria, an action it plans to implement.

In regard to the need to develop criteria for measuring the productivity of dentists, HEW commented that it has initiated efforts to gather data to develop such criteria. HEW should expedite its efforts to develop this criteria.

CHAPTER 3

STRONGER EFFORTS NEEDED TO ASSURE HEALTH CENTER SERVICES ARE DIRECTED TO MOST NEEDY

The primary purpose of community health centers, including the neighborhood health centers, is to serve areas with limited or nonexistent health care services as well as populations with special health needs. Almost 45 million persons reside in over 7,200 areas which HEW has designated as having a shortage of health services and therefore considers medically underserved. About 75 percent of the areas are not served by a community health center program.

HEW has not assured that the limited resources available for health center services are directed to the most needy areas. Centers which serve areas that do not have a shortage of personal health care resources duplicate services already available and compete with providers of such services for patients. While most HEW-supported neighborhood health centers serve several medically underserved areas (MUAs), some centers' service areas contain no census tracts designated as MUA and some contain only one MUA.

The large unmet need represented by MUAs not served by a health center underscores the importance of properly directing the limited resources available to the most needy.

HEALTH CENTER COVERAGE OF MUAs

Section 330 of the Public Health Service Act specifies that grants should be given only to community health centers that serve medically underserved populations. As defined by section 330, the term "medically underserved population" means:

> "[The]...population of an urban or rural area designated by the Secretary [of HEW] as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services."

Section 330's definition of a medically underserved population is the same as that of section 1302(7) of the act (42 U.S.C. 300e-1(7)) for establishing health maintenance organizations. To meet its requirements for health maintenance organizations, HEW issued regulations in September 1975, identifying 8,236 medically underserved areas. In October 1976 it updated its statistics on medically underserved areas and cited that 7,212 areas were medically underserved.

The more recent data compiled by HEW indicates neighborhood health centers service areas include only 711 (10 percent) of designated MUAs and that the other components of the community health center program service areas include 1,095 MUAs (15 percent). HEW estimates that 45 million people--about 21 percent of the Nation's population--live in the 7,212 areas.

Number of medically underserved being reached by neighborhood health centers is unknown

HEW estimates the population of the neighborhood health centers' service areas to be about five million people. HEW data collected from health centers indicates about 1.4 million individuals are registered as patients at the 112 centers. HEW studies validating the number of registrants at centers have shown that centers' reported statistics are overstated by about 22 percent. Adjusting for this, the actual number of registrants more closely approximates 1.1 million.

Some centers' service areas contain a preponderance of non-MUA census tracts. HEW has not compiled data on the number of center users who do not live in MUAs or on the number who do. Consequently, HEW does not know how many of the 45 million medically underserved people are being served by neighborhood health centers.

Some centers serve few or no MUAs

The large unmet need represented by MUAs not served by a community health center underscores the importance of properly directing the limited resources available to the most needy people. Although HEW guidance states that centers should primarily serve MUAs, HEW believes it complies with the law if a health center's target area contains only one MUA.

While most centers' service areas include several MUAs, HEW data showed at the time of our fieldwork that at least six centers' areas encompassed only one MUA and that the service area of 16 centers encompassed no MUAs. In 1976, HEW advised its Regional Health Administrators that program grantees could expand their targeted service areas so as to include a contiguous area which is designated as an MUA.

During informal discussions on our draft report, HEW provided data compiled in August 1977 showing that 14 of the 16 centers now included an MUA in their service area. Most of the 14 expanded their service areas by one or more census tracts to identify themselves with an MUA. Some of the 14 had census tracts recently designated as MUAs.

We believe that the need for some centers to expand their service areas for the sole purpose of including one or more MUAs illustrates the need for HEW to more closely evaluate whether such centers are meeting the intent of the Congress that they serve primarily medically underserved areas. When a center's target area includes an entire county designated as an MUA, the center obviously meets the intent of the law. However, an urban center's target area may encompass several census tracts, only one of which is an MUA. (One such center had 64 tracts with only one MUA.) We question whether this meets the intent of the Congress, particularly if few of the center's users come from the MUA census tract.

The Mission center, which was one of the six centers included in our review, illustrates the potential for HEW to redirect its resources to serve the most medically underserved. At the time of our review we found that the target area of the center contained no MUAs. We also noted that:

--The number of private physicians practicing in the area had increased from about 20 when the center opened in 1968 to about 200 in 1976. The number of private dentists practicing in the area had also increased significantly.

--A city hospital, located about 1 mile from Mission center, operates an outpatient program that offers a full-range of family health care services. About one-third of the hospital outpatient clinic's users live in Mission center's service area. The outpatient program also has a satellite clinic in the center's service area.

--Another hospital, located in the center's service area, also operates an outpatient clinic used primarily by indigent residents of Mission center's area.

--The city public health department operates an ambulatory health clinic a short distance from the center.

HEW funds two of the above outpatient programs, in addition to Mission center, for about $3.5 million a year.

