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REPORT TO THE CONGRESS 095904



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**Comprehensive Health Planning
As Carried Out By State And
Areawide Agencies In Three States**

B-164031(2)

Department of Health, Education,
and Welfare

**BY THE COMPTROLLER GENERAL
OF THE UNITED STATES**

APRIL 13, 1974

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

B-164031(2)

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

This is our report on comprehensive health planning as carried out by State and areawide agencies in three States. The Department of Health, Education, and Welfare administers the program under which these agencies operate.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare.

A handwritten signature in cursive script, reading "James B. Axtell".

Comptroller General
of the United States

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ABBREVIATIONS

CHP	comprehensive health planning
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare

D I G E S T

WHY THE REVIEW WAS MADE

Authority for the comprehensive health planning program under the Public Health Service Act expires on June 30, 1974.

Sections 314(a) and (b) sought to promote the most effective and efficient use of existing and future health resources in meeting the health needs of the American people by establishing state and areawide comprehensive health planning agencies to undertake comprehensive and continuing health planning.

To assist the Congress in its deliberations on extending or modifying this program, GAO reviewed the work of

- State comprehensive health planning agencies in California, Maryland, and Ohio;
- two areawide agencies in each of these three States; and
- the Department of Health, Education, and Welfare's (HEW's) administration of the program.

FINDINGS AND CONCLUSIONS

The comprehensive health planning (CHP) agencies reviewed by GAO have

had beneficial impact on the health care delivery system, mostly by

- fulfilling responsibilities to review and comment on federally financed projects for delivery of health services,
- performing review and approval functions for health facility construction, and
- reacting to health problems brought to their attention by various sources rather than through a systematic planning process. (See p. 25.)

The Maryland CHP agency, for example, through its review and approval function, stopped construction from July 1970 through November 1972 of four unneeded health facilities valued at \$10.8 million and approved, after such modifications as eliminating unnecessary equipment, facilities, and services, 29 projects valued at \$129.3 million.

The organization and planning activities of the agencies reviewed centered around advisory councils and working committees comprising volunteers representing government, provider, and consumer interests. These were assisted by professional staffs which the agency officials considered too small to carry out

agency responsibilities effectively.

Attendance at most council meetings was generally less than 50 percent, and only two agencies had consumer majorities in attendance at half the meetings. The councils were not always geographically and socio-economically representative, and two agencies' councils did not have the consumer majorities required by law. (See p. 24.)

The extent to which the agencies had mature working committees contributing to planning varied. Some had committees still being organized or inactive even though the agencies had been operating for several years.

Although the use of volunteers for CHP functions is consistent with the partnership arrangement envisioned by the Congress in enacting CHP legislation, the result in practice has made the decisionmaking process inherently cumbersome and slow. (See p. 41.)

Some of the areawide agencies had significant problems raising required local matching funds. This activity requires much staff and volunteer time and also affects the agencies' abilities to recruit and retain qualified staffs. Most of the agencies said they did not have sufficient Federal and local funds to provide staffs to assist the volunteer councils and committees. Some donors stopped or reduced contributions or threatened to do so because of positions taken by the agencies.

The Maryland agencies, however, did not have fund-raising problems because the State contributed most of the local matching funds.

One State agency and three areawide agencies had developed comprehensive health plans, but these plans needed refining and revising before they could be used for implementing actions. Other agencies had made little progress toward developing comprehensive health plans. (See p. 25.)

Establishing a health planning process and developing related plans have been impeded also by shortcomings in available data, ineffective working relationships between State and areawide agencies, and geographic makeup of planning areas.

Control functions (review and comment or review and approval) of CHP agencies showed mixed results. On the one hand they had a beneficial impact on the health care delivery system. On the other, they sometimes were performed without following systematic procedures and without being based on developed plans.

In addition, review and comment requirements were disjointed, some agencies were not aware of projects they should have been reviewing and have not always been given opportunities to comment on proposed projects. (See p. 42.)

HEW assistance to State and areawide agencies in planning techniques has been limited, and its review and monitoring responsibilities have not always been effective, because of insufficient staff and the desire to not interfere with functions considered to be State and local matters. (See p. 32.)

HEW's recently established agency assessment program should give agencies the needed guidance and

technical assistance. (See p. 38.)

If agencies are assessed objectively on the basis of developed performance criteria, their primary problems can be identified and corrected. The schedule for assessing agencies will give HEW a timely basis for determining agencies' ongoing needs and for determining whether the CHP program can become a viable nationwide program able to substantially improve the health care delivery system,

As of February 1973, 56 State agencies (50 States plus the District of Columbia, American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Trust Territory of the Pacific Islands), 194 areawide agencies, and 4 State-assisted local councils were receiving Federal funds to perform comprehensive health planning.

The Federal Government may pay up to 100 percent of State agency costs and up to 75 percent of areawide agency costs. Federal funds granted the States since the program began in 1967 through fiscal year 1972 totaled about \$36 million, and funds granted to areawide agencies from the first grant in January 1968 through fiscal year 1972 totaled about \$41 million.

HEW operated under a joint continuing resolution in fiscal year 1973, and the State and areawide CHP agencies were funded at the congressionally approved level of \$9 million and \$20.2 million, respectively. HEW requested and received appropriations of \$10 million and \$23.75 million, respectively, for State and areawide agencies in fiscal year 1974. (See pp. 7 and 8.)

RECOMMENDATIONS

The Secretary of HEW should direct the Comprehensive Health Planning Service to develop recommendations for legislative or administrative action to alleviate the following problems.

- Sources of matching funds and difficulties in raising the required amounts.
- Lack of staffs.
- Selection and participation of volunteers in planning activities.
- Geographic makeup of planning areas.
- Proper relationships between State and areawide agencies.
- Performance of control functions without sound criteria and systematic procedures.
- Agencies' not being given opportunities to review and comment on proposed Federal health projects.
- Shortcomings in data bases available to State and areawide agencies.
- Lack of an implementation process for developed recommendations.

The agency assessment program should be expanded to include areawide agencies receiving organizational grants before they reach planning phases. (See p. 44.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW agreed with these recommendations

and said that the Comprehensive Health Planning Service was working toward alleviating many of the problems identified by GAO.

In addition, the Department was working on a legislative proposal which would affect the future of the CHP program. (See p. 45.)

The three State and six areawide agencies reviewed were given an opportunity to comment on GAO's

findings. Their comments have been considered in this report.

MATTERS FOR CONSIDERATION
BY THE CONGRESS

The matters this report discusses may assist the Congress during deliberations on extending or modifying legislative authority for the CHP program and on the proper levels of Federal, State, and local financial support of the program.

CHAPTER 1

INTRODUCTION

The Comprehensive Health Planning and Public Health Services amendments to the Public Health Service Act, as amended, established the comprehensive health planning (CHP) program in November 1966 to assist States¹ and local communities, through Federal grants, in developing continuing planning processes to produce comprehensive plans for meeting their current and future health needs.

The CHP program, commonly known as the Partnership for Health program, is a decentralized program administered by the Comprehensive Health Planning Service, Health Services and Mental Health Administration,² Department of Health, Education, and Welfare (HEW), and by the regional health directors at the 10 HEW regional offices.

Headquarters responsibilities include providing program leadership; developing program policies and guidelines; maintaining liaison with other Federal agencies and national organizations; technically assisting regional offices; assessing progress of State and areawide planning agencies for use in guiding Federal policy; and administering section 221 of Public Law 92-603. (section 1122 of the Social Security Act) which provides controls over the construction of hospitals and other health facilities. (See p. 21.)

¹In this report, States include the 50 States, the District of Columbia, American Samoa, Guam, Puerto Rico, the Virgin Islands, and the Trust Territory of the Pacific Islands.

²Effective July 1, 1973, the Administration was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health. The Comprehensive Health Planning Service was placed in the Bureau of Health Resources Development, Health Resources Administration.

The regional health directors are responsible for approving, funding, managing, and monitoring State and areawide grants and for providing consultation and technical assistance to grantees.

Section 314(a) of the Public Health Service Act, as amended, authorizes grants to States for State-wide health planning. To qualify for a grant, a State must submit, and have approved by the Secretary of HEW, a State CHP program which, among other things, provides for (1) designating a single State agency to administer the program, (2) developing a representative advisory council, (3) encouraging cooperation among governmental and nongovernmental health groups and with similar groups in education, welfare, and rehabilitation, and (4) assisting in planning for health care facilities within the State.

Section 314(b) authorizes project grants to public or nonprofit private agencies for areawide health planning. Areawide agencies may be awarded organizational grants for up to 2 years to carry out developmental activities and planning grants for up to 5 years to undertake areawide health planning. The planning grants are renewable.

Section 314(c) authorizes project grants to public or nonprofit private organizations to cover all or part of the costs for training, studies, or demonstration projects to develop improved or more effective health planning. Authorization for this section was to expire on June 30, 1973, and HEW did not plan to request an extension. However, in June 1973 the Congress extended the authorization to June 30, 1974.

The CHP program is carried out at State levels by designated State agencies and at areawide or community levels by private agencies or organizations. State and areawide CHP agencies--with broad participation by health providers, consumers, and government representatives--are charged with undertaking comprehensive health planning to promote the most effective and efficient use of existing and future health resources in meeting the country's health needs.

STATE CHP AGENCIES

All the eligible 56 States participate in the CHP program. The following schedule shows its organizational placement in the States at the time of our review.

<u>State placement</u>	<u>Number of agencies</u>
Health and Welfare or Human Resources departments	8
Health departments	26
Governors' or State planning offices	18
Independent agencies	2
Interdepartmental	<u>2</u>
Total	<u>56</u>

Federal funds are granted annually to each State according to a formula based on population and per capita income, but no grant can be less than 1 percent of the total funds appropriated. This Federal assistance has generally been available for up to 100 percent of State planning costs; however, it was limited by law to 75 percent of State costs for fiscal year 1970 and by administrative action for fiscal year 1971.

Federal funds granted to the States for fiscal years 1967-72 totaled about \$35.7 million. HEW operated under a joint continuing resolution in fiscal year 1973, and the CHP program was operated at the congressionally approved budget level of \$9 million. An appropriation of \$10 million was requested and received for fiscal year 1974.

HEW has estimated that State agencies need at least \$15 million annually to effectively carry out their planning responsibilities. As one HEW regional official stated, however, additional funds will not necessarily solve the agencies' problems, because certain States have very low salary structures and consequently will be unable to hire qualified planners.

The three State CHP agencies reviewed have received the following Federal funds.

	Fiscal years <u>1967-72</u>	Fiscal year <u>1973</u>
California	\$2,482,900	\$ 618,000
Maryland	521,700	125,700
Ohio	<u>1,570,100</u>	<u>361,800</u>
Total	<u>\$4,574,700</u>	<u>\$1,105,500</u>

AREAWIDE CHP AGENCIES

Grants to areawide agencies are approved annually by the HEW regional office after grant applications have been approved by State health planning agencies. Federal assistance for areawide planning may not exceed 75 percent of the actual cost of the areawide planning agency; however, HEW has administratively limited most grants to less than 75 percent of such costs. Federal funding in 1972 averaged about 54 percent and ranged, depending on demonstrated need, from 25 to 75 percent; however, only 10 of 94 agencies received less than 50 percent. Grantees must raise funds for the remaining costs, and the amount of the Federal grant becomes contingent on the amount of local funds raised. In fiscal years 1968-72, areawide agencies received \$40.9 million in grants.

HEW operated under a continuing resolution in fiscal year 1973, and the areawide CHP program was operated at the congressionally approved level of about \$20.2 million. An appropriation of \$23.75 million for areawide agencies was requested and received for fiscal year 1974, which will provide for increasing the number of areawide agencies and State-assisted local councils from 198 to 260, including 24 additional State-assisted local councils. State-assisted local councils are authorized by Public Law 91-515, approved October 30, 1970, which provides for project grants to State CHP agencies to assist local health-planning councils when resources are not otherwise sufficient to support areawide CHP agencies.

As of February 1973, 194 areawide agencies were participating in the program, 65 operating under organizational grants and 129 under planning grants. In addition, there were three State-assisted local councils in Montana

and one in Colorado. The first grant to an areawide agency was made in January 1968.

More than 70 percent of the Nation's population was being served by areawide CHP agencies or State-assisted local councils, which cover only about 31 percent of the land area. The population covered by an areawide agency ranged from 26,000 to 7.9 million. The median population size was about 380,000.

Arkansas, California, Maine, Massachusetts, and Wisconsin are fully covered by areawide CHP agencies; Ohio and Michigan are substantially covered. Hawaii, Rhode Island, South Dakota, and Wyoming (in addition to the District of Columbia, and the five eligible territories) have no areawide agencies but do have State CHP agencies. Thus, 39 States are partially but not substantially covered by areawide agencies.

Shown below are the varying types of organizations performing comprehensive health planning at the areawide level.

<u>Organization</u>	<u>Number of agencies</u>
Nonprofit private corporation	150
Economic development district	17
Councils of government	8
Local governments	3
Regional commissions	16
State-assisted local councils	<u>4</u>
Total	<u>198</u>

Several estimates have been made of the minimum cost to obtain nationwide coverage by areawide agencies, ranging from HEW's estimate of about \$50 million as the Federal share (using a 50 percent matching requirement the total cost would be \$100 million) to a private consulting firm's estimate of \$145.6 million. The latter figure includes local matching funds and is based on a projection of 301 areawide agencies having minimum staffs of 10 and incremental staff increases based on the population covered. The level of Federal, State, and local funding (about

\$25 million in 1972) is significantly less than the above estimates. We did not review the reasonableness of these estimates.

The following schedule shows the Federal funds granted through fiscal year 1972 to the six areawide agencies reviewed.

<u>Agency</u>	<u>Date funded</u>	<u>Total grants through fiscal year 1972</u>
Comprehensive Health Planning Association of Imperial, Riverside, and San Diego Counties (San Diego)	July 1, 1968	\$ 495,563
Bay Area Comprehensive Health Planning Council, (San Francisco)	Jan. 1, 1969	1,059,827
Regional Planning Council (Baltimore)	July 1, 1968	692,488
Health Planning Council of the Eastern Shore, Inc. (Salisbury, Md.)	June 15, 1971	62,050
Southeastern Ohio Health Planning Association (Cambridge, Ohio)	June 1, 1969	205,284
Health Planning Association of Northwest Ohio (Toledo)	June 1, 1969	389,481

NATIONAL ADVISORY COUNCIL ON CHP PROGRAMS

Public Law 91-515 required the Secretary of HEW to appoint a National Advisory Council on CHP programs to assist and advise him in preparing general regulations and policy for administering section 314 of the Public Health Service Act. The council was to consist of the Secretary or his designee and 16 other members consisting of at least 6 consumers, 1 State agency official, 1 areawide agency official, 1 member of the National Advisory Council on Regional Medical Programs, and the remainder health providers.

Although the Secretary established the National Advisory Council on CHP programs in September 1971,

membership was not completed until January 1973 and the council did not meet until April.

STATUS OF CHP LEGISLATION

Sections 314(a) and (b) of the Public Health Service Act, as amended, authorizing the CHP program was to expire June 30, 1973. On March 29 the Secretary of HEW proposed legislation to extend the program for 3 years. His letters to the President of the Senate and the Speaker of the House of Representatives stated:

"Although we propose to extend the legislation under which we foster comprehensive State and areawide health planning, we do so with awareness that the comprehensive health planning system is beset with weaknesses that interfere with its effectiveness. One significant problem with comprehensive health planning, for example, is that the legislation and the accompanying rhetoric have articulated very ambitious missions which, by and large, the CHP system has been unable to carry out. Moreover, Federal implementation of program requirements has not been effective to assure an open public planning process or consumer participation in that process. The degree to which some CHP agencies are accountable to the local public has therefore been compromised.

"Despite the widespread disenchantment with the CHP system that these problems, among others, have engendered, the evidence is persuasive that unconstrained health resource development, particularly of inpatient facilities, contributes significantly to the problem of excessive and unnecessary increases in health care costs. The lack of effective competition, the dependence of patients on the judgment of their physicians regarding their health care needs (and the consequent capability of supply to generate its own demand), the predominance of cost reimbursement as a means of paying for institutional health care services, and pressures for institutional aggrandizement in a noncompetitive economy, combine to offset normal

competitive constraints on building surplus capacity. Thus, unless or until reasonably effective competition is established, there is a need to maintain some effective control over construction or expansion of health care institutions.

"On balance, we conclude that, given the broad authority in current law, new legislation is not needed to overcome the weaknesses in the present system. We propose, instead, to extend current law for a period sufficient to allow us to improve and redirect CHP through greatly improved management. A plan for this management approach is currently under review within the Department. This plan for improved management of the program will be based on a serious evaluation of the strengths and weaknesses of the existing CHP agencies and will seek to assess ways in which the planning process can impact most favorably on the health care system. We expect to study carefully the potential applicability to CHP on a national basis of the activities now under way in various States with regard to facility certificate-of-need and rate setting procedures." (Underscoring supplied.)

In June 1973 the Congress extended the programs authorized by the Public Health Service Act, including comprehensive health planning, until June 30, 1974.

SCOPE OF REVIEW

We reviewed the CHP program to (1) provide an overview of the status of comprehensive health planning nationwide, (2) determine progress and problems of selected State and areawide agencies, and (3) assess the HEW leadership role. Our work was done principally at HEW headquarters in Rockville, Maryland; HEW regional offices in Philadelphia (Region III), Chicago (Region V), and San Francisco (Region IX); State planning agencies in Maryland, Ohio, and California;

and areawide planning agencies¹ in Baltimore and Salisbury, Maryland; Toledo and Cambridge, Ohio; and San Diego and San Francisco, California.

¹The areawide agencies we reviewed actually perform comprehensive health planning for areas of from 3 to 11 counties. However, we have generally referred to these agencies by the principal cities within the planning areas. The Health Planning Council of the Eastern Shore, Inc., moved its Office from Salisbury to Cambridge, Maryland, in February 1973. To avoid confusion, we have continued to refer to it as Salisbury.

CHAPTER 2

PURPOSES AND FUNCTIONS OF CHP AGENCIES

PURPOSE OF CHP PROGRAM

The program's primary purpose is to promote adequate health care for all persons through effective and efficient use of all health resources.

In their reports on the enabling legislation, the Senate Committee on Labor and Public Welfare and the House Committee on Interstate and Foreign Commerce expressed concern over the inadequacies of the Nation's health care delivery system in meeting the health needs of all the people. They recognized that uncoordinated efforts by Federal, State, and local governments and private and voluntary interests resulted in gaps in health service coverage and wasteful fragmentation and duplication of scarce health resources. The committees stressed the need for directing the federally assisted health programs to State and local health needs and priorities as determined by State and local agencies.

In establishing the CHP program, the Congress concluded that insuring high-quality care for everyone would require the collaboration of all elements of the health industry--government, private and voluntary groups, and consumers--and the marshaling of all Federal, State, and local health resources.

HEW statistics show that total national health expenditures have almost doubled and Federal Government health expenditures have quadrupled since the CHP program was established in 1966.

National Expenditures for Health

	<u>Fiscal Year</u>		<u>Increase</u>
	<u>1966</u>	<u>1972</u>	
	-----(billions)-----		
Federal Government	\$ 5.4	\$21.6	\$16.2
State and local governments	5.4	11.3	5.9
Private	<u>31.3</u>	<u>50.5</u>	<u>19.2</u>
Total	<u>\$42.1</u>	<u>\$83.4</u>	<u>\$41.3</u>

In hearings on the health care crisis in America, held in 1971 by the Subcommittee on Health, Senate Committee on Labor and Public Welfare, the Subcommittee Chairman indicated that the Nation's health care industry had failed to meet the needs of the people and described it as "the fastest growing failing business in the Nation." He said that health care in America continues to be plagued by high costs, inconsistent quality, inefficient organization and delivery, and scarcity of health manpower.

HEW, in a health policy statement issued in 1971, stated that the United States ranked below other nations on several measures of the national health status and that factors contributing to the health care crisis included:

- Socioeconomic status and geographic location deny many people access to needed health care.
- Health care costs have far outstripped the increase in the cost of living.
- Poor organization, management, and financing of the health care system has resulted in inefficient and ineffective use of scarce health resources and contributed to higher health care costs.

In its report on the enabling legislation, the House Committee on Interstate and Foreign Commerce described the CHP program as follows:

"* * *[Comprehensive health planning] would not supplant existing planning mechanisms in specialized programs. For example, hospital and other health facilities construction programs, mental retardation programs or construction of community mental health centers. Rather, [it] is designed to help bring order into the Statewide health planning process, which is now spotty and fragmented. It would provide, for the first time, resources to measure and understand the special health needs of each of the States and would make it possible to establish priorities for meeting these needs.

"Comprehensive health planning is necessary to link up existing and varied health program planning activities. It is a continuous process and not limited to a particular set of disease entities, to a segment of the health services system, or to a collection of health programs. Comprehensive health planning can provide the mechanism through which--

"All health planning can be linked and strengthened and clear purpose secured;

"Health status can be measured, goals and objectives defined, priorities set, and actions planned for;

"Service, manpower, and facility needs can be identified and interrelated; and program accomplishments assessed."

FUNCTIONS OF CHP AGENCIES

Legislation and HEW guidelines generally permit State and areawide agencies to carry out their planning missions in their own ways, according to their own priorities and needs. According to HEW guidelines, the CHP process involves

- identifying health needs and assessing available resources for meeting these needs;
- establishing goals ,and objectives showing unmet health needs;
- assigning priorities for meeting health needs through available or new health resources;
- developing current and long-range policy and action recommendations for meeting identified health needs through public, voluntary, or private efforts; and
- developing criteria for evaluating health programs and their contributions toward attaining established health goals and objectives.

Recommendations produced by this process are to form the bases for developing comprehensive health plans.

HEW guidelines indicate that the functions of State and areawide agencies also include

- promoting coordination among public, voluntary, and private agencies and groups concerned with health and health-related activities;
- planning and assisting health agencies and organizations in planning for specialized or short-term health activities;
- reviewing and commenting on health projects and plans proposed by other health agencies when requested or required under Federal or State law; and
- reviewing and approving health facility construction when provided by State legislation.

Comprehensive health plans

Before a CHP agency can develop a comprehensive health plan or effectively perform its review and comment and review and approval responsibilities, it must assess area health needs.

In a previous review¹ we found that in responses to a questionnaire on health facilities:

- Less than half of 163 health planning agencies (131 of which received some funds under section 314(b) of the Public Health Service Act) indicated knowledge of 1972 needs for types of inpatient and extended and ambulatory care facilities and beds.
- The number knowing 1975 bed needs was even lower.
- Most knew the number of existing health facilities.

A recent Comprehensive Health Planning Service draft of performance criteria for areawide agencies describes the planning process and related health plan as follows:

"The health plan is a statement of the areawide long-range goals and policies, their translation into action recommendations and the definition of activities required to achieve the implementation of these recommendations. The plan consists of a description of the current health needs and delivery components of the geographic area, the recommendations for changes in the health care delivery system and the delineation of alternative courses of action required to meet the future health needs of the area.

"The plan should be seen as a flexible, revisable, public document. It should be comprehensive and developed from a process that considers the broad range of factors that influence health--physical, mental and environmental. It should be areawide and take into account the health problems and needs of all geographic, social, cultural, economic, and educational segments of the community. In doing this broad community input and support should be solicited.

¹"Study of Health Facilities Construction Costs" (B-164031(3), Nov. 20, 1972).

"The plan will normally be developed in increments moving toward comprehensiveness. The 'first draft' might contain only a framework of the system of health services which a community desires to develop over time along with a description of service resources and needs identified as its priority areas of concern. As the planning process evolves, the health planning council with staff assistance and community input should refine and broaden its plan. The number, use, and accessibility of health services should be evaluated. Health services needs should be more rigorously identified and projected. Objectives and recommendations for action should then be developed."

Our review showed that, nationally, few State and areawide agencies had actually prepared comprehensive health plans. A private health consultant's report stated, however, that most CHP agencies were developing such plans, though little agreement existed as to the nature, purpose, or content of the plan document. On the basis of information provided by private consultants studies and our interviews with HEW officials, it appears that the prepared plans are not comprehensive in scope and are so general they cannot be used in making decisions or recommendations.

Of the CHP agencies we reviewed, only the California State CHP agency and three areawide agencies (two in California and one in Maryland) had prepared health plans, all of which need refining and revising before they can be used for implementing actions. The Salisbury areawide agency was in the organizational phase at the time of our review. (See ch. 3 and app. II for additional information on plan development.)

Review and comment

Through Federal laws and HEW program regulations and guidelines, CHP agencies have been given review and comment responsibility for various health programs financed by HEW and other Federal agencies. In addition, Office of Management and Budget Circular A-95 requires that CHP agencies review and comment on applications for financial assistance

for health-related projects under certain Federal programs before the applications are submitted to the responsible Federal agency. CHP agencies are also requested occasionally to comment on projects not covered by these requirements. The purpose of the review and comment is to insure that proposed projects are consonant with the goals, priorities, and needs of the local community as seen by the CHP agencies and to assist Federal agencies in making this determination.

A private consulting firm under contract with HEW completed a study in November 1972 of areawide agency performance of review and comment functions. The firm collected plans, procedures, and criteria that 109 areawide agencies used as guides in review and comment functions and assessed the completeness and quality of documentation available. The study concluded that, in general, the completeness and quality of documentation reviewed was only fair and recommended that:

- The agencies begin immediately to develop quality baseline areawide comprehensive health plans. The plans should be supported by supplementary documentation articulating and defining review and comment procedures and identifying evaluation criteria for assessing project applications.
- HEW strengthen and refine its review and comment guidelines.
- Regional directives implement these improved guidelines as soon as they are established.

Review and approval

CHP agencies' review and approval responsibility for health facility construction projects comes through certificates of need legislation, which is enacted by the States primarily to insure that health facilities are properly distributed and to prevent unneeded facilities and services. There is little uniformity among these laws, but they all include CHP agencies in the certification process through the review and approval function. This allows agencies to prevent unnecessary construction of health facilities and to

direct (i.e., by proposing alternate actions) available financial and other resources to areas of greater health needs. For example, an agency could disapprove a hospital's proposed construction of additional bed space by suggesting that the available resources be used to improve outpatient services.

Because the judgments of need must be sound and legally defensible, the review and approval function--as well as the review and comment function--makes it imperative that CHP agencies develop formal health plans and other criteria upon which to base decisions on the need for health facility construction or other changes in the health care delivery system. Unless the CHP agencies develop such plans and criteria, their judgments are subject to challenge.

As of February 1973:

- 21 States had enacted certificate of need legislation giving CHP agencies varying degrees of control over construction of health care facilities.
- 7 States had legislation pending.
- 6 States had drafted legislation.
- 10 States had considered but had not passed legislation.
- 5 States had taken no action.
- North Carolina's legislation had been declared in violation of the State constitution.

Of the three States included in our review, Maryland and California have enacted certificate of need laws and in both States the certificate is a requirement for licensure.

Further controls over constructing hospitals and other health facilities were established recently by a provision in Public Law 92-603, which amended title XI of the Social Security Act and which will be administered by the CHP Service.

Under this law, operators of health care facilities will not be reimbursed by Medicare, Medicaid, or the Maternal and Child Health programs for depreciation, interest, or return on equity capital (for proprietary facilities) for capital expenditures not first recommended by a designated State agency. The law applies to capital expenditures which exceed \$100,000, change the bed capacity of the facility, or substantially alter the services provided.

The law provides that the State planning agency designated by the Governor shall inform the Secretary of HEW of proposed capital expenditures by or for health facilities or health maintenance organizations which are inconsistent with plans for meeting the communities' facilities needs. The designated agency may be the State CHP agency; however, if it is not, the designated agency must consult with the State CHP agency before it makes a recommendation to the Secretary of HEW. The appropriate areawide agency will also have an opportunity to participate in the review process. An appeals mechanism is provided for at both the State and Federal levels. In California, Maryland, and Ohio, the State CHP agencies have been designated to make the reviews required by Public Law 92-603.

For this legislation to be fully effective, the designated review agency must, in our opinion, develop a sound plan for health facility needs. Without it, the agency may be unable to adequately defend decisions which are appealed.

CHAPTER 3
ORGANIZATION, ACTIVITIES, AND IMPACT
OF CHP AGENCIES

ORGANIZATION AND ACTIVITIES

The CHP program authorizing legislation provides that (1) the activities of designated State CHP agencies be guided by advisory councils composed of providers and consumers of health services, with a majority of consumers and (2) the areawide agencies, which may be either public or private nonprofit organizations, have health planning councils composed of providers, local government representatives, and consumers, with a majority of consumers.

HEW guidelines provide that (1) consumer volunteers on CHP boards and councils be socioeconomically and geographically representative of the areas covered by the agencies, (2) councils may be organized in administrative and planning committees to assist in planning activities, (3) areawide agencies may also have subarea or county councils, and (4) State and areawide agencies have directors and sufficient staffs to carry out their responsibilities.

HEW guidelines do not prescribe how agencies are to assess health needs and make and implement recommendations for meeting those needs nor what constitutes sufficient staffs to perform such functions. The guidelines state that agencies should adopt a planning process which will yield complete and periodically revised comprehensive health plans, including (1) statements of broad health goals, (2) identification of health needs, (3) assessments of available resources for meeting needs, and (4) assignments of priorities and recommendations for meeting health needs. No time frame for completing such plans is suggested. The guidelines state, however, that, in developing comprehensive health plans, it is not expected that all agencies will use identical planning methods or schedule their activities uniformly.

Although the agencies we reviewed had some organizational similarities, the ways they approached planning responsibilities, assessed needs, and gave priorities to developing health plans varied considerably. Their organizations and planning activities centered around advisory councils and working committees made up of volunteers. These groups were assisted by professional staffs, which agency officials considered to be too small to effectively carry out agency responsibilities.

Attendance at council meetings for most agencies reviewed was generally less than 50 percent, and only two agencies had consumer majorities attending half their meetings. The councils were not always geographically and socioeconomically representative, and the California State and Baltimore areawide agencies' councils did not have the required consumer majorities.

The extent to which the agencies had mature working committees making a contribution to the planning varied. Some agencies had committees still being organized or inactive even though the agencies had been operational for several years.

We were told that the use of volunteers for council and committee activities was hindered by the fact that they did not have the time, or sometimes the interest, to get involved in CHP activities. A lack of knowledge of the planning process and the health care delivery system was also cited as impeding volunteer participation.

Some areawide agencies had significant problems raising the required local matching funds. This activity requires much staff and volunteer time and affects the agencies' abilities to recruit and retain qualified staffs. The Maryland agencies did not have fund-raising problems because the State contributed most of the local matching funds. Most of the agencies, however, stated that they did not have sufficient overall Federal and local funds to provide staffs necessary to assist the volunteer councils and committees. Also, some donors had stopped or reduced contributions, or threatened to do so because of positions taken by the agencies.

One State and three areawide agencies had developed comprehensive health plans, but these plans needed refining and revising before they could be used for implementing actions. Also, an effective implementation process was lacking for developed plans.

The other agencies had made little progress toward implementing a planning process or developing comprehensive health plans. Establishing a health planning process and developing related plans had been impeded by shortcomings in available data bases, ineffective working relationships between State and areawide agencies, and geographic makeup of planning areas. The geographic problems may be best exemplified by the problems of the Cambridge, Ohio, agency. (See p. 77.)

The control functions (review and comment or review and approval) of CHP agencies, although resulting in beneficial impacts on the health care delivery system, were sometimes performed without following systematic procedures and without being based on developed plans. Some agencies were not aware of projects they should be reviewing and were not always given opportunities to comment on proposed federally funded health projects.

Appendix II describes in detail the agencies' organizations and activities. It provides further insight into their difficulties in establishing viable planning organizations and their progress and problems in carrying out responsibilities.

IMPACT

All the CHP agencies reviewed have had some beneficial impacts on the health care delivery system. However, we found that the areawide agencies had more visible impacts than the State agencies which had been involved heavily in developing areawide agencies and in other administrative matters.

Most agency impact has come from (1) fulfilling responsibilities to review and comment on projects for delivery of health services, (2) performing review and approval functions for health facility construction, and (3)

reacting to health problems brought to their attention by various sources rather than through a systematic planning process.

As stated previously, comprehensive health planning is intended to promote adequate health care for all people through effective and efficient use of all health resources. HEW guidelines stipulate that health planning is of little value unless changes occur in the health care delivery system and that CHP agencies should:

- Concentrate on high priority issues.
- Develop and seek adoption of recommendations to modify health services.
- Adopt a role of advocate or mediator, acting in the public's interest.
- Mobilize the influence and power to improve community health.

Since they generally have little authority to control the health care delivery system other than through approving facility construction in States having certificate of need legislation, CHP agencies must act as catalysts to induce other organizations to adopt their recommendations. Therefore the extent of CHP involvement is not always obvious. The following examples were compiled to show the types of impact CHP agencies have had.

Proposed construction stopped

Overbuilding of health facilities in some areas has been a major cause of rising medical costs, resulting in underused beds and services, the costs of which are passed on to the consumer. California and Maryland agencies, through their States' certificate of need legislations, have prevented some unneeded construction. For example:

- From July 1970 through November 1972, the Maryland State CHP agency disapproved four construction projects valued at \$10.8 million.

- In calendar years 1970-72, California areawide agencies stopped the addition of about 2,700 of 23,200 proposed hospital beds. One areawide agency stopped the addition of 638 of 1,988 proposed beds for the area and cut capital costs by an estimated \$24 million.
- During a 3-year period, a California areawide agency advised proponents of 12 projects, involving about 1,000 beds, that the beds were not needed. Accordingly, applications for these projects were not submitted. Another California areawide agency told us of 16 proponents that were similarly discouraged. The California State agency reported that at December 1972 proponents of about 13,000 total new beds had been dissuaded from applying.

Although Ohio did not have similar legislation, a moratorium precluding unnecessary acute-care hospital bed additions was agreed to through cooperation between hospitals and an areawide agency. This agency also persuaded two hospitals to limit previously approved bed additions. A privately owned hospital in another area voluntarily submitted its construction plans to the Ohio State agency and, at the agency's recommendation, reduced construction costs by about \$2 million and expanded outpatient services.

Previous GAO review

Our November 20, 1972, report to the Congress entitled "Study of Health Facilities Construction Costs" (B-164031(3)) stated that some health planning agencies had been effective in preventing construction and expansion of unneeded health care facilities. These observations were based on answers to questionnaires sent to 208 health planning agencies, 157 partially funded under section 314(b) of the Public Health Service Act, as amended.

The report pointed out that the 175 agencies--140 of which were areawide 314(b) agencies--responding to the questionnaire reported 79 examples when unnecessary construction was prevented and 36 examples when it was not. The agencies also reported 52 examples of stopping proposals

which, if implemented, would have duplicated highly specialized equipment and facilities, such as are used for open-heart surgery and renal dialysis.

Proposed construction or services modified

Construction approvals by California and Maryland agencies were often contingent on proponents' modifying planned construction or service. For example, in California:

- An areawide agency's recommendations to 16 hospitals for improving service were generally accepted. For example, one hospital hired a Spanish-speaking pharmacist to better serve Mexican-American patients and another hospital added staff to its obstetrics-gynecology department.
- Another areawide agency's reviews indicated that a hospital's facilities were already adequate, so proposed additional renal dialysis units were not installed.

In Maryland, over a 29-month period the State agency approved, with modifications, 29 projects valued at about \$129.3 million. The required modifications included

- eliminating unnecessary equipment, facilities, and services;
- improving accessibility for the medically indigent and minorities; and
- making services and programs more comprehensive.

New health services to meet community needs

With about \$85,000 provided by HEW, an areawide agency subcontracted with local organizations to develop proposals for a comprehensive range of health services in three areas. As a result, outpatient centers were established in two of the areas. Other efforts that agencies initiated to meet community health needs include:

- An areawide agency identified the need for a communications network as the initial step in developing an areawide emergency medical system. Therefore it obtained a 2-year, \$1.2-million grant from HEW to create a nonprofit corporation for improving communications.
- As a result of a report issued jointly by an areawide agency and a State CHP agency, a resort area medical commission established three first-aid stations, drafted a disaster plan, and began legal work to create a corporation to promote better health care in peak tourist seasons.
- An areawide agency persuaded the Model Cities Program to provide \$200,000 to a city hospital for a needed emergency care facility.
- An areawide agency worked with three other local health agencies to provide a mobile clinic in a county served by only one physician.

Existing services made more efficient or economical

One areawide CHP agency brought officials of seven family planning agencies together, and they formed a family planning council which developed joint purchasing and data collection. On the recommendation of another areawide agency, a county government started requesting competitive proposals before contracting for county-sponsored mental health services.

Proposing and supporting legislation

CHP agencies took actions to propose and support legislation. For example:

- A committee of Ohio State agency and areawide agency representatives drafted recommendations for certificate of need legislation which, if enacted, would have given the State CHP agency authority to approve proposed facility construction or modification.

- The Maryland State CHP agency cooperated with other interested groups in developing legislation which created a State commission to certify the reasonableness of charges and to specify a uniform system of accounting at specified types of hospitals and related facilities.
- An areawide agency analyzed votes by the State legislature and contacted delegates responsible for defeating a bill extending CHP agency approval authority over health facility construction to proprietary nursing homes. Subsequently, the bill was reconsidered and passed.

Improving access to existing services

On the basis of recommendations in an areawide agency study, a major hospital in an urban low-income area arranged for bus service to the hospital for area residents and another hospital in the area expanded its outpatient services. Community groups, using data an areawide agency collected, demonstrated where transportation to health facilities was deficient and obtained improved transportation.

Increasing health manpower

An areawide agency assisted in convincing a local university to make it easier for licensed vocational nurses to become registered nurses. Two State agencies helped to secure the designation of organizations to coordinate the States' programs for placing former military corpsmen in civilian doctor assistant positions.

Improved communications between providers, consumers, and governments

CHP program officials stated that much CHP impact was not describable by example but was exhibited in the climate of cooperation the CHP program created among formerly antagonistic interests. In almost every agency we visited, CHP served as a forum for discussion and improved understanding between providers, consumers, and government interests and assisted in educational efforts. For example:

- In conjunction with another group, an areawide agency prepared a report for the public about the need to improve sanitary waste-water disposal.
- An areawide agency issued a press release urging controls over sewage from camping vehicles.
- In a brochure entitled "Why Health Education?" an areawide agency made recommendations for improving health education in public schools.
- An areawide agency helped develop a workshop on emergency treatment of athletic injuries and produced a film on home nursing care.

CHAPTER 4

HEW MANAGEMENT AND GUIDANCE

HEW has provided only limited guidance and technical assistance to State and areawide CHP agencies primarily because of insufficient staffing and the desire to not interfere with the performance of health planning which HEW considers to be State and local functions. As a result, progress made by CHP agencies in organizing viable organizations and establishing processes for developing and updating health plans has varied considerably.

Although the CHP Service is responsible primarily for the CHP program, many of its monitoring responsibilities have been delegated to the 10 HEW regional health directors. The Service has no direct authority over the regional office staffs but is expected to provide general guidelines for carrying out CHP program responsibilities.

HEW HEADQUARTERS

We found that the CHP Service had done little to provide program leadership, maintain liaison with other Federal agencies and national organizations, provide technical assistance to HEW regional offices, or assess the progress of State and areawide agencies, primarily for the reasons stated above. As of January 1973 the Service was authorized 27 permanent employees, including 8 secretarial or nonprofessional positions. HEW, in commenting on this report, advised us that the Department had increased the CHP Service staff by 15 and had authorized an additional number of positions when the Service was given responsibility for administering section 1122 of the Social Security Act.

Service officials acknowledge that, during the early years of the CHP program, they had provided little technical assistance or direction to the agencies. Regulations and guidelines were issued, but few requirements were placed on the agencies, and these had not always been enforced. For example, HEW guidelines for State CHP agencies state that a comprehensive health plan should be developed; yet, the Service has not required that State agencies develop health

plans or set a time frame for developing them. HEW Region V, however, told the Ohio agencies to develop plans within a specified time frame.

The former Service Director stated that, without trying to defend the earlier low profile maintained by headquarters, the lack of direction might have been justified. He based this on the fact that, to demonstrate that CHP was a partnership and that the planning process and determination of health priorities was a matter for State and local decision, HEW headquarters allowed the agencies time to organize and plan in their own ways. He pointed out that staffing at headquarters and in the regional offices had been insufficient to provide much assistance.

Officials of most State and areawide agencies we visited stated that they needed, but had not received, technical assistance from HEW. Some also stated that comprehensive health planning had not had the visibility at the Federal level needed to demonstrate at the local level the importance of such planning and that CHP administration should be at a higher Federal level.

CHP evaluations

Until recently, HEW headquarters evaluations of the performance of State and areawide CHP agencies have consisted primarily of funding special studies by private consulting firms. Between January 1971 and February 1973, seven such studies were completed, six for the CHP Service and one for the National Center for Health Service Research and Development. Several non-Federal-funded studies of the program had also been made.

We discussed the use made of these studies and actions taken on their recommendations with HEW headquarters and regional offices and, except in one region, were told that no specific action had been taken as a result of any of the studies. Officials stated, however, that all the studies were useful to varying extents as background information. They added that a report on expectations for CHP agencies and one on assessing documents that areawide agencies used as guides in review and comment functions were particularly helpful in developing an agency assessment program and

review and comment guidelines. The Service distributed the review and comment guidelines to the agencies in February 1973. We were also told that the report on expectations for CHP agencies had been distributed to the agencies and should be particularly useful to them as principles and as a guide in developing their organizations.

HEW REGIONAL OFFICES

Early in 1970 HEW regional offices were delegated authority to direct and coordinate a comprehensive program to improve the ability of States, communities, and voluntary groups to organize and deliver physical and mental health services. Included within this authority was the administration of the CHP program.

A full-time-equivalent professional staff of about 29 (averaging about three per region) carries out regional office CHP responsibilities. Administration activities of the three HEW regional offices (Regions III, V, and IX) we reviewed follow.

Assistance in planning techniques

The role of regional CHP staffs in program improvement includes technically assisting State and areawide agencies in planning techniques and in organization and grants management. The CHP staffs in Regions III and V provided little or no assistance in developing a planning process. The assistance provided related primarily to organization and grants management. This situation was due, in part, to the lack of capability of the CHP staffs to assist in planning techniques and to their belief that such assistance was not necessary because the areawide agencies were just getting organized.

We reviewed the type of assistance provided to areawide agencies by one regional office CHP staff and found that, during the grant review and monitoring process, the problem areas it identified related primarily to organization and grants management. For example, of 11 deficiency-oriented conditions attached to grants made to areawide agencies for 1972 and 1973, 9 related to such matters as preparing staff

position descriptions and developing proper accounting systems.

Region IX had a 2-man CHP staff and did not have the capability to technically assist the agencies. However, 12 of the 15 areawide agencies in this region are in California, so by combining resources with the California State agency and by hiring a consultant, the staff was able to provide areawide agencies with a planning method. As a result, 8 of these 12 agencies have developed health plans.

As of February 1973, CHP staffs in Regions III and V had not evaluated agency performance because of insufficient staff and because the CHP Service had not provided performance criteria. However, Region V hired a consultant to evaluate the performance of one areawide agency at the insistence of the agency's board of directors. The evaluation disclosed numerous operational deficiencies. Because of funding constraints, this regional office plans no similar evaluations.

In contrast, Region IX by using consultant services had developed an evaluation model for areawide agencies which encourages their performance by providing for allocating funds on the basis of their accomplishments. These include plan development, application review, policy recommendation, problem identification, program analysis, interagency coordination, conflict resolution, education, public information, community mobilization, data system maintenance, and administration. The model had been in use only in calendar year 1973, so we could not determine whether it would effectively evaluate areawide agency performance.

Review and monitoring

Region V review and monitoring activities were ineffective because of insufficient staff, inadequate grant administration, and an effort to maintain a low-key posture. By comparison, Region IX, with limited CHP staff, appeared to be more effective because of its extensive cooperation with and reliance on the review and monitoring activities of the California State CHP agency.

Region V reviews of areawide agency grant applications highlighted only the deficiencies, with little or no written analysis of agency work programs. A CHP staff member told us that some of the reviews were not meaningful because they were made within the regional office by other personnel who either had little insight into the areawide agency activities or were too busy to make adequate reviews. For example, a review of one areawide agency application cited no weaknesses and made no constructive criticism. Instead, the reviewer merely recapped basic application data, such as the amount of the application, budget period, and sources of matching funds. We believe that review of areawide agency applications should, as a minimum, include analyses of the merits of the proposed work programs.

We found that the regional CHP staff maintained contact with areawide agencies through personal visits and telephone discussions, but because documentation was lacking, we could not determine the purpose of the visits or any agreements reached with the agencies. Therefore we could not determine whether the CHP staff should have been aware of some agencies' lack of compliance with conditions of grant awards. For example, an areawide agency entered into contracts without prior approval of the regional office, even though the grant award required such approval. We found no indication that the regional office knew of this situation. In one instance the regional office gave approval after the contract had been completed.

Also in this regional office the philosophy of the CHP staff toward requiring compliance with the conditions of an approved grant award was not logical. We were told that compliance with such conditions was not required because CHP policies and regulations had no such requirement. In approving a 1972 grant application for one areawide agency, this regional office included as a condition the requirement that the agency develop a system of self-evaluation. This condition is made a part of the grant award when the CHP staff believes the areawide agency has limited its scope of planning, such as concentrating on facilities planning rather than comprehensive health planning. This agency did not develop a self-evaluation system. Even though the regional office knew this, it approved the agency's 1973 grant with no mention of this matter.

In contrast, Region IX relied heavily on the California State agency staff to assist in reviewing areawide agency applications. The process, which appeared to be very comprehensive, included three phases of review and evaluated common CHP functions against a model developed by a consultant. The results of the State review, in which the regional office CHP staff participated, were subsequently discussed with areawide agency staffs. The regional office then completed its own evaluations of the areawide agencies' applications. The close coordination of the regional office and State agency staffs generally resulted in agreement on conditions which were attached to each areawide agency grant award.

We also found that this regional office made a major effort to have areawide agencies meet conditions of their grant awards. For example, in our review of 5 areawide agency applications, we found that 16 of 20 conditions attached to their 1972 grant awards had been fulfilled as of December 31, 1972.

In Region III, the areawide agency grant applications were reviewed by the regional CHP staff and distributed to the regional health director, various regional program directors, and consultants for their comments. Many questions and comments were discussed at a joint meeting of representatives of the HEW regional office, the State agency, and the applicant. A regional review committee, consisting of the regional health director and regional program directors, made final decisions on applications. These procedures appeared to be adequate for determining whether the applications should be approved.

HEW headquarters has recently recognized the need for providing guidance and technical assistance to its regional offices and to State and areawide agencies and is developing (1) a management information system to provide information to HEW headquarters and regional offices on the status of State and areawide agency planning and (2) an agency assessment program, including performance criteria, site visits to agencies, and technical assistance to correct problems noted during the site visits.

In March 29, 1973, letters to the President of the Senate and the Speaker of the House of Representatives, the Secretary of HEW recognized the weaknesses of CHP agencies and the need for improved HEW management of the program. (See p. 11.)

MANAGEMENT INFORMATION SYSTEM

This system, called the agency program reporting system, is designed to provide HEW headquarters and regional office staffs with data required for reviewing and analyzing the program's progress. The data should also enable HEW to assist and direct State and areawide CHP agencies.

Inputs from State and areawide agencies will create the data base for the system, and each agency will be required to furnish and update data annually or semiannually. HEW regional offices will be responsible for monitoring the input.

The system will include (1) a State and areawide agency module, which will include information on organization, staffing working relationships, and planning, and (2) a planning information library, which will provide a quarterly updated bibliography of health-planning literature.

AGENCY ASSESSMENT PROGRAM

This program, which the CHP Service began developing in 1972, consists basically of detailed performance criteria, training of site visit teams, assessing CHP agencies on the basis of the developed criteria, and providing technical assistance to correct deficiencies. The Service also expects that the performance criteria will be used by the agencies for self-evaluation and by the States and HEW regional offices during the annual review of the areawide agencies grant renewal applications.

The Service originally intended that, depending on the availability of funds, site assessment teams would visit 10 areawide agencies in fiscal year 1973 and that performance criteria for evaluating State CHP agencies would be developed by September 1973, with site assessments of the State agencies to begin shortly after that.

Each site assessment team for areawide agencies was expected to comprise four to six people, including representatives from HEW headquarters, the administering HEW regional office, the State CHP agency, and an areawide agency in the region.

The assessment process was expected to consist generally of a (1) 2-day preassessment visit to explain the purpose, objectives, and process of the assessment and followup procedures, (2) 1-week assessment visit, (3) report to the agency on accomplishments and problems within 1 week after the visits, and (4) 2-day implementation visit to develop an action plan, including identifying any technical assistance needed.

We reviewed the criteria developed from this assessment program and found that functions covered by the criteria were clear and specific as to agency expectations, yet general enough to apply to all agencies. For example, for the required preparation of a work program, the criteria state that it must (1) divide work by agency function, delineate the tasks required, and describe the resultant product, (2) clearly delineate who is to do specific work, (3) indicate time allocated to specific tasks and specify the deadline for product delivery, and (4) spell out other resources required, such as consultants, and indicate how they will be used.

We discussed the results of our review with HEW officials and expressed our concern that the expected level of effort (10 agencies to be assessed in fiscal year 1973) was insufficient to assess the 56 State and 198 areawide agencies within a reasonable period. Soon after this, we were informed that, because of the interest expressed by the Office of the Secretary of HEW, additional personnel were being assigned so that all the State CHP agencies and the approximately 150 areawide agencies in the planning stage could be assessed and given technical assistance by June 30, 1974. The Director of the CHP Service advised us that he envisioned the assessment program as a continuing program and not a one-time effort.

The agency assessment program does not include those agencies receiving organizational grants. While agencies

are in the organizational phase, they carry out such developmental activities as establishing committees and relationships with other organizations and obtaining community support, financial and otherwise. We believe that, before an agency is advanced from the organizational to the planning phase, HEW should assess it to insure that the agency is properly organized and able to carry out its CHP responsibilities. Priority should probably be given to agencies already in the planning phase, but we believe the assessment programs should be expanded to include the pertinent agency organizational activities, including the developed planning process, before the agencies advance to the planning phase. The Director of the CHP Service advised us that the assessment program would be expanded to include agencies in the organizational phase.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

ORGANIZATION AND ACTIVITIES

As discussed in chapter 3, the organization and planning activities of the agencies reviewed centered around advisory councils and working committees comprised of volunteers. These were assisted by professional staffs which agency officials considered to be too small to effectively carry out agency responsibilities.

The advisory councils for the California State and the Baltimore areawide CHP agencies did not have the required consumer majorities. Also, of the 96 council meetings we analyzed, consumers represented a majority at only 35. Attendance at the council meetings for most of the agencies reviewed was generally less than 50 percent, and only two had consumer majorities attending half the meetings. The councils were not always geographically and socio-economically representative, as indicated by the absence of racial and ethnic minorities of the California council, for example.

For the agencies reviewed, a few had relatively mature working committees contributing to the planning effort while others had committees still being organized or inactive even though the agencies had been operational for several years. Also, provider representation dominated some of the committees.

Using volunteers in CHP activities enhances the necessary community commitment to the program to make health planning the partnership arrangement envisioned by the Congress in enacting CHP legislation, but it has made the decisionmaking process inherently cumbersome and slow. We were told that the use of volunteers was hindered by the fact that they do not have time, or sometimes the interest, to get involved in CHP activities. A lack of knowledge of the planning process and the health care delivery system was also cited as impeding consumer volunteer participation.

Some areawide agencies we reviewed had significant problems raising the required local matching funds. This

activity requires much staff and volunteer time and also affects the agencies' abilities to recruit and retain qualified staffs. The Maryland agencies did not have the fundraising problems because the State contributed most of the local matching funds. Most of the agencies, however, stated they did not have sufficient Federal and local funds to provide staffs necessary to assist the voluntary councils and committees. Also, some donors stopped or reduced contributions or threatened to do so because of positions taken by the agencies.

One State and three areawide agencies had developed comprehensive health plans, but these plans needed refining and revising before they could be used for implementing actions. Other agencies had made little progress toward implementing planning processes or developing comprehensive health plans.

However, all the CHP agencies reviewed had had some beneficial impact on the health care delivery system. Areawide agencies had more visible impact than State agencies which had been involved heavily in developing areawide agencies and in other administrative matters.

Most agency impact had come from (1) fulfilling responsibilities to review and comment on projects for delivery of health services, (2) performing review and approval functions for health facility construction, and (3) reacting to health problems brought to agency attention by various sources rather than through a systematic planning process. Examples of impacts resulting from a systematic planning process were scarce. The control functions (review and comment or review and approval), although resulting in beneficial impacts on the health care delivery system, were sometimes performed without being based on developed plans.

Review and comment functions generally were not effective because:

- Requirements were disjointed and the agencies were not always aware of projects they should have been reviewing.

- Some agencies were not always given opportunities to comment on proposed health projects.
- Some agencies had not developed guidelines or criteria on which to base their comments and, since some agencies had not assessed needs, they had no effective basis on which to determine needs for specific projects.
- Some agencies had been reluctant to comment adversely on projects that would bring Federal funds into communities, regardless of need.
- One agency had problems in providing objective and independent comments on proposed projects.

HEW MANAGEMENT AND GUIDANCE

As discussed in chapter 4, HEW assistance to State and areawide agencies in planning techniques has been lacking, and HEW has not always effectively performed its review and monitoring responsibilities because of insufficient staff and the desire to not interfere with functions considered to be State and local matters. We believe, however, that HEW's agency assessment program should result in agencies' receiving the needed guidance and technical assistance and, as a continuing program, should serve as an effective management tool.

We believe that, if agencies are objectively assessed on the basis of the developed criteria, their primary problems can be identified and corrected. The revised schedule for assessing the agencies will give HEW a timely basis for determining agencies' ongoing needs and, maybe more importantly, determining whether the CHP program can become a viable nationwide program able to substantially improve the health care delivery system.

The assessment program should also identify CHP agencies having organizational and planning problems caused by the geographic makeup of planning areas and possible methods of alleviating these problems. However, the assessment program should be expanded to include areawide agencies receiving organizational grants before they reach the

planning phase, to insure that such agencies are properly organized and able to carry out CHP responsibilities.

RECOMMENDATIONS

We recommend that the Secretary of HEW direct the Comprehensive Health Planning Service, in carrying out the agency assessment program, to develop recommendations for legislative or administrative action to alleviate the following problems.

- Sources of matching funds and difficulties encountered in raising the required amounts.
- Lack of staffs.
- Selection and participation of volunteers in planning activities.
- Geographic makeup of planning areas.
- Proper relationships between State and areawide agencies.
- Performance of control functions without sound criteria and systematic procedures.
- Agencies' not being given opportunities to review and comment on proposed Federal health projects.
- Shortcomings in data bases available to State and areawide agencies.
- Lack of implementation processes for developed recommendations.

We further recommend that the agency assessment program be expanded to include the areawide agencies receiving organizational grants before the agencies advance to the planning phase.

AGENCY COMMENTS

By letter dated December 14, 1973 (see app. I), HEW said that this report would provide the Congress with a realistic picture of the CHP program nationwide as of the time the materials for the report were collected but that the following steps had been taken to strengthen the program.

1. In October and November 1973 performance standards for State and areawide agencies were developed and distributed as part of an effort to improve the agencies' performance of comprehensive health planning.
2. The agency program reporting system (see p. 38), which has been undergoing development for over 2 years, would be implemented soon.
3. The CHP Service created an office of Planning Technology to develop new methodologies to assist the agencies to plan more effectively.
4. The Department increased the CHP Service staff by 15 toward the end of fiscal year 1973. An additional number of positions were authorized when the CHP Service was given responsibility for administering section 1122 of the Social Security Act.

HEW agreed with our recommendations and stated that the CHP Service was already working toward alleviating many of the problem areas. HEW also advised us that the Department was working on a legislative proposal which would affect the future of the CHP program.

The three State and six areawide agencies reviewed were given an opportunity to comment on our findings. Their comments have been considered in this report.



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

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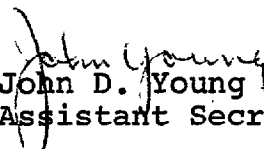
Mr. Willis L. Elmore
Assistant Director
Manpower and Welfare Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Elmore:

Enclosed are the DHEW comments on the draft of a proposed report prepared by the General Accounting Office on comprehensive health planning.

We appreciate having had the opportunity to make these comments and to meet with representatives of the General Accounting Office to discuss the report.

Sincerely yours,


John D. Young
Assistant Secretary, Comptroller

Enclosure

APPENDIX I

This report will provide the Congress with a realistic picture of the comprehensive health planning program nationwide as of the time that the materials for the report were collected, but it must be pointed out that much has happened since then in terms of steps taken to strengthen the program.

The CHPS has developed with consultation from the health planning field and distributed performance standards for both State Health Planning Agencies (November 1973) and Areawide Health Planning Agencies (October 1973) to define the roles and responsibilities (or functions) of these agencies. The standards have been developed as part of an effort to improve the performance of comprehensive health planning in the nation. Each State and areawide comprehensive health planning agency is expected to meet the defined standards which are being used as assessment criteria in the agency assessment process now taking place throughout the country. The Agency Development Plan produced as a result of the assessment process will describe how the agency plans to address the standards which are not yet met. It is expected that the direction provided by the standards and assessment effort will help agencies increase their effectiveness.

The Agency Program Reporting System (a program management information system) has been undergoing development for over two years and will be implemented shortly. This system is being developed to fill many of the management information needs of the comprehensive health planning program, and the data collected through the APRS will support such CHPS functions as program planning, program analysis and evaluation, budget formulation

and justification, and public information. In addition, the APRS will provide data to support the major resource development and technical assistance effort.

In order to meet a particular need articulated by the field, the CHPS has created an office of Planning Technology to develop new methodologies to assist the agencies in doing more effective planning. In addition, this Office will be developing standards, criteria, and guidelines to assist the agencies in conducting effective reviews of proposals for new and/or expanded facilities or services.

As a result of the Department's determinations that the CHPS staff should be strengthened in order to manage the program more effectively, 15 additional positions were made available to us toward the end of fiscal year 1973. Also, when the CHPS was given the responsibility for administering Section 1122 of the Social Security Act, an additional number of new positions was authorized.

The problem areas identified in the Recommendations to the Secretary of HEW are quite real, and the CHPS is already working toward alleviating many of them. In addition, the Department is now working on a legislative proposal which will affect the future of the comprehensive health planning program.

ORGANIZATION AND ACTIVITIES

OF CHP AGENCIES

REVIEWED BY GAO

CALIFORNIA STATE CHP AGENCY

Organization

At the time of our fieldwork, California's department of public health was the designated State CHP agency. CHP functions, however, were carried out by a professional staff of 18 within the department and by the State health planning council, which was advisory to the department director. The council was authorized 25 members, 13 consumers, and 12 providers, but because of vacancies, consumers were not in the majority during 1972. Attendance at the council meetings held in 1972 averaged 16, 9 providers, and 7 consumers.

The council had no racial and ethnic minorities until February 1973, when two minority members were appointed.

Effective July 1, 1973, the department of public health was abolished and the new department of health became the designated State CHP agency. In addition, the membership of the advisory council was changed from 25 to 21.

The State advisory council had committees on health facilities, public relations, finance, health services, environmental health, health manpower, and health information systems, consisting of members of the advisory council and other volunteers. Only the health facilities committee has met regularly. Reasons for this appear to be that the State health plan was developed by a task force approach rather than by committees and that plan implementation is being sought through a similar procedure. Also, the State is reorganizing council committees to conform to the organization of the new department of health.

The council's most active committee, health facilities, met five times in 1972. Although membership consisted of 14, attendance averaged only 5 consumers and 4 providers.

According to data provided by the State, of the approximately \$1,619,000 it spent for comprehensive health planning in fiscal years 1971 and 1972, the State provided about \$444,000 and the Federal Government about \$1,175,000.

Activities

Plan development

The State CHP agency's basic planning approach has been to develop a State health plan, refine it, and get it implemented.

Development of the initial State health plan began in March 1970, when the CHP staff and the State health planning council organized a task force for this purpose. The process used to develop the plan consisted of obtaining position papers on a wide variety of issues and creating volunteer committees to review the papers and other data to identify health problems, arrive at recommendations, and set priorities.

Papers on specific health issues were solicited from a wide variety of sources. Each author was requested to discuss the status of his topic and the interrelationship between it and other health problems or issues and to identify alternative recommendations. A total of 124 solicited and unsolicited papers were received.

The papers were then summarized into a list of health goals and ranked according to adopted criteria. Then a draft State health plan was prepared and distributed to individuals and organizations for comment. Also, public hearings on the draft were held.

The State health plan was approved by the State health planning council in May 1971 but as of January 1973 had not been adopted as a guide to spending of State funds or used as framework for developing necessary organizational and legislative approaches for solving health problems.

We were told that the greatest problem in developing the State plan was the lack of complete, accurate, and current information on health needs and available health

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resources. By November 1972 the CHP staff had developed a system for estimating health manpower and facilities needs.

The State CHP staff had initiated a process to obtain implementation of selected recommendations included in the plan. Because of the magnitude of the task, this initial implementation effort was directed toward a manageable number of recommendations. Health and health-related organizations that had participated in the plan's development, areawide CHP agencies, and State health planning council members were asked to assist in selecting recommendations to be implemented from 49 selections submitted. Advisory council committee chairmen and area and State representatives selected the following nine recommendations.

1. Develop health care standards.
2. Improve hospital cost accounting practices.
3. Improve health insurance coverage.
4. Include health components in environmental management systems.
5. Provide nutritious school lunches.
6. Emphasize preventive medicine.
7. Promote early child development services.
8. Develop criteria for facilities and services plans.
9. Review physician manpower.

Staff members were assigned one or more of the recommendations, and study committees comprising State officials and council members, areawide agency representatives, and other health officials were asked to develop methods for implementing the recommendations. The implementing approaches these committees developed, which varied from specific recommendations for actions by State agencies to proposing new State legislation, were then presented in public meetings held in San Diego, San Francisco, and Sacramento to obtain public recommendations and

comments. The Chief of the State CHP staff stated that the next step was to present these recommendations, suggested approaches to implementation, and public comments to the advisory council for action. It was initially intended to repeat the implementation cycle, described above, on a quarterly basis. He stated, however, that the process had been delayed because the State government questioned the propriety of the CHP staff and council going beyond their planning and advisory roles to seek implementation of their plans.

Control functions

California has certificate of need legislation which provides for the 12 areawide agencies to review and decide on the need and desirability of individual proposals for construction or for expanding or altering State-licensed health facilities to increase bed capacities or change license categories.

The State advisory council's role in administering certificate of need legislation is to act as an appeals body for decisions made by areawide agencies. The State CHP agency has issued guidelines to areawide agencies for use in review and approval functions.

The State agency is not heavily involved in the review and comment function because few Federal projects are submitted to it, although required, and only one staff member is assigned to this function. It has reviewed several Federal health program proposals, but a staff official said its comments were generally subjective and were not based on specific criteria.

State legislation authorizes the State CHP advisory council to review all health-related project grant applications for public funds directly or indirectly administered by State agencies, except funds appropriated by the legislature. However, the council has not assumed this responsibility because of its preoccupation with facilities reviews, and, as noted, the State CHP agency has assigned only one staff member to assist the council in this function.

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MARYLAND STATE CHP AGENCY

Organization

The Maryland Comprehensive Health Planning Agency within the Department of Health and Mental Hygiene is the designated State CHP agency. It has a professional staff of 7 and a State advisory council of 21 consumers, