HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

Vol. 2, No. 1 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. Jan.-Feb. 1975

AMBULATORY CARE PROGRAM— *A ROLE FOR THE CONSUMER*

Recent issues of Health Perspectives have dealt with the inspection programs in New York hospitals and the possible participation of consumers in the inspections made by the Joint Commission on the Accreditation of Hospitals. Obvious problems, such as infrequent inspections and inadequate follow-up, as well as poor public accountability, have been described. However, there is one program in the City, the Ambulatory Care Program (formerly known as the Ghetto Medicine Program, where consumers have become an integral part of the inspection process. Does this consumer participation make any difference?

Although there is still much to be accomplished, the answer is definitely "yes." The Community Boards to the Ambulatory Care Program in New York City voluntary hospitals have gained in influence in the last year or two and have succeeded in improving the quality of some ambulatory care program by increasing the responsiveness of the delivery system, and by establishing a cooperative relationship with the New York City Department of Health. How and why this happened has its roots in the history of the program and in the ability of all three parties involved—hospitals, health department, and consumers—to perceive the gains to be obtained from a collaborative effort.

The Background

The federal Medicaid program, adopted in 1965, provides grants to states to help pay for a range of medical services for the poor and the medically indigent. Medicaid programs are developed and administered by each state. Originally, New York set up one of the more comprehensive programs in the nation, both in terms of the scope of services provided and in the definition of eligibility requirements. The New York State legislature felt that this program was too expensive for the state, and in 1968 and 1969 eligibility requirements were tightened and benefits reduced, leaving significant numbers of poor people without medical coverage.

In an attempt to compensate for this, amendments to the New York State Public Health Law were passed, effective June 1968. Under one of these amendments, known as the "Ghetto Medicine Act," the State would share with city and county health departments the cost of operating neighborhood health centers. These centers were allowed to charge a fee-for-service, but the goal was the provision of care at little or no charge for indigent populations.

A State Aid Manual issued in October, 1968 provided guidelines for this "Ghetto Medicine" program. It described a health center as "... an ambulatory medical care clinic providing comprehensive family centered medical and dental care services to residents of a neighborhood.... In order to insure that the organization and operation of the health center is of maximum value to the community served, an advisory committee, the majority of whose members are consumers of health service in the community, should be appointed." The principle of consumer participation was thus basic to the state health department's original concept of a mechanism to assure medical services for under-served, indigent populations.

In New York City, at this time, out-patient departments and emergency rooms in both municipal and voluntary hospitals were actually providing most of the general medical care received by populations in ghetto and other under-served areas. The state cutbacks in Medicaid funds, however, had included a "freeze" on rates paid to hospitals for Medicaid inpatients, and thirteen voluntary hospitals claimed that as a result their financial plight was critical and they could not afford to continue many outpatient services. Political pressure was applied in Albany by the hospitals and despite strong objections from many public organizations and consumer groups then—Governor Rockefeller secured the consent of legislative leaders to channel funds to the voluntary hospitals through the "ghetto medicine" provisions. Although later action gave the hospitals compensation for the freeze on inpatient Medicaid rates, contracts were eventually awarded to 22 voluntary hospitals which provided almost 12 million dollars in city and state funds for ambulatory care in the six months period ending July 1, 1970. As a result, the clinics were kept open and an interesting experiment began in which the voluntary hospitals,

City health department, and consumer activists were involved in cooperatively designing medical care programs for outpatients.

Guidelines for Ambulatory Care Programs

For a hospital to be a participant in the Ambulatory Care Program it had to agree among other things to subject its services to contractual standard setting, monitoring, and enforcement by the New York City Department of Health, and it had to accept an all-inclusive fee schedule for self-paying patients related to family income and not to cost-of-service. It also had to become associated with an Ambulatory Services Advisory Committee. The guidelines issued by the Department of Health in 1970 state that: "The Ambulatory Services Advisory Committee shall advise and consult with the Commissioner of Health and the hospital on the following:

1. Physical plant standards
2. Maintenance of facilities
3. Patient registration
4. Patient eligibility
5. Fee schedules
6. Billing for self-pay patients
7. Staffing patterns
8. Hours of service
9. Establishment of health program priorities
10. Review of patient grievances
11. Methods of handling patient admissions." This list was later enlarged to include:
12. Quality of care
13. Compliance with the terms of the contract
14. Availability of reports to the Community Boards
15. Development of a patients' rights document consistent with the general aims of the agreement.

In accordance with these guidelines the majority of the committee membership had to be consumers of ambulatory services of the hospital (these committees were later called Community Boards.) Membership ranged from 10 to 19 with an average of 15 members. The district health officer of the City health department, the hospital director, and the director of the hospital's ambulatory care services had to be included in the minority of non-consumer members. The remainder of the non-consumer community board members comes from hospital employees appointed by the hospital. Consumers have become members in a variety of ways, including special elections, solicitation of community organizations, and the drawing of lots among consumers of ambulatory care services.

Twenty two voluntary hospitals agreed to permit their services to be scrutinized by the City Health Department and to cooperate with consumers because they were desperate for funds. One hospital pulled out of the program after one year, because it would no longer accept the fee schedule. Other hospitals joined in the program later. Some hospitals didn't join because of the requirement for community boards. (Since 1971 Beth Israel Hospital has been receiving money only for the emergency room. In order to use the outpatient department, the patient must have medicaid medicare or pay the medicaid rate of $67.29 per visit.) These hospitals signed contracts with the New York City Department of Health which stipulated the services to be provided by the hospital and allowed the health department to inspect for compliance. No penalty provisions were included, however, and the contract therefore could not be considered a strong instrument for enforcement of standards.

Teams of health department professionals did make on-site visits to the hospitals to check for compliance. The analyses and recommendations of these visits were circulated to the hospital administrator as party to the contract, to a hospital representative on the community board, to a consumer representative on the board, to the Greater New York Hospital Association, and to several community organizations.

As the program developed, a city-wide steering committee of Ambulatory Care Community Board representatives was established. This steering committee met monthly and suggested many improvements that should be made in the Program, two of which were implemented in 1971. A most important advance was the inclusion of consumer representatives on the teams for health department inspections of hospitals. This meant that consumer concerns and perceptions would now be added to the observations of health department professionals.

Next, a Consumer Council to the Health Department was set up which, in effect, replaced the steering committee. Thus, within two years, the consumers on the community boards had succeeded in establishing a close, on-going relationship with the health department in relation to the operation of the Ghetto Medicine Program. By 1972, Lowell Bellin, M.D., then First Deputy Commissioner, New York City Department of Health could write: "When the Ghetto Medicine Program started, the hospitals, the consumers, and the health department lacked experience. We have learned a great deal since then. We are now negotiating a new contract that will encompass socially desirable spinoffs as legal obligations. As the consumers become more confident and more assertive about their role, they will request and will receive more in the contract."

Influence of Community Boards

Since 1971, negotiations for the general contract which covers all hospitals in the program have been done by a tripartite committee of consumers and city-wide representatives, hospital providers, and the health department. At the insistence of consumers, this contract now contains provisions for penalties which can be used by the health department to apply pressure for compliance. Section A, subsection 8b of this contract declares a hospital in default if the hospital has not been executing the proper performances of its services according to the contract. It goes on to say that "In the event of such partial default, the Hospital shall be given written notice thereof by registered mail and shall proceed to cure such default promptly to the satisfaction of the Commissioner or his authorized

representative. If such partial default is not cured by the Hospital within a reasonable period of time after receipt of notice thereof, . . . the City shall have the right to withhold monthly payments hereunder until such time as the default is cured."

Several hospitals have been penalized with fiscal penalties for lack of compliance, and perhaps equally important is the probable coercive effect of the threat to withhold funds. On two occasions, hospitals have been asked to leave the program entirely because of a lack of contractual compliance.

Other important consumer contributions to the contract are spelled out in Section D, relating to Outpatient Department guidelines, which states that "It is expected that the Hospital as a participant in the Ambulatory Care Program will render comprehensive health care in a dignified manner to all patients using its outpatient clinics." Consumers on the negotiating committee have fought diligently to remove such vague terminology as "move towards" or "wherever possible."

Primarily as a result of consumer pressure the contract now stipulates that "The Hospital shall appoint a Director of Ambulatory Care who . . . shall be a full time director who shall have no other major inpatient or service responsibility in other departments." This provision is significant in that it aims to ensure a responsible party in charge so that there is recourse in case of any complaint. By restricting the Director's responsibility to the Ambulatory Care Program it also serves to eliminate any conflict of interest if the Program has to deal with other Departments such as Medicine or Pediatrics.

Other important provisions in the contract concern the emergency room of the hospital. The Fee Schedule for Ambulatory Care is now required to be used in the Emergency Room for all regular clinic patients. Because this fee schedule is related to family income, when it is used the charge for a service may be less than one eighth as great for a poor person as when that serve is provided to one who can afford to pay full fee. (TABLE I) Extension of the fee schedule to the emergency room is a first step to assure twenty-four hour care at reasonable prices.

The contract also bars the use of interns as primary care physicians in the emergency room. "Physicians of resident level or licensed physicians shall be assigned and present in the emergency room seven days a week, 24 hours a day." Although interns make a real contribution to medical care in any large hospital, it is obvious that, particularly in the early months of their training, they may not be prepared or qualified to handle patients without supervision from a more experienced physician.

TABLE I

NEW YORK CITY DEPARTMENT OF HEALTH
OUTPATIENT DEPARTMENT FEE SCHEDULE

(Fee-category based on family size and annual gross income)

Family Size	A = $3* Medicaid = $2	B = $6	C = $9	D = $12	E = $15	F = $20	G = $25	H = Charges
1	up to 3,199	3,200 3,899	3,900 4,599	4,600 5,299	5,300 5,899	5,900 6,499	6,500 7,399	7,400+
2	up to 4,699	4,700 5,699	5,700 6,699	6,700 7,699	7,700 8,599	8,600 9,499	9,500 10,699	10,700+
3	up to 6,599	6,600 7,999	8,000 9,399	9,400 10,699	10,700 11,999	12,000 13,299	13,300 14,999	15,000+
4	up to 7,999	8,000 9,699	9,700 11,299	11,300 12,899	12,900 14,499	14,500 15,999	16,000+ Charges	16,000+
5	up to 9,699	9,700 11,199	11,200 12,699	12,700 14,499	14,200 15,999	16,000+ Charges	16,000+ Charges	16,000+
6+	up to 11,299	11,300 12,799	12,800 14,299	14,300 15,999	16,000+ Charges	16,000+ Charges	16,000+ Charges	16,000+

*(If individual is enrolled in Medicaid and subject to co-payment, the payment in Category A is reduced to $2, by decision of the Commissioner of Health.)

Consumers from each hospital are also involved in the negotiations for Schedule C of the contract which contains the specific sections negotiated for each individual hospital. Schedule C specifies the particular services considered appropriate to the patient population at that hospital and the facilities and staff available. Schedule C tends to focus on major deficiencies in each hospital and to guide the hospital in deciding which portions of the general contract it must implement first. The situation is comparable to that in the labor movement, where a national union may develop a general contract for all members, but each union local will negotiate work rules for the individual plant.

During 1974-75 a Select Committee has been set up, composed of consumers, hospital providers, and the City Health Department, to design a rating system for hospitals. The Committee has agreed on five base line requirements for entry into the program. No hospital will be considered for funding which does not have the following:

1. A Functioning Community Board for Ambulatory Care
2. Full-time Director of Ambulatory Care who shall be responsible for the clinic and emergency room and have no other major hospital assignments.
3. The use of the Fee Schedule, including a sliding scale in the emergency room for clinic patients
4. Primary care to be provided by a family physician
5. At least five sessions of general medicine and general pediatric clinics to be scheduled each week.

TABLE II
BUREAU OF AMBULATORY CARE
CONTRACT EXPENDITURE
(in dollars)
December 1969–June 1975

Hospital	12/1/69 6/30/70	7/1/70– 6/30/71	7/1/71– 6/30/72	7/1/72 6/30/73	7/1/73– 6/30/74	7/1/74– 6/30/75
Beekman Downtown	–	–	–	200,000	263,000	277,500
Beth Israel	1,706,700	3,765,600	332,400	288,200	360,000	379,800
Bronx Lebanon	869,000	1,650,000	1,050,000	945,000	1,145,000	1,208,000
Brookdale	349,400	751,200	665,000	665,700	764,300	806,300
Brooklyn	–	–	–	152,800	211,100	222,700
Columbus	202,300	391,200	293,300	240,200	327,200	345,200
French & Polyclinic	288,800	351,000	350,600	398,800	250,000	400,000
Joint Diseases	367,300	855,600	605,500	708,600	822,500	867,700
Jamaica	259,100	194,600	–	41,700	150,000	158,300
Jewish of Brooklyn	119,800	–	–	92,700	179,100	188,900
Jewish Memorial	–	–	–	–	80,000	168,800
Kingsbrook Jewish	–	–	–	–	100,000	211,000
Knickerbocker-Logan	292,800	235,200	192,000	580,000	1,012,000	611,900
Lutheran of Brooklyn	–	–	–	–	50,000	105,500
Lutheran Medical Center	102,400	300,000	193,000	143,200	200,500	211,500
Maimonides	–	–	–	364,200	443,600	468,000
Mary Immaculate	340,000	476,400	283,100	416,700	501,400	529,000
Methodist	260,400	277,200	303,900	259,900	383,900	405,000
Misericordia	219,200	561,600	314,700	301,100	374,200	394,800
Montefiore	548,200	615,000	1,055,200	994,100	1,136,500	1,199,000
Mt. Sinai	683,500	1,065,000	1,589,600	1,428,500	1,614,300	1,703,000
Flower & Fifth	70,300	213,600	191,800	93,800	146,200	154,200
NENA	–	–	–	64,700	100,000	105,500
Roosevelt	360,900	1,282,500	1,105,300	676,600	787,300	830,600
St. Clare's	219,400	386,400	234,600	278,200	349,000	368,200
St. John's	219,700	140,400	228,000	182,300	243,500	256,900
St. Luke's	496,100	241,500	848,500	822,200	947,400	999,500
St. Mary's	335,000	572,400	152,900	231,100	347,200	366,300
St. Vincent's NY	776,300	1,555,800	1,200,000	1,058,400	1,207,300	1,273,600
St. Vincent's SI	–	57,300	136,700	123,300	154,100	162,600

All other items in the contract will be weighted in numerical terms and all hospitals must reach a percentage level of compliance (still to be determined) to remain in the program.

The Ambulatory Care Program

The Ambulatory Care Program is now more than five years old and there are thirty participating institutions in the city which receive more than 15 million dollars in city and state funds (Table II).

Although the program was intended to provide comprehensive family-centered care to large numbers of medically indigent people, no one can pretend that this has been accomplished. Site visit reports on participating hospitals indicate that the Ambulatory Care Program today is little more than public subsidization of hospital outpatient clinics which have long been notorious for inadequate medical care. In most clinics patients are still kept waiting long hours in crowded and uncomfortable waiting rooms for fragmented care. Patients are shunted from one specialty clinic to another with no primary-care physician responsible to see that the patient actually gets well.

Major compliance with the terms of the contract is still to be achieved in most hospitals. The large amount of public funding, however, gives the health department some leverage to upgrade the quality within the program. Another major drawback is the fact that the Municipal Hospitals are still excluded from participation in this program by the state.

On November 4, 1974, the New York Times carried a story headlined:

"THREE HOSPITALS ARE FINED BY CITY
Charged With Not Meeting
Ghetto Medicine Standards"

The hospitals, Misericordia in the Bronx, St. Clare's in Manhattan, and Brooklyn Hospital were fined $135,000 after failing to correct deficiencies found on site visits by health department inspection teams. According to Al Schwarz, Assistant Commissioner of Health.

