

Special Report

The Bedford-Stuyvesant/Crown Heights demonstration project

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The Bedford-Stuyvesant/Crown Heights demonstration project in Brooklyn, New York, provided Federal and New York State funds to offset the deficits of three hospitals and three freestanding health centers while the six institutions worked to improve service quality and financial viability of the local health care system. The demonstration project resulted in a merger between two of the participants: at the end of 1982, the Jewish Hospital and Medical Center of Brooklyn and St. John's Episcopal Hospital of Brooklyn merged to form Interfaith Medical Center.

Introduction

The Bedford-Stuyvesant/Crown Heights demonstration project was a 3-year experiment in health care system reconfiguration and cost containment in Brooklyn, New York, jointly funded by the Health Care Financing Administration, U.S. Department of Health and Human Services (DHHS), and by New York State, and involving six health care institutions. Three of the institutions were hospitals: the Jewish Hospital and Medical Center of Brooklyn (JHMCB), St. John's Episcopal Hospital of Brooklyn, and St. Mary's Hospital of Brooklyn. The other three were freestanding health centers: the Bedford-Stuyvesant Family Health Center, the Lyndon Baines Johnson Health Complex, and the Charles Drew Neighborhood Health Center. The project began in November 1979 and ended in November 1982, with the phase-out funding for project staff continuing through February 1983. An evaluation of the project was conducted by Arthur D. Little, Inc. (1983).

Background and initial project design

The project was established primarily in response to a fiscal crisis at the Jewish Hospital and Medical Center of Brooklyn (JHMCB), which had filed for bankruptcy and was in danger of closing. Closing of the hospital would have jeopardized availability of acute health care services in the Bedford-Stuyvesant/Crown Heights area, and contributed to further economic and social deterioration in the area. Also, JHMCB had a long tradition as Brooklyn's leading voluntary hospital, and allowing it to close would have been politically difficult. Governor Carey of New York State had publicly committed himself to keeping it open.

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Although past management deficiencies exacerbated the financial situation of the hospital, the hospital contended that a more basic problem was uncompensated care given to the medically indigent (i.e., patients who are ineligible for Medicaid but have no other health insurance). New York State had for some time been interested in trying to solve this and other problems in the State reimbursement system, which were believed to be contributing to growing deficits in hospitals throughout the State.

At the time of JHMCB bankruptcy filing, a voluntary Statewide group called the Council on Health Care Financing, headed by two State legislators, was in the process of studying the State reimbursement system and developing recommendations for change, including coverage for indigent care and integration of Medicare, Medicaid, and Blue Cross into a uniform State-administered reimbursement system. The State saw an opportunity both to help JHMCB and to pursue its reimbursement aims by designing a demonstration project embodying these reimbursement features.

After intensive lobbying and negotiation, accompanied by newspaper speculation regarding the politics involved, the U.S. Health Care Financing Administration (HCFA) formally agreed to Federal participation in a demonstration project, but not in a reimbursement experiment. Instead, the design of the project called for deficit funding to participants during a period of three years, during which time they were to institute management improvements and health system changes, including hospital bed reductions, which would eliminate the need for deficit support after three years. Participants did not believe this would be possible, but accepted the temporary financial relief it offered.

The six institutions participating in the project were as follows:

- (1) The Jewish Hospital and Medical Center of Brooklyn (JHMCB) had been the leading voluntary hospital in Brooklyn, with a tradition of academic medicine, but it suffered from a badly deteriorated physical plant, severe deficits and a large accumulated debt, and inadequate management and financial systems. At the start of the project it had 636 beds, reduced to 576 shortly thereafter.
- (2) St. John's was a 369-bed community hospital owned and operated by the Church Charity Foundation of Long Island, an Episcopal organization. It was the only hospital in the project to offer inpatient psychiatric care, and it had an extensive ambulatory care outreach program with four freestanding clinics. St. John's facility was newer than JHMCB's and its financial situation was less severe, although

the financial situation was rapidly worsening at the time the project began and continued to worsen.

- (3) St. Mary's was a 270-bed community hospital affiliated with, but separately incorporated from, the Catholic Medical Center of Brooklyn and Queens. The hospital had a new facility and was also in the best financial situation of the three project facilities, but also had growing deficits, particularly from emergency room care. St. Mary's was seeking to improve its financial position through recruitment of private physicians to its staff and through referral of uninsured clinic patients to a hospital-based private practice group.
- (4) The Bedford-Stuyvesant Family Health Center, opened in 1978, was largely dependent on grant support. Until 1982 it received "Section 330" funds from the U.S. Public Health Service (PHS) to subsidize care to the medically indigent. At the time the project began, the Center was quite new and was experiencing difficulty attracting patients, despite efforts to improve service mix and marketing.
- (5) The Lyndon Baines Johnson Health Complex (LBJHC) opened in 1969, under the sponsorship of the Office of Economic Opportunity, Department of Health, Education and Welfare. In 1975 the LBJHC lost Federal funding because of poor management and filed for bankruptcy. By the time the project began, new management had reorganized the LBJHC, cut programs and staff, and stabilized its financial situation. The Center had about 23,000 patient visits per year, predominantly Medicaid.
- (6) The Charles Drew Neighborhood Health Center was the largest of the three health centers, with 55,000-60,000 patient visits per year. More than half of its patient volume was self-paying—i.e., uninsured—and the Center was heavily depend-

ent on Public Health Service "Section 330" funding. It operated in an extremely deteriorated main building and two small satellites. At the start of the project, it was experiencing growing deficits beyond the level of PHS support, as well as management problems.

The institutions were located in North Central Brooklyn, an area with a generally low-income minority population. North Brooklyn had been judged to have an excess of hospital beds. A large new municipal hospital, Woodhull Medical and Mental Health Center, was opened there in November 1982, offsetting bed closings elsewhere.

The original administrative design of the project was complex. Instead of being managed by the State as had been proposed, it was initially managed by a group called the Project Control Board (PCB), which represented the Health Care Financing Administration (HCFA), Public Health Service (PHS), the New York State Departments of Health and Social Services, the City of New York, and Blue Cross. A second group, the Area Health Corporation (AHC), represented the institutions, the New York City Health Systems Agency (HSA), and the public, and was responsible for carrying out the substantive goals of the project. These goals consisted of health system and institutional management improvements. The financial provisions of the project were twofold. First, Medicare and Medicaid both contributed amounts designed to cover the ambulatory care deficits of all six participating institutions plus the inpatient deficit of JHMCB. Early in the project it was agreed that in the case of the health centers the deficit funding would replace any PHS funding, making the latter available for ambulatory care improvements. However, the funds were never made available to do this, and the project paid only deficits exceeding the PHS grants. Table 1 shows the deficit funding paid to each institution over the life of the project; all except the LBJ Center received deficit funding.

Table 1
Funds granted under the project, by institution: 1979-1982

	1979 ¹	1980	1981	1982 ²	Total
Total	\$1,023,825	\$12,523,371	\$11,274,623	\$11,169,708	\$35,991,527
Jewish Hospital and Medical Center of Brooklyn	529,883	5,768,408	5,391,759	5,355,729	17,045,799
St. Mary's Hospital of Brooklyn	219,906	2,226,417	2,238,850	2,251,681	6,936,854
St. John's Episcopal Hospital-Brooklyn	274,036	4,222,344	3,337,812	3,336,226	11,170,418
Bedford-Stuyvesant Family Health Center	-0-	-0-	-0-	226,072	226,072
Charles Drew Neighborhood Health Center	-0-	306,202	306,202	-0-	612,404
Lyndon Baines Johnson Health Complex, Inc. ³	-0-	-0-	-0-	-0-	-0-

¹Funding received for Nov. 30 - Dec. 31, 1979.

²Funding received for Jan. 1 - Nov. 27, 1982.

³LBJ was retrospectively determined not to have incurred deficits exceeding its Public Health Service funding.

The second component of project financing was the use of Periodic Interim Payments (PIP) (i.e., reimbursement via weekly fixed payments based on projected use for the year and subject to year-end adjustment). Normally, while Medicare and Blue Cross use PIP, Medicaid reimburses on a claim-by-claim basis following review of each claim. By changing to PIP for Medicaid, the project improved cash flow in all the institutions, regardless of the level of deficit funding.

Evolution of the project

Early experience and project redefinition

The project immediately relieved the hospitals from financial emergencies, enabling them to make internal improvements, mainly in financial systems including Medicaid eligibility finding, and patient billing and collections. It helped JHMCB and St. John's recruit new top management. It also resulted fairly early in limited cooperative arrangements, such as agreements making JHMCB the referral center for certain specialized services for which the other hospitals had formerly referred patients to more distant hospitals. Before the project, the hospitals had virtually no contact at all; during the project, they developed a productive working relationship.

The initial achievements were modest, however, and by the end of a year there was no promise of significant improvements in health system efficiency or finances of the institutions. Criticisms both from the Health Care Financing Administration and from the New York State Office of the Welfare Inspector General intensified pressure on the institutions and the Area Health Corporation (AHC) to show more progress.

One of the problems impeding progress in the first year was an overly cumbersome project structure. The Project Control Board (PCB) was not an efficient decisionmaking mechanism because:

- Members came from six different agencies.
- Members were not always authorized to speak for their agencies.
- Members had limited access to the State regulatory and reimbursement system.

In March 1981, the PCB decided to disband and turned the project over to a State monitoring team reporting to the New York State Health Department.

A second problem was that the project contract demanded approximately 100 "deliverables" (i.e., studies, inter-institutional agreements, and health system changes). The AHC found that compliance with the "deliverables" list, some items of which were extraneous to the main goals of the project, was distracting attention from a comprehensive and focused approach. The State agreed, and developed a reduced list of required activities aimed at three broad goals: ambulatory care reconfiguration, hospital service realignment, and fiscal stabilization.

Later project activities and related events

In 1981 and 1982, the second and third full years of the project, this more focused approach led to three proposals for much more extensive system changes than had previously been accomplished:

- (1) Consolidation of the nonemergency ambulatory care currently provided by the hospitals under a separate corporation (certificate-of-need (CON) application submitted October 1981);
- (2) Consolidation at JHMCB of the obstetrical services currently provided jointly with St. John's Episcopal Hospital (application submitted September 1981).
- (3) A complete merger between JHMCB and St. John's Episcopal Hospital (application submitted May 1982).

When the merger was proposed, the other two applications were tabled at the request of the AHC.

The merger concept was first seriously considered in 1981 when the obstetrical consolidation was nearing completion. The hospitals felt that a merger would take advantage of JHMCB's strength in tertiary care, neonatal and maternity care, and teaching; and of St. John's facilities and strength in psychiatry. By creating a "substantially changed" facility, the merger would also make possible a rate increase. Religious, ethnic, and academic differences would have previously prevented the institutions from thinking of each other as likely merger partners, but joint activities under the project, and worsening fiscal situations of both hospitals made the proposal seem reasonable.

After the CON application was submitted in May 1982, a number of modifications were made before it was approved. During the summer and fall of 1982 the two hospitals and the State Health Department worked intensively to develop a workable bed configuration, capital improvement plan, and proposal for JHMCB's bankruptcy settlement. Major features of the resulting plan were:

- Elimination of 295 beds.
- Leasing of the two hospital facilities from their respective boards by the merged institution, with an option to buy; use of the proceeds to settle the debts of the hospitals.
- Waiver of the "preferred creditor" status of Medicaid and Medicare, by the State and by HCFA, thereby making settlement of the bankruptcy possible.

As these efforts proceeded, both hospitals developed contingency plans in the event that the merger could not be implemented.

During the same period, New York State was awaiting a Federal waiver approving Medicare participation in a proposed experiment involving major changes in the Statewide hospital inpatient reimbursement system. The reimbursement experiment provided for an environment in which the merged institution would have a good chance of surviving, and on that basis the Health Department successfully urged approval of

the CON application in November. When the project ended at the end of that month, implementation of the merger was under way.

Under the project, the State monitoring team (SMT) provided technical assistance to the Bedford-Stuyvesant Family Health Center and the Lyndon Baines Johnson Health Complex. The LBJ Center received extensive technical assistance in quality assurance, medical records maintenance, patient registration, and financial management. The State monitoring team also helped the Center to obtain additional Public Health Service funding for program expansion, plant renovation, and equipment procurement (or maintenance).

The Family Health Center (FHC) and the Charles Drew Neighborhood Health Center were drastically affected by the Public Health Service discontinuing their Section 330 funding in 1982. In the case of the FHC, the project picked up most of the financial difference for the final year, enabling the center to continue improvements. In 1982 the FHC conducted an intensive marketing effort in order to build patient volume. In the case of the Drew Center, the State concluded that the management problems were too persistent and the deficits too large to warrant similar assistance, and in March 1982 the Center closed. St. Mary's Hospital, which is located near Drew, obtained temporary assistance from PHS to provide walk-in services for former Drew patients.