Representatives of the local health planning agency and the city health department told us that the center duplicated and competed with other services available in the area. Also, an HEW regional office official acknowledged that the center is no longer needed because of the available health care

facilities in the area. He said the patients using the center would be served as well if not better by the other facilities, and the money would perhaps be better spent elsewhere.

Despite this condition, HEW has continued to fund the Mission center. During our study, the center expanded its service area to 26 census tracts by including two contiguous tracts not designated as MUAs in order to include a third tract which was designated as an MUA. The extent that residents of MUA will use the services of the Mission center is questionable because they would have to pass by another HEW-funded and city-operated comprehensive health facility to get to the Mission center. Furthermore, the census tract's MUA designation has become borderline. 1/

HEALTH PLANNING AGENCIES HAVE BEEN INEFFECTIVE

To assure that neighborhood health centers served MUAs and to avoid costly overlap and duplication of existing health care resources, HEW regulations required that centers be funded only after review by the local areawide comprehensive health planning agency. The areawide agencies were to develop comprehensive area plans for coordinating existing and planned health services. Comprehensive health planning agencies were generally ineffective, however, for various reasons, including lack of (1) regulatory power over the health delivery system, (2) authority to approve or disapprove funding, and (3) sufficient data on the existing health care system.

The National Health Planning and Resources Development Act of 1974 (Public Law 93-641) established a national network of health systems agencies, which replaced comprehensive health planning agencies. Health systems agencies have authority to approve or disapprove each proposed use of Federal funds affecting the health delivery system within their health service area, and, therefore, should have more regulatory power over the health care delivery system. Most health systems agencies were conditionally designated in April or July of 1976. No analyses have been made on their effectiveness in controlling the placement of health resources.

1/HEW computes an index of medical underservice and a score of under 62 an indicator of an MUA. This census tract had an index of 57.1 in September 1975 and 60.2 in October 1976.

CONCLUSIONS

Resources available for health centers--which are to serve primarily the medically underserved--are small in relation to the large unmet need for their services. HEW has not assured that the limited resources available are directed to the target population. Some neighborhood health centers have no MUAs in their service areas and some have only one. HEW has allowed centers whose targeted service area did not include an MUA to expand their service areas so as to include a contiguous area which is designated as an MUA. We question whether this meets the intent of the Congress, particularly if no or few residents of MUA obtain health services from the centers.

We believe that funding decisions should consider the number of MUA residents using a center, rather than the number living in an area. HEW, however, does not keep records showing how many center registrants live in MUAs and how many do not. Consequently, HEW does not know whether centers are serving primarily the medically underserved, or how many of the 45 million medically underserved Americans are being reached by the centers.

Better coverage of the millions in need of health center services could be achieved. Ultimately, health systems agencies should cause the centers to be located where needs exist.

RECOMMENDATIONS

We recommend that the Secretary of HEW take immediate action to:

--Compile and maintain records to identify the number of center registrants who live in MUAs and identify centers whose registrant workload is not primarily from MUAs.

--Stop funding centers that serve only or primarily people who do not live in MUAs, particularly where the residents have access to other health care providers. Funds to these centers should be reallocated to areas where people live in MUAs and will be the centers' primary workload so as to achieve the greatest coverage with the limited resources available.

AGENCY COMMENTS AND OUR EVALUATION

The above recommendations were not included in a draft of this report forwarded to the Secretary for comment. We discussed them, however, with representatives of HEW's Bureau of Community Health Services. They stated that a requirement for centers to collect the recommended demographic data would be inconsistent with present Federal efforts to streamline Federal paperwork requirements and would require diversion of health care delivery funds to administrative recordkeeping. We believe that collection of such data would be cost beneficial in identifying available funds to meet the health needs of residents of MUAs who have no or little access to health care. We also believe that such data will provide information to assure that the centers serve the population intended by the Congress.

The Bureau representatives concurred with the concept of achieving the greatest coverage with the limited resources available. They expressed concern over their compliance with the authorizing legislation if they limited the centers to delivering care to only residents of MUAs. They stated that many of the patients served by a center have low incomes or are unemployed and are medically needy. We acknowledge that many clinic registrants have these characteristics. We also acknowledge that many identify with the clinics as the primary place to receive health services. However, we believe that in many cases the accessibility to health providers has changed since the centers were established. As shown by the Mission center, other health providers have established or expanded their service delivery capability in the areas serviced by the neighborhood health centers. We noted at this center, as well as at other centers included in our study, that the newly established or expanded capacity was also federally funded. The increased availability of care is one factor that has resulted in some areas "losing" their MUA designation. Because of the large number of medically underserved Americans, we still believe that it would be cost beneficial for HEW to reallocate its resources, which currently fund centers which have no or a limited number of patients from MUAs, to establish centers in areas which have a concentrated medically underserved population.