"Following the site visit the hospital is notified of any contractually obligated areas where the deficiencies were found. The notification gives the hospital 30 days to correct the deficiencies and to respond to us concerning those areas of non-compliance. If there is a disagreement over the deficiencies, a hearing is held within two weeks of the elapse of that 30 day period where the hospital's case is made. Revisits will be made if they are deemed necessary, but the results of that hearing will be to levy the default or suspend the process entirely. The hospital has the option to appeal to the Board of Health for redress."

The procedure is carefully designed to protect the hospital as well as the consumer.

Unfortunately, this system often overprotects the hospital, perhaps at the expense of the patients and certainly at the expense of public funds. The citation of default against Misericordia Hospital was reversed by the Board of Health, based on a technical error in assessing the default retroactively. Technical error does not seem adequate when measured against the report of a site visit, made on October 23, 1974, which assessed the clinic care at Miseracordia in the following terms: "The general impression of medical care delivered, as indicated from all specialties, was unsatisfactory, especially pediatrics and gynecology. The care delivered in Medical Diabetic Clinics was considered fair to poor."

The inspection team, which included a physician and a nurse, as well as two consumers, supported its conclusion with a review of 55 charts from General Medicine, Diabetic, Gynecology, Pediatrics, and Urology Clinics. Twenty-five charts were reviewed from the General Medicine, Diabetic, and Hypertension Clinics, and on 14 of these it was found that indicated tests and examinations had either not been done or not been recorded. On 10 of the 20 pediatric charts reviewed important physical findings were not recorded. Seven of the 10 gynecological charts reviewed were cited as either incomplete or as examples of poor medical care.

This report may be horrifying, but it should *not* be viewed as discouraging. The mechanism has been developed to enforce the Ambulatory Care contract and as long as consumers are able to participate in the process there is some chance that their interests will be protected. Repeat site visits will be made to Misericordia and other hospitals and Community Board members will accompany health department staff to make sure that deficiencies are reported. Next time, a "technical error" may not serve to find the hospital without fault.

The Consumer Council to the Department of Health is also developing improved guidelines for consumers so that the participation of the Community Boards can be increased and carry more weight. These guidelines suggest that each Board form a committee to deal with contract compliance and site visits on an on-going basis. Consumers are asked to, and in many cases already do, make their own site visits, using their own questionnaires which highlight the need for grievance procedures and a patients' bill of rights. Just as there is wide variation among hospitals in the amount of compliance with individual contract provisions, so too there is a wide variation in the effectiveness of each Community Board. The Consumer Council is working to increase the expertise and effectiveness of local Community Boards.

One implication of the process should not be overlooked.

The Freedom of Information Act (see Health Perspectives, July-August 1974) has given consumers, for the first time, the opportunity to examine inspection reports and evaluate for themselves the quality of medical care provided by doctors in hospital clinics and judged by professional medical personnel. The results may be shocking, and serve to make us suspicious of hospital care in general. At the present time, except for the Boards of Municipal Hospitals, consumers have the power to influence only the Ambulatory Care Programs in New York City hospitals. The deficiencies in ambulatory care may represent only the tip of the ice-

berg. Until the public is permitted to examine all programs of medical care paid for by public funds there is no way to be sure that high standards will be upheld.

Recommendations

The Consumer Commission offers the following recommendations to improve ambulatory health services:

1. The New York City Department of Health, backed by the Board of Health, should use its power to more stringently inspect and levy fines against hospitals in default of the Ambulatory Care Program contracts.
2. Consumers should be involved in the evaluation of all hospital care and not just those portions of it that come under the Ambulatory Care contracts.
3. All Site Visit Reports should be easily available to the public.
4. The Consumer Council to the New York City Health Department should assist that Department to set priorities which effect its service and evaluation programs.

Selected Reports and Correspondence— Misericordia and Mt. Sinai Hospitals

It is our purpose to show the kinds of problems and their potential dangers to consumers that may exist in hospitals in New York City. Some of the problems outlined in these official reports have been corrected since the date of the survey. Unless periodic re-inspections are made and the findings reported, the public will not be aware of improvements or continued deficiencies at hospitals in the City.

March 5, 1975

Mr. Kenneth Adamec
President Misericordia Hospital Medical Center
600 East 233 Street
Bronx, New York 10466

Dear Mr. Adamec,

This is a report based on a site visit to Misericordia Hospital Medical Center on February 27, 1975 by a Health Department team from the Bureau of Ambulatory Care. The team was specifically following up on the deficiencies that were listed in the default letter of August 15, 1974.

This report represents a notification of our intent to default your institution (in accordance with the partial default clause "8 (G)", page 6 of our contract) for those deficiencies still outstanding. These deficiencies must be corrected within the time specified.

The deficiencies detailed in the report must be remedied within 30 days of the receipt of this notice.

You are requested to discuss necessary actions with the Community Board for Ambulatory Care. A response by the institution and the Community Board for Ambulatory Care indicating whatever remedial action has been taken should be received by this Bureau within two weeks after termination of this 30 day grace period (i.e., within 6 weeks from the receipt of this notification).

A reinspection to determine compliance will then be scheduled. In the event that the Department finds substantial compliance or removal of the above deficiencies the default will be cancelled.

Where no substantial compliance is found, the default will become immediately effective.

Disputed items will be subject to adjudication at a hearing in my office. The institution shall request a hearing on disputed items. Prior to such request the Community Board for Ambulatory Care will review the above listed deficiencies. The decision of this hearing will be either to cancel the default process or, effective immediately, to order the default.

At such time that a default is ordered, the institution has, in accordance with the contract 30 days to appeal to the Board of Health, whose decision will be final.

Sincerely,
Al Schwarz, CSW, ACSW
Assistant Commissioner

The City Of New York
Department of Health
Bureau of Ambulatory Care
Misericordia Hospital Medical Center

As requested by the Board of Health, a reevaluation visit was made to Misericordia Hospital Medical Center on February 27, 1975. The purpose of this visit was to evaluate the Hospital's compliance with the deficiencies that were listed in the default letter of August 15, 1974. The members of the team included:

Lucille Cop, PHN, MA, Program Research Analyst
Naomi Carr, PHN, Program Research Analyst
Patricia Nolan, M.D., MPH, Public Health Physician

The Community Board was represented by:
Heleine Cooper, Chairperson
Trefus Grant, Consumer

The items of deficiencies and the findings are:

1. No Director of Ambulatory Care

The Hospital has hired a Director of Ambulatory Care who has been on the staff since September 1974.

2. Lack of pediatric screening tests—sickle cell, lead, vision, and audiometric.

Although the Hospital has responded that sickle cell testing is done on blacks and hispanics, this was not evident in the charts reviewed that were deemed appropriate.

The Hospital has stated that lead testing is performed on these children where indicated.

Lead levels were not found in the charts reviewed. It appeared that these children were symptom free.

We were informed that vision screening is performed by the nursing staff. There was no evidence in the charts that vision screening is being performed. The Hospital has purchased audiometric equipment and should be testing hearing on a routine basis in the near future.

3. No triage in the Emergency Room.

The present triage system is one in which the Head Nurse comes out to the waiting room every 20-30 minutes to screen patients.

When the new Emergency Room is completed (two weeks), a nurse will be assigned to the function of triage. A separate area has been set aside for this purpose. The nurse will be the first contact the patient has when he/she enters the Emergency Room.

4. Charge unregistered pediatrics walk-in patients the emergency room fee.

The Hospital is applying appropriate fees in accordance to the Ambulatory Care Program contract.

5. No walk-in clinic to decongest the Emergency Room.

Currently, there is no walk-in clinic. There will be a walk-in clinic within the new Emergency Room and should be operational shortly.

6. Nurses leaving the Emergency Room to answer inhouse cardiac arrest codes.

This practice is still in effect but we have been reassured that the patients in the Emergency Room are not deprived of

nursing coverage and emergency care. There are plans to maintain drug packs on each individual floor and to have the inhalation therapy department to respond with appropriate equipment, thus reducing the need for the cart to leave the Emergency Room.