In the final project year the institutions, AHC, and SMT were increasingly concerned about the impact of returning to conventional reimbursement, which would result in loss of deficit funding, and a return to Medicaid retrospective payment from the Periodic Interim Payment (PIP) schedule. The hospitals were continuing to show large deficits, and without some alternative form of continued deficit funding, it was expected that none of the hospitals would remain in operation long. As discussed below, the Statewide reimbursement experiment alleviated this problem.

The transition from PIP to the normal reimbursement schedule was expected to cause serious cash flow problems for the institutions. Toward the end of the project, SMT focused on securing a more gradual phaseout of PIP funding. This was accomplished in the form of an eight-month phaseout of PIP for the health centers and a three-year phaseout for the hospitals. The entire project ended in November 1982.

Evaluation findings

Arthur D. Little, Inc. evaluated the project during 1981 and 1982. A summary of major findings follows.

Causes of financial distress

Implicit in the project design was the hypothesis that the financial condition of the hospitals resulted in large part from excessive costs due to duplication of resources and inefficient management. The evaluation findings did not support this view. The project hospitals compared favorably with other similar hospitals regarding the overall cost of delivering services. The

analysis suggested that the hospitals were not "high-cost" in comparison with their "peers" and that their financial problems did not result from high inpatient costs. This conclusion is supported by the fact that these hospitals had not incurred cost disallowances for inpatient routine or ancillary costs under Medicaid.

The deficits were found to result mainly from inadequate reimbursement for services covered by third-party payers, and self-pay bad debt (i.e., non-payment of bills by uninsured patients) and charity care. Analysis suggested that the inadequate reimbursement was primarily responsible for the inpatient deficit at St. Mary's, while bad debt and charity care were mainly responsible for the inpatient deficits at the other two hospitals and the outpatient deficits at all three facilities.

A Statewide analysis of fiscal distress in New York State hospitals by Arthur D. Little, Inc. (1982) showed that financial distress was widespread among New York State hospitals and, if current trends continued, additional hospital closures would be unavoidable. Large hospitals in or near New York City were the most severely affected, with financial indicators similar to those of the project institutions prior to the project.

The Statewide analysis also showed that inpatient services accounted for 13 percent of the average hospital deficit across all hospitals. Bad debts were the chief contributor to this deficit, closely followed by reimbursement shortfalls (i.e., insufficient reimbursement by third-party payers for care to their covered patients). Outpatient services accounted for 51 percent of the average hospital deficit—22 percent for clinic services and 29 percent for emergency room services. (The remaining 36 percent of the total deficit resulted from a wide range of other activities.) Bad debts accounted for about 66 percent of the clinic deficit and 59 percent of the emergency room deficit; reimbursement shortfalls accounted for the remaining deficit.

Financial impact of the project on the hospitals

Activities undertaken under the project clearly reduced operational deficits (net of project funding) of the participating hospitals, but not by enough to materially change their financial outlook. On several indicators of financial health, their status was poor and deteriorating as of the end of the project's second year.

Working capital

To be assured of adequate liquidity, a hospital's ratio of current assets to current liabilities should be 2.0 or more; that is, it should have at least \$2 worth of current assets for every \$1 of current liabilities. Project funds included, the Church Charity Foundation was the only project participant with a current ratio greater than 1.0 (1.011) in 1981, a figure reflecting the combined performance of St. John's and the Foundation's more fiscally stable hospitals. The ratio for JHMCB was 0.623 and that for St. Mary's 0.752.

Although the PIP payments reduced the hospitals' accounts receivables, cash and other liquid assets continued to decline. If PIP payment had terminated, severe cash flow problems would have resulted.

Fund balances and debt versus equity financing

From 1974 to 1981, JHMCB, St. Mary's and Church Charity (separate figures for St. John's were not available) all experienced declines in the fund balance (i.e., the excess of total assets over total liabilities). In 1981, both JHMCB and St. Mary's had negative fund balances, -\$3.8 million and -\$2.7 million respectively. The figure for Church Charity was still positive, but was declining sharply.

As fund balances decline, so does a hospital's equity ratio, or the ratio of the fund balance to total assets. This means that any capital improvements—needed urgently by JHMCB and to some extent by St. John's—must be financed by debt rather than equity, a course of action that is both difficult and hazardous for any hospital already in financial difficulty.

Operating revenues and expenses

A ratio of operating expenses to operating revenues which exceeds 1.0 indicates that operations are running at a loss. When project funding is excluded, this ratio exceeded 1.0 for the participating institutions throughout the project period.

Hospital deficit analysis

With deficit financing excluded, the combined deficit of the project hospitals in 1981 came to \$16.7 million: \$6.5 million at JHMCB, \$5.3 million at St. Mary's and \$4.9 million at St. John's. The combined figures represent a decrease of \$1 million since 1979. This decrease shows a greater impact from the project than would appear, since the deficit would have been significantly greater in 1981 than in 1979 had existing trends continued. If, for example, the deficit-to-cost ratio had been the same in 1981 as in 1979, the aggregate deficit would have come to \$22.1 million. Thus, the hospitals showed an improvement of \$5.5 million or more compared to what otherwise might have been expected.

The composition of the hospital deficits changed substantially between 1979 and 1981. Inpatient deficits were substantially reduced in all three project hospitals, and the ambulatory care deficits substantially increased in all three. The aggregate inpatient deficit declined sharply from \$10.1 million to \$4.7 million, a 53 percent reduction. The aggregate outpatient deficit, on the other hand, rose substantially from \$9.0 million in 1979 to \$12.0 million in 1981, a 33 percent increase. The greater outpatient deficit was significantly related to "bumping up" against the Medicaid cap. Net revenues arising from other sources (other patient services, nonpatient service activities and non-operating revenue) declined \$1.3 million, decreasing at both JHMCB and St. John's, but increasing at St. Mary's.

Financial impact of the project on the health centers

Reporting requirements for the health centers were not sufficiently detailed to permit an analysis of their 1981 financial position comparable to that done for the hospitals. However, the Family Health Center and the Charles Drew Center were dependent on grant support for about two-thirds of their budgets. Loss of this support for 1982 caused the closing of the Drew Center, and the Family Health Center was able to continue only with an infusion of Demonstration funds. Only the LBJ Center was financially self-sufficient, showing a positive net income through the project period even before grant support was taken into account. The LBJ Center was able to keep per-visit costs low and also treated very few self-paying patients.

Management impact of the project

During the project, the hospitals unquestionably improved their management. Improvements were made in the following areas:

- Improved management capability (e.g., hiring of new personnel).
- Improved management systems (e.g., computerized billing).
- Improved reimbursement (e.g., greater attention to reimbursement appeals).
- Enhanced Medicaid case finding and screening of uninsured patients.
- Improved collections.
- Consolidated services (e.g., bed reductions).
- Reconfigured systems (e.g., the proposed merger).
- Reduced costs (e.g., contracting for services).

JHMCB made the greatest improvements in these areas, and its accomplishments can be unambiguously attributed to the support provided by the project. Indeed, if it were not for the "breathing space" afforded by the project, or some alternative form of aid, JHMCB would probably have closed. The considerable improvements achieved by the other hospitals could not have been undertaken without the temporary financial cushion offered by the project.

The three health centers differed with respect to management changes:

- (1) The loss of funding and eventual closure of the Drew Center resulted in part from a perception by PHS and the State that the Center had serious management problems which it could not correct on its own and for which it resisted outside help.
- (2) Major improvements were made in several aspects of the operations of the LBJ Center with technical assistance from the State Monitoring Team. These contributed to the Center's ability to obtain PHS funding for plant improvements, equipment, and programs.

- (3) As the project ended, it appeared that the FHC was beginning to show some utilization increases as a result of its marketing program, although additional increases were needed to assure the Center's viability.

The project was essential to the efforts of both surviving health centers. The LBJ Center, without the free assistance received from the SMT, could not have gained access to comparable expertise from any other source. The FHC received marketing assistance from the SMT and was kept in operation during 1982 by project funds.

Reimbursement changes in New York State

On July 3, 1982, in the final year of the project, the New York State legislature enacted the Lombardi-Tallon Act, which established the New York Prospective Hospital Reimbursement Methodology. Implementation was conditional upon Federal approval of a waiver allowing Medicare to participate in the new reimbursement method. The waiver was approved September 30 on the basis of a three-year demonstration.

Major features of the new methodology include:

- A uniform prospective rate setting system for Medicare, Medicaid, and Blue Cross, eliminating uncertainties and reimbursement shortfalls that resulted from prior differences in reimbursement method (notably the so-called "Medicare carve-out").
- A pool of supplemental funds to help offset costs of bad debt and charity care, allocated on a regional basis in proportion to the region's level of bad debt and charity care costs.
- A "discretionary allowance" in the form of a 1-percent add-on to each hospital's per-diem rate, to be used at the discretion of the hospitals.
- An allowance for financially distressed hospitals allocated at the discretion of the State on the basis of applications to be submitted by the hospitals.

The methodology applies only to inpatient rates and therefore does not address problems due to outpatient costs exceeding the cap on outpatient reimbursement. However, outpatient bad debt and charity care costs are included in determining allocations from the bad debt and charity care pool.

By allocating inpatient costs more fairly among payers and providing for partial relief of both inpatient and outpatient bad debt, the new reimbursement system addresses some of the problems identified by this study. The discretionary allowance and distressed hospitals allowance provide a means of compensating for insufficient bad debt reimbursement and other causes of fiscal distress. Hospitals under the new system still have a strong incentive to keep outpatient costs within reimbursement limits.

Update on the project participants

Interfaith Medical Center opened on January 1, 1983, merging the former JHMCB and St. John's Episcopal Hospital, and offering services at both hospital sites. Over the course of 1983, 295 beds were eliminated, for a final bed complement of 650. This involved eliminating about 800 personnel positions, through a combination of attrition and layoffs. A new Board has been constituted and the medical staffs consolidated.

Renovations are nearly complete which will permit consolidation of all medical and surgical services at the JHMCB site and all maternity, pediatrics, psychiatry, and detoxification at the St. John's site. The hospital is reassessing its tertiary care and teaching programs with a view to concentrating on a limited number of areas of existing strength. Planning has also begun for an expanded program for ambulatory care.

St. Mary's Hospital experienced high occupancy during 1983 and 1984, which it attributes partly to the Interfaith bed reductions and partly to its own marketing activities. It has also obtained additional PHS funding to operate satellite clinic services formerly provided by the Charles Drew Center.

Both Interfaith and St. Mary's received substantial deficit funding from the State's new bad debt/charity care pool and financially distressed hospital pool. With this support, both are currently in good financial condition, but both say that they are heavily dependent on the support.

The continued marketing efforts of the Bedford-Stuyvesant Family Health Center resulted in 31 percent more patient visits in 1983 than in 1982, and the FHC is optimistic about breaking even financially. This center, the LBJ Center and three other health centers in Brooklyn and Queens are in the process of forming a consortium for the purpose of coordinating services, pooling and reducing costs, and establishing a common position on issues of mutual interest.

Conclusions

Developments during and following the project suggest the following conclusions regarding the goals defined at the time the State assumed responsibility for the project and the long-range outlook for the institutions.

Major progress was made toward the goal of hospital service realignment. Bed reductions totaled 355, consisting of 60 JHMCB beds closed at the start of the project and 295 beds closed as a result of the JHMCB/St. John's merger. The merger constituted a major realignment of services of the two hospitals, involving a full consolidation of management, medical staffs, and programs. All three hospitals participated in more limited agreements to coordinate specialty services and teaching programs.

Steps were initiated toward ambulatory care reconfiguration, but any major results are still in the future. The management improvements in the LBJ Center and the marketing activities of the FHC prepared these centers to be more effective providers of ambulatory services; however, the health centers were not effective participants in system reconfiguration efforts conducted during the project. Changes in ambulatory care may be forthcoming as a result of Interfaith's current planning efforts and of the formation of a consortium of Brooklyn and Queens health centers.

Most, though not all, of the Demonstration participants improved their financial viability through actions taken under the aegis of the project. In the case of JHMCB and St. John's, the merger design enabled the merged institution to receive an increased rate of reimbursement. The merger also led to an arrangement for settling the JHMCB bankruptcy. All three hospitals made substantial improvements in financial systems and other areas. The combined deficit of the three hospitals in 1981 was about 25 percent lower in real terms than would have been the case without the project.

The Drew Center was unable to overcome its financial problems despite its participation in the project. However, both of the other health centers improved their financial condition.

In order for the service realignment and financial viability goals to be realized, the project was a necessary, but not a sufficient, condition. The project participants agree that the internal improvements made could not have been made without the temporary financial relief afforded by the project and that service realignment would never have occurred without a combination of financial relief, the interinstitutional contacts enforced by the project and facilitated through the AHC, and the problem-solving assistance provided by the SMT and New York State Health Department. However, realization of the merger and

the achievement of financial viability necessitated, in addition to the above, either the new Statewide reimbursement system or an equivalent change in revenues for the project hospitals. Finally, the solutions achieved required willingness at both the State and Federal levels to make special efforts to assure implementation and success, such as the PIP extension and the waiving of preferred creditor status. This willingness in turn must be credited partly to persistence on the part of the institutions, particularly JHMCB and St. John's, which exerted constant pressure for the changes needed for their survival.

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