CHAPTER 4

HEALTH CENTERS' PROGRESS IN MAXIMIZING NONGRANT REVENUE

Before enactment of section 330 of the Public Health Service Act, HEW required neighborhood health centers to become self-sufficient--that is, able to operate without Federal grant revenue. Section 330 emphasized self-sufficiency but did not require it. HEW and our previous studies have shown that self-sufficiency would require either (1) drastic cuts in the services provided or (2) broader service coverage through some form of national health insurance.

In making this review, we found that the prospect for self-sufficiency has not improved. In fact, an HEW study indicated that centers had nearly reached their maximum level of nongrant revenues. While we generally agree, we believe that improvement in centers' billing and collection efforts would increase some nongrant revenue. Due to the emphasis on increasing nongrant revenue, some centers have enlarged or eliminated their service area boundaries to try to attract new patients who can pay for service directly or through third-party coverage.

CURRENT LEVEL OF NONGRANT REVENUE

In fiscal year 1975 about 69 percent of community health centers' total operating costs were supported by grant funds. Of the 31 percent covered by nongrant revenue, 20 percent came from third-party reimbursements--primarily Medicaid--and 11 percent came from other nongrant funding sources, including State and local contributions. The amount of total costs covered by nongrant revenue at the six centers we reviewed ranged from 11 to 52 percent, as shown below.

Center	Percent of costs covered by nongrant revenue
Hough Norwood	11
Mission	25
Homewood-Brushton	33
North East Neighborhood Association Comprehensive Health Service	39
South Brooklyn	45
West Oakland	52

Generally, Medicaid reimbursements represent the largest single source of nongrant revenue. Therefore, centers in States with high Medicaid reimbursement rates are likely to get a larger proportion of nongrant revenue. For example, the North East Neighborhood and South Brooklyn centers, with nongrant revenue of 39 and 45 percent, respectively, are both in New York City; 49 percent of all Medicaid reimbursements nationwide were made in HEW's New York region.

Even the two New York centers, however, depend upon Federal grant support for over half their costs. Many center users are not covered by a third-party payer, and the grant must absorb all their service costs. Also, center costs often exceed reimbursements because (1) reimbursement rates are not based on actual costs and (2) services such as social and transportation, and some preventive health care do not always qualify for reimbursement. It appears, therefore, that most centers will continue to depend heavily on Federal grant support unless services are reduced or the number of people and services covered by a third-party payer are increased.

RESULT OF EMPHASIS ON INCREASING NONGRANT REVENUE

While centers are no longer required to become self-sufficient, HEW still emphasizes maximizing nongrant revenue. Because of this emphasis and the fact that many center users are not covered by third-party insurers, some health centers have dropped target area boundaries and residency requirements to attract patients who have third-party coverage or can pay for their services. All six centers we reviewed served patients from outside their target areas.

The Homewood-Brushton center, for example, began serving patients living outside its target area in April 1973. The Mission and Hough Norwood centers followed suit in 1975 and 1976, respectively. The West Oakland Health Center in Oakland, California, serves patients living outside the target area, but only if they can pay for services. About 20 percent of West Oakland center's patients live outside the target area.

The end result of the above is competition with other facilities, some of which are supported in part by other Federal programs.

SOME INCREASE IN NONGRANT REVENUE POSSIBLE THROUGH BETTER BILLING AND COLLECTION EFFORTS

With its emphasis on maximizing nongrant revenue, HEW has tried to assist centers in improving their billing and collection efforts. While some improvements have been achieved, our tests of the billing and collection procedures followed by the six centers reviewed showed that nongrant revenue could be further increased. Because of the time that would have been required, we did not determine how much of an increase would be possible. Review of the records of a sample of patients at each center showed that the centers were not

--billing self-pay patients or third-party payers for all reimbursable services and/or

--collecting all reimbursements that were billed.

Billing

Two of the centers appeared to be doing an adequate job of billing for reimbursable services. Four centers, however, failed to bill for from 12 to 49 percent of the reimbursable medical services provided to patients in our sample.

We found that the Mission center, for example, did not try to collect from patients service costs which the patients' private insurance would not pay. During one 10-month period, such costs amounted to $132,000. The Hough Norwood center did not bill private insurance companies for medical services provided to covered patients.

Collection

While available records at the centers showed that most billed services were collected, we did note certain problems in collection activities. For example, our sample at the South Brooklyn center showed that only 13 percent of the patients billed paid for their services. In addition to the difficulty of collecting from some self-pay patients, inadequate and/or nonexistent accounts receivable records also hindered three of the centers' collection efforts. Without proper control over accounts receivable, the centers could not determine which billings had not been paid and, therefore, could not properly follow up for collection.

CONCLUSIONS

Health centers are likely to depend on Federal grant support for 65 to 70 percent of their total operating costs for the foreseeable future. This conclusion is supported by an HEW study which indicated that centers have nearly reached their maximum level of nongrant revenues--which for fiscal year 1975 were about 31 percent of total operating costs.