7. Underbooking of medical clinic appointments.

There has been an effort by the Hospital to overbook their appointments in Medical Clinic. A revision of their appointment system has been instituted since moving into the new quarters. New patients are being scheduled later in the session and additional revisits are scheduled at the beginning of the session to compensate the broken appointment rate.

8. No study made of the needs of a full time medical clinician in the Emergency Room.

An informal study was made and submitted to the Health Department. The Hospital feels that the present staffing pattern of rotating resident physicians with attendings available for consultation is adequate. Also the Hospital feels that at this time, they cannot afford the additional financial burden of a full time physician's salary.

9. Medication and clinic attendance sheets not utilized.

The Hospital has not fully implemented the use of a medication sheet in the chart.

What was evidenced in the chart was that the medication sheet is being used as an order sheet and this was most often not kept up to date. The clinic attendance sheet was found and is being utilized.

10. No study made of increased laboratory availability to outpatient department patients.

The Hospital has expanded laboratory hours to the outpatient from 4 days a week to 5 days a week.

11. No security guard in the evening designated to the emergency room.

Presently, there is 24 hour coverage by a security guard in the Emergency Room.

12. No study made of the role of clinic nurse in the care of clinic patients.

The Hospital is continually studying the role of the clinic nurse. The charge nurse has the responsibility to interview all new patients in the Medical Clinic and will be trained to conduct physical examinations. Also the Hospital is exploring the possibility of training some staff nurses to be Pediatric Nurse Practitioners.

The Mt. Sinai Hospital
Site Re-Visit Report

I. Introduction

On September 11, 1974 a Health Department evaluation team made a re-site visit to the Mt. Sinai Hospital Outpatient Department to determine compliance with the Department of Health Ambulatory Care Program contract and general program goals for patient care.

The site visit team consisted of:

Naomi Carr, P.H.N., Program Research Analyst
Joseph Gapper, M.P.A., Associate Managment Analyst
Lucille Cop, P.H.N., Program Research Analyst
Patricia Nolan, M.D., M.P.H., Medical Specialist
Thomas Travers, D.D.S., Public Health Officer Trainee
William Shepperson, Social Work Consultant, Dept. of Health

The consumer members of the Community Board for the Ambulatory Care Program were represented by Ms. Ru Bye C. Wright, Chairperson, Ms. Charlette Flavin and Ms. Stella Shaw.

The site visit team found that the most significant progress since the last site visit report was the moving of the Outpatient Department and Emergency Room into the Annenberg building.

The size and climate of the new building provides modern and spacious facilities which are generally conducive to the maintenance of privacy and human dignity.

We were concerned that this very progress has engendered such problems as incompleted information systems, some delays of operational clinical facilities and inability of the patient to easily negotiate the health care system.

Substantive progress responsive to the schedule "C" items and to a lesser degree, implementation of recommendation of the last site visit report was evident.

We ask that the Hospital in conjunction with the Community Board prepare a timetable of implementation responsive to the issues raised in this report. The plan and timetable is to be submitted to the Bureau of Ambulatory Care by January 20, 1975.

1. Provide greater accessibility to General Medical Clinic by:
   a) increasing physician utilization
   b) accommodating a larger number of drop-in patients

2. Devise a system whereby the patients can receive x-ray procedures on the same day.

3. Devise a standardized system for the appropriate review and follow-up of delinquent clinic appointments and x-ray and laboratory test results.

4. Undertake a study of existing problems in the Emergency Room registration area.

5. Devise a mechanism to identify those patients using the acute care clinic and Emergency Room for primary care and integrate them into the health care system.

6. Assign physicians in the Emergency Room, at least *resident level* on all shifts to be responsible for the primary care of the patient.

7. Broaden the scope of preventive services e.g., Pap smears, vision and hearing, etc.

8. **Social Service**
   a) Devise a system of obtaining a more accurate breakdown of the social worker's activities spent in Outpatient Department and Emergency Room services.
   b) Ascertain accountability of social service staffing pattern in the Outpatient Department and Emergency Room.
   c) Seek to resolve the problem encountered in placing the social worker's recording into the patients unit record.

9. **Dental Service**
   a) Survey (as contractually obligated) the dental services by volume and type, including data on productivity.
   b) Consider modification of one operatory room from 3 chairs to 2 chairs to thus provide an area of training convenient to the use of assistants.
   c) Establish a chart review committee on a formal basis to examine records for completeness and quality of care. Standardized approach to use of forms must also be promulgated.
   d) Please see other recommendations in the body of report.

11. **Some Contractual Items Implemented since the Last Schedule "C" Negotiations:**
   The Hospital has:
   1. Instituted a computerized system of individual ap-

pointments with individual physicians in general medical clinic general Pediatric Clinic and medical subspecialties.
2. Revised the patients services brochure.
3. Promulgated the A.H.A. patient bill of rights.
4. Implemented a nurse conference program with documentation in the patients charts.
5. Implemented the use of multilingual drug labels.

III. Professional Care

There has been no substantive change since the last site visit in this area. The Director of Ambulatory Care continues to be the Director of the Pediatric Acute Care and the Adult Emergency Room. The responsibility for the operation of the Outpatient Department service is shared with other Administrators and Chief of services.

Assignment of the Medical staff remains under the control of the Chief of service. It is conceivable that if there are conflicting responsibilities such as ward duty versus clinic sessions, the physicians alliances would naturally be with the Chief of service.

The Hospital reports that the physicians "stay" in the clinic area has markedly improved. However, coverage for absent physician in the medical services continues to be difficult.

a) **Audit Committee**

There is no formal audit committee which reviews Outpatient Department charts. Individual daily reviews by clinic services are said to be done. We recommend that the hospital institutes a Medical Record Committee for the purpose of reviewing a sampling of charts from all Outpatient Department Clinics and from the Emergency Room. We consider this to be imperative since attending physicians do not countersign charts of patients who have been treated by the house staff.

Due to the vastness and complexity of the physical structure, the possibility exists that some patients find it difficult to negotiate the health care system. We encourage the Hospital to prominently place directional signs so that the clinical areas will be more accessible to the new patient.

V. Structure of Care

A. Medical Walk-In

This clinic does not really exist. It was observed and reported that this service is just a subsection of the Emergency Room and may be considered only as a way of seeing some non-emergent patient's during the two hours period between 11:30 to 1:30 p.m. We therefore suggest that the use of the title Walk In Clinic is a misnomer and perhaps a more appropriate name for this area should be used.

B. Medical Clinic

Overall, the service aspect of the general medical program did not seem to have improved since the last site visit.

We believe, however, that the practice of post conferencing all patients is extremely praiseworthy. A separate conference room has been designated for this purpose. However, this function could be improved considerably by the following:

(1) Make all charts available to the nurse for recording of the nurses' notes.
(2) Designate conference space that is closer to the patients examining areas.
(3) Relieve the nurse of clerical functions such as Laboratory and x-ray report retrieval, filing, etc.

Some aspects of the medical services appeared to have been less operative on this visit than on previous ones. For instance:

(1) There is no standardized procedure for the follow-up of delinquent clinic appointments. The practice of having clerks review delinquent records and send follow-up appointments has been discontinued.
(2) There is no longer a review of charts for completeness prior to the patients clinic visit.

We remind the hospital that these items are contractual requirements and therefore recommend that these procedures be reinstituted.

Consumer Commission on the Accreditation of Health Services, Inc.
381 Park Ave. South, New York, N.Y. 10016

☐ Enclosed is my $25 Annual Subscription to Health Perspectives and CCAHS Quarterly.

☐ Enclosed is my $______ tax-deductible contribution.

ORGANIZATION ________________

ADDRESS ________________

CITY ________ STATE ______ ZIP ______

NAME ____________ TELEPHONE ______

THE COMMISSION IS A NON-PROFIT ORGANIZATION

PUBLISHED BY CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES INC.
381 PARK AVENUE SOUTH
NEW YORK, N.Y. 10016
TELEPHONE: 689-8959

-corrected address requested-