Although some centers could improve their billing procedures, it appears that the only way to significantly decrease dependency on Federal grant support is to drastically reduce the services provided or increase the number of persons and/or services that qualify for reimbursement.

HEW has emphasized maximizing nongrant revenue through collections from patients and third-party resources. This emphasis has caused some centers to drop target area boundaries in an effort to attract self-pay patients or patients with third-party coverage from outside the target area who were using existing health care resources. We believe that this emphasis tends to work at cross-purposes with the goal of serving the medically underserved. As discussed in chapters 2 and 3, we believe that centers with more service capacity than needed to serve target area residents should be reduced to a more reasonable size--rather than allow them to use the excess capacity to serve patients from areas outside their target areas where there is not a shortage of health care services, while millions of medically underserved Americans go without access to such services.

RECOMMENDATIONS

We recommend that the Secretary of HEW continue to encourage and assist centers to seek reimbursement from private insurance companies and self-pay patients whenever possible. In addition, the Secretary should enforce the requirement that all centers maintain adequate accounts receivable records.

However, since the centers probably will not become self-sufficient, the Secretary should assure that centers concentrate on serving target area residents--who may lack personal resources or third-party coverage--rather than seek to serve patients in areas that do not have a shortage of personal health services to try to increase nongrant revenue.

AGENCY COMMENTS AND OUR EVALUATION

In commenting on our draft report, HEW concurred with our first two recommendations but not with our recommendation that centers concentrate on serving target area residents. HEW stated that, by law, the centers must serve anyone who seeks their services. We noted that section 330 of the Public Health Service Act only requires centers to serve residents of its target area. We agree that patients from outside the target area who seek the centers' services should not be turned away, provided target area residents are adequately served. However, we do not believe that the law requires health centers to serve nontarget area residents, nor that HEW should allow centers to seek patients from outside merely to increase nongrant revenue.

CHAPTER 5

LACK OF PATIENT DEMAND FOR PREVENTIVE HEALTH CARE SERVICES

The Public Health Service Act requires health centers to provide preventive health care services. We found, however, that most patients go to the centers to seek cures for illness, not to prevent it. People to whom the program is directed are more concerned with solving the problems of day-to-day existence than seeking preventive health care. Also, centers have a financial disincentive to provide preventive care services. While only a limited number of patients have third-party coverage, even fewer have coverage which provides for payment for preventive health services.

Because of these practicalities, two health centers we visited had not tried to provide preventive care. Those that had tried, often found their efforts hindered by the patients' lack of response.

NATURE AND BENEFITS OF PREVENTIVE HEALTH CARE

Preventive health care services include periodic physical examinations, immunizations, health counseling, and various laboratory and other screening tests.

Health centers view preventive care as generally more costly than episodic or illness care because preventive care can require more of the physician's time. For example, a patient needing episodic care may require only 15 minutes of the physician's time; a complete physical examination may take 45 minutes or more of his time. Physicians at a center told us that, generally, a patient must make two visits to complete the medical history, physical examination, various screening tests, X-rays, and discussions of test results, especially when health problems are found. Such tests should be repeated at various intervals, depending on the patient's age.

The high cost of preventive health care at the centers is contrary to the generally accepted premise on preventive health services, that is, prevention or early detection and treatment of illness and disease on an outpatient basis is less costly than treatment and care on an inpatient basis. HEW claims that preventive care results in reduced rates of hospital admissions and reduced length of stay in hospitals,

where the costs are much higher. A number of health care experts agree, saying that the costs are greatly offset by decreased hospitalization and other less tangible savings.

LACK OF PATIENT RESPONSIVENESS

While preventive care may save money in the long run, its success depends heavily on patient responsiveness, which appears to be severely lacking in the health center program. In 1974, only about 12 percent of health center visits nationwide were for preventive care; 10 percent were for routine care; and 78 percent were for illness. HEW has not required centers to report such statistics since June 1975, but we found a similar pattern at the six centers we reviewed.

Officials of one HEW regional office told us that health centers' efforts to provide preventive care have been the least successful aspect of the neighborhood health center program. They said that the people served by the centers generally seek episodic rather than preventive care.

Another factor hindering preventive care is the number of broken appointments. We noted that the broken appointment rate at the six centers reviewed ranged from 30 to 40 percent. Appointments are usually broken for preventive care; patients suffering from an illness will usually keep an appointment for treatment of the illness.

Officials at the six centers visited generally agreed that implementing an effective preventive care program was very difficult because:

--It is human nature to seek episodic care. Preventive care takes a low priority with the poor because they have more pressing needs, such as food, jobs, and shelter. Breadwinners often cannot afford to take off work to get a checkup and feel little incentive to do so when they feel well.

--The target population is generally unaware of the importance and benefits of preventive care. It is a relatively new concept and has not been fully accepted.

--Some health insurance plans do not cover preventive-type services.

--Patients are difficult to contact for followup. Many do not give correct addresses and many do not have telephones. The population tends to be very transient.

--Centers serve illegal aliens who are afraid to seek more than necessary care for episodic needs.

--The sometimes humiliating and embarrassing nature of preventive care tests hinders patient acceptance.

--Inadequate space and funding limitations.

Of the six centers visited, Hough Norwood appeared to make the strongest effort to provide preventive care. However, the center conducted a study that illustrates some patients' indifference toward preventive care. A sample of active patients registered with the center for 5 years showed about 30 percent of the adults (over 15 years old) had not received a complete physical during that length of time. Twenty percent of the children (15 years and under) had not received a complete physical. According to the center's director of pediatrics, the latter group should have a complete annual physical.

At the Homewood-Brushton center, only 16 percent of our random sample of active patients had been registered with the center more than 5 years. About 31 percent had been registered more than 4 years, and about 20 percent of those had only one or two visits during their registrations. The limited number of visits and lengths of time with the center also hinders providing preventive care on a continuing basis.

CENTERS' EFFORTS TO PROVIDE PREVENTIVE CARE

Reports by HEW's consulting review groups on various health centers showed generally weak efforts in providing preventive care. One of the centers we visited, West Oakland, did not try to provide preventive care because of patient indifference. Center officials told us that only about 6 percent of their visits were for preventive care, and most of those were for children's physical examinations and innoculations required for school admission. Mission center had not provided preventive care in the past but initiated a family-oriented preventive care program in March 1976.

At the other four centers, we reviewed the medical records of a sample of patients selected randomly from the active patient registration. The purpose was to determine if the center was trying to provide preventive care, as stated by center officials. The type and frequency of care provided to each patient was evaluated by a medical doctor on our staff.

He concluded that while the four centers were generally trying to provide preventive care to their patients, improvements were possible. Evidence of the centers' efforts at preventive care existed for 138, or 57 percent, of the 243 patients sampled; no such evidence existed for 69 patients, or 28 percent. Only questionable evidence existed for the remaining 36, or 15 percent, of the patients.

As previously stated, patient responsiveness to available preventive health care services is generally lacking and some HEW officials have characterized the effort of providing such services as the least successful aspect of the program. The Congress has endorsed the concept of preventive health care services and enacted legislation intended, partly, to promote participation in preventive health care services. The legislation, National Consumer Health Information and Health Promotion Act of 1976 (Public Law 94-317) authorizes the Secretary to support new and improved programs of health information and health promotion, preventive health services and education in the appropriate use of health care. The report of the House of Representatives, Committee on Interstate and Foreign Commerce, on the legislation stated that:

> "[T]here are recognized to be many people who either do not use the health system when they should delaying seeking care for problems which would be less expensive to care for if seen early or by seeking care of the wrong type or in the wrong setting when it is sought. Thus, it is believed that if people could be given the knowledge necessary to make effective use of the health system, and the information necessary to use the knowledge, that the capacity which now exists would be used to better effect."

We believe that the centers established under the community health center program could serve as demonstration projects on how to promote preventive health care services to inner city residents.

CONCLUSIONS

A basic ingredient necessary for a successful preventive health care program--patient responsiveness--is lacking in the neighborhood health center program. A patient's socioeconomic environment is a major factor that hinders patient responsiveness. People to whom the program is targeted have many needs, and regarding health needs, appear to use the

centers to cure today's sickness, rather than prevent tomorrow's. As a result, even those exposed to preventive care often do not return to receive the full battery of tests and examinations involved.

The lack of patient responsiveness is not totally unique to this program. The Congress has enacted legislation to promote participation in preventive health care services. Community health centers could be used for demonstration efforts on how to promote such participation. Another obstacle to the success of preventive care is that the center "loses" money on it. Some services are not covered by third-party reimbursements, and preventive care requires more physicians' time.

For these reasons, some health centers do not even try to provide it. Those that do often find their efforts hindered by patient lack of responsivenss, further contributing to increased program costs.

RECOMMENDATION TO THE SECRETARY OF HEW

We recommend that the Secretary of HEW have health centers initiate efforts to promote the participation of the centers' users in preventive health care services. The Secretary should use selected health centers as sites for demonstration projects authorized under the recently enacted National Consumer Health Information and Health Promotion Act of 1976.

AGENCY COMMENTS AND OUR EVALUATION

HEW concurred with this recommendation and stated that it plans to actively pursue such projects under the act.

NEIGHBORHOOD HEALTH CENTERS REVIEWED

Name and location of center	Years in operation (note a)	Annual budget (note b)	Funding period ended
		(millions)	
Hough Norwood Family Health Center, Cleveland, Ohio	9	$4.9	8/31/76
Homewood-Brushton Neighborhood Health Center, Pittsburgh, Pa.	8	2.0	10/31/76
West Oakland Health Center, Oakland, Calif.	7	2.6	6/30/76
Mission Neighborhood Health Center, San Francisco, Calif.	9	2.4	7/31/76
South Brooklyn Health Center, New York, N.Y.	8	1.9	12/31/76
North East Neighborhood Association Comprehensive Health Service Center, New York, N.Y.	7	2.8	12/31/76

a/Approximate number of years of operation under Federal funding.

b/Approximate annual funding or requested budget (all sources).

COSTS OF UNNEEDED SERVICES AT NEIGHBORHOOD HEALTH CENTERS REVIEWED

Name of center	Primary physicians	Dentists	Medical support personnel (note a)	Supplemental support	Total
Hough Norwood Family Health Care Center	$ 35,666	$ -	$432,159	b/$136,349	$ 604,174
Homewood-Brushton Neighborhood Health Center	44,336	-	-	-	44,336
West Oakland Health Center	-	15,800	-	-	15,800
Mission Neighborhood Health Center	43,772	39,406	179,180	c/30,000	292,358
South Brooklyn Health Center	13,620	-	81,341	c/43,839	138,000
North East Neighborhood Association Comprehensive Health Service Center	-	3,250	25,636	-	28,886
Total	d/$137,394	$58,456	$718,316	$210,188	$1,124,354

a/Includes laboratory, X-ray, pharmacy, medical records staff, and all medical staff except physicians. Costs include fringe benefits ranging from 15 to 19 percent.

b/Family health care workers--$92,349.
Transportation personnel--$44,000.

c/Transportation personnel.

d/Costs calculated on basis of HEW's minimum productivity standard. (See app. III for costs calculated on basis of consultant's standard.)

APPENDIX II

OVERSTAFFING OF PRIMARY PHYSICIANS

Name of center and productivity criterion	Full-time equivalent: Actual staff level	Computed no. required	No. overstaffed	Percent overstaffed	Cost of overstaffing
Hough Norwood					
2.7 (HEW's standard)	12.4	11.4	1.0	9	$ 35,666
3.57 (Consultant's standard)	12.4	8.6	3.8	44	135,174
Homewood-Brushton					
2.7	7.2	5.6	1.6	29	44,336
3.57	7.2	4.2	3.0	71	81,283
West Oakland					
2.7	3.3	3.7	-	-	-
3.57	3.3	2.8	.5	18	16,494
Mission					
2.7	6.4	5.0	1.4	28	43,772
3.57	6.4	3.9	2.5	64	78,165
South Brooklyn					
2.7	6.7	6.3	.4	6	13,620
3.57	6.7	4.8	1.9	41	67,403
North East Neighborhood Association Comprehensive Health Service					
2.7	10.0	10.5	-	-	-
3.57	10.0	8.8	1.2	14	42,093
Total (note a)					
2.7			4.4		$137,394
3.57			12.9		$420,612

a/Four centers with overstaffing.

APPENDIX III

APPENDIX IV

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

February 27, 1978

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D. C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Are Neighborhood Health Center Services Provided Efficiently and to the Most Needy?". The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Thomas D. Morris
Inspector General

Enclosure

THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (HEW) COMMENTS TO THE GENERAL ACCOUNTING OFFICE (GAO) DRAFT REPORT TITLED "ARE NEIGHBORHOOD HEALTH CENTER SERVICES PROVIDED EFFICIENTLY AND TO THE MOST NEEDY?"

GENERAL COMMENTS

We have reviewed the GAO draft report. Overall, the Department supports the majority of the recommendations contained in the report because we have identified many of the same problems and have initiated action steps to address them. However, there are some areas of the report that we believe should be clarified before it is finalized. They include:

1. The reference to 112 Neighborhood Health Centers should be footnoted to reflect that most of the Neighborhood Health Centers were originally funded by the Office of Economic Opportunity (OEO). Administrative authority for these projects was transfered to DHEW in 1973. With the passage of Public Law 94-63 in 1975, the Department encompassed all of its Family Health Centers, Networks and Neighborhood Health Centers under the nomenclature of Community Health Centers (CHC), all of which were required to meet the statutory and regulatory requirements of this legislation. In fiscal year 1977, the Department supported 455 Community Health Centers.

   Under OEO, all centers funded had several mandates, one of which included providing for extensive participation by and involvement of the population to be served, both in policy making and as employees, with less of an emphasis on cost effectiveness and management efficiency. With the assumption of responsibility for these centers by HEW, emphasis has been placed on the improvement of project management and cost effectiveness which mandated for example that the centers increase the proportion of support from non-grant funds. Initially, these centers were receiving only 5-7% of their overall support from third-party sources. In fiscal year 1976 - 29%, fiscal year 1977 - 31%, and in fiscal year 1978, we project a 35% level.

2. The statement on pages i and ii of the Digest which reads: "Demand for health services form the neighborhood health centers is not likely to increase, as the population of target areas has stabilized and/or other sources for health care have become available."

   In January 1977, the Bureau of the Census estimated that 17.1% of the American population moved from one address to another during the period March 1975 through February 1976. Thus, it is difficult to accept the statement that the population of CHC target areas has stabilized. The experiences of the CHC program and available data show that demand for services in CHCs has increased and will continue to increase. Between 1973 and 1977, the number of people served by ongoing 164 CHCs more than doubled (from 1.0 million in 1973 to 2.1 million in 1977). The demand

APPENDIX IV

for services from these centers should continue to increase for the next several years for the following reasons:

- CHC's only serve medically underserved areas;
- The need for health services in these areas has not been satisfied; and
- CHC's continue to be the only real source of ambulatory care available to the residents of the areas they serve.

Moreover, in the event of passage of some form of national health insurance, the demand for primary care services in CHCs will likely increase. Given the high level of acceptance for CHCs, CHC utilization will increase as the near poor are covered by a national entitlement which finances care provided in an ambulatory rather than inpatient setting.

3. A rewording of the various conclusions would impart a more objective and less subjective connotation. For example, in the "Summary for Cover Sheet," and the word "intended" should be replaced by the word "designed." The sentence would read, "The 455 community health centers funded by the Department of Health, Education, and Welfare, are designed to provide ambulatory health care services to residents of areas designated by DHEW as medically underserved."

GAO RECOMMENDATION

We recommend that the Secretary, HEW, reduce the service capacity at inefficient centers to levels consistent with the demand for services.

DEPARTMENT COMMENT

We concur. The Department has taken steps to improve project efficiency and effectiveness through implementation of new and revised program indicators and funding criteria contained in the U.S. DHEW Publication, Funding Criteria for Bureau of Community Health Services Programs FY 1977. This publication applies to grants funded under Section 319, 329, 330, and 1001 of the Public Health Service Act and Section 1110 of the Social Security Act. This is the second publication which addresses the issue of Funding Criteria and Program Indicators. The first, published in 1975, outlined an initial set of criteria which have recently been revised to establish stricter norms. For example the norm of a 4:1 ratio of clinic support staff to physicians was revised to a norm of 3:1. However, it is appropriate to point out that Community Health Centers are designed to deliver primary health care to medically underserved populations. Centers have filled a void, providing access to health services for populations that had no other sources of care. Unique features of centers have included an emphasis on preventive and comprehensive care, including services not generally provided by other health care sources, such as outreach and transportation. Many projects have developed family-centered, multi-disciplinary approaches to providing health services. Organizational

models have emphasized an increased role for consumers of health services in decision-making. Each center is a complex but integrated system of services and activities responsive to the needs of the local population served. Therefore, improved project management and increased program efficiency is a dynamic process that is evolving and is not easily mandated to occur overnight.

GAO RECOMMENDATION

We recommend that the Secretary of HEW better enforce compliance with existing productivity and staff size criteria.

DEPARTMENT COMMENT

We concur. Further steps to strengthen present productivity have been and will continue to be undertaken through judicious application and enforcement of newly revised program indicators. An increasing number of CHC's do meet these more stringent clinic support staff ratio criteria. For example, for the quarter ended June 30, 1977, data reported by projects required to report for that period show that for the new indicator of "Ratio of Clinic Support Staff to Physicians," 150 of the 290 projects (68%) are in compliance with the norm of 3:1 ratio for this indicator. This is an improvement from the quarter ended December 31, 1976, where (62%) of the projects were in compliance with this indicator.

GAO RECOMMENDATION

We recommend that the Secretary of HEW develop criteria for measuring the productivity of dentists.

DEPARTMENT COMMENT

We concur in the need for such criteria and have taken steps toward gathering the data necessary for its development. Once these criteria are established, tested, and their effects evaluated, we will hold centers accountable for their levels of dentist staffing. Before discussing the specifics of actions we have taken or plan to take, we would like to place the relative priority for developing these particular criteria--and the complexities involved--into better perspective.

Many factors influence the use and productivity of center dentists such as (i) the appropriateness of equipment, support staff, examination and consultation space; as well as (ii) less apparent factors as the socio-economic and attitudinal characteristics of the consumers. While these factors interrelate and influence each other, we have not yet determined the most significant outcome such as provider productivity. Several conditions we have noted underscore the complex nature of the delivery of ambulatory care. For example, our reading of available data suggests that the longer a center has been in operation, the higher the quality of care and productivity becomes.

Without a fuller understanding of the relationship of the many factors involved, we believe it would be limiting to the operation of the centers to set criteria for measuring the productivity of dentists.

In view of the above, the first thrust of our corrective action was directed towards strengthening and refining the Bureau Common Reporting Requirements which was implemented on October 1, 1976. The utilization and cost reporting data derived from these systems will permit us to associate productivity levels with levels of other aspects of center operations. We believe it is through this type of association, and not by viewing dentist productivity in isolation, that we will be able to develop a more realistic standard for utilization of health center dentists.

An evaluation contract has been developed to assist in the above. This contract, let in September 1977, has as its specific goal the development of dental program evaluating measures of the effectiveness of all components of a dental program. Decisions concerning provider productivity, manpower needs by number and specialty and cost/income analyses for specific services can then be based on statistical data. We expect the final report in September 1978.

As soon as the data from the reporting system in the centers has been developed to a level considered adequate--and checked out for validity--it will be utilized in the development of criteria which will measure productivity for health centers. Also, as stated, once these criteria are tested and appropriately evaluated, we will hold centers accountable for their levels of performance.

CAO RECOMMENDATION

We recommend that the Secretary, HEW, in addition to using cost criteria to control supporting and general service costs, assure closer evaluation of the reasonableness of such costs at each center in relation to the level of service provided.

DEPARTMENT COMMENT

We concur. Revised program indicators such as project utilization, physician productivity, clinic support staff ratio, administration costs, and penetration effectiveness are being used to assure closer evaluation of the reasonableness of such costs at each center in relation to the level of service provided. Funding decisions for centers are based on reported project users and encounters and objective assessment of each project's performance in accord with these program indicators. The Bureau of Community Health Services' Common Reporting Requirements system became completely operational during the last quarter of fiscal year 1976. The reports generated by this system are provided to our regional offices for use in insuring projects are in compliance with requirements. Project compliance has improved by 18% since 1975 and activities designed to

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improve overall compliance are continuing as evidenced by the use of new and more stringent indicators and by the redirection of funds previously expended for excessive administrative costs to the provision of medical care services.

[See GAO Note 2.]

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GAO RECOMMENDATION

We recommend that the Secretary of HEW continue to encourage and assist centers to seek reimbursement from private insurance companies and self-pay patients whenever possible.

DEPARTMENT COMMENT

We concur. The Department has been actively engaged in this activity for the last several years and our efforts for CHC's to be recognized as providers of care under all State Medicaid programs will continue. In 1977, it is estimated that third-party reimbursement levels for CHC's will be 31% of their total operating costs in 1978, 35%.

GAO RECOMMENDATION

The Secretary of HEW should require that all centers maintain adequate accounts receivable records.

DEPARTMENT COMMENT

We concur. The regulations pertaining to CHC's (Title 42, Subchapter D, Part 51(c) and Health Services Funding Regulations (Title 42, Part 50

Subpart A) require the maintenance of such records.

GAO RECOMMENDATION

The Secretary of HEW should assure that centers concentrate on serving target area residents--who may lack personal resources or third-party coverage--rather than seek to serve patients in areas that do not have a shortage of personal health services in an effort to increase non-grant revenue.

DEPARTMENT COMMENT

A CHC is to serve primarily medically underserved populations but it is also available to serve anyone who seeks its services, as mandated by law. To do anything less would be to foster a separate class system of health care in this country. CHC's are primary health care centers--centers which serve as an entry point into the health care system for all persons who utilize it. Certainly efforts have been made and will continue to reach all potential patients in the target areas whatever their financial resources.

GAO RECOMMENDATION

We recommend that the Secretary of HEW have CHC's initiate efforts to promote the participation of the center's users in preventive health care services. The Secretary should use selected CHC's as sites for demonstration projects authorized under the recently enacted National Health Information and Health Promotion Act.

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DEPARTMENT COMMENT

We concur. Patient non-responsiveness has been an impediment to health care providers in all settings, whether it is in a private physician's office, a Health Maintenance Organization, or a CHC. It can be argued that the CHC patient population may have greater health care needs and would benefit more from regular preventive care. Recognizing the difficulties to provide preventive care, a demonstration project which increases the awareness and acceptance of preventive care in the patient population could benefit patients in any type of health care setting. The Department will actively pursue such projects under the National Health Information and Health Promotion Act. It should be noted, however, that a recently completed National Health Insurance Study indicates that CHC's are quite effective in providing some type of preventive health care:

- Between 89-92% of the children participating in CHC's have had shots, immunization or oral vaccine.
- Between 56-64% of the women age 14 and over participating in CHC's had had a pap smear in the last year-- this compares to a national average for women age 17 and over of 58%, within the last two years.

GAO Notes:

1. Page references in this appendix refer to the draft report and do not necessarily agree with the page numbers in the final report.
2. Deleted comments relate to statements that were in the draft report that have been omitted from this report.

PRINCIPAL OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEW:		
Joseph A. Califano, Jr.	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
ASSISTANT SECRETARY FOR HEALTH:		
Julius Richmond	June 1977	Present
James F. Dickson (acting)	Jan. 1977	June 1977
Theodore Cooper	May 1975	Jan. 1977
Theodore Cooper (acting)	Feb. 1975	Apr. 1975
Charles C. Edwards	Mar. 1973	Jan. 1975
ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION:		
George I. Lythcott	Sept. 1977	Present
John H. Kelso (acting)	Jan. 1977	Sept. 1977
Louis M. Hellman	Apr. 1976	Jan. 1977
Robert Van Hoek (acting)	Feb. 1975	Apr. 1976
Harold O. Buzzell	July 1973	Jan. 1975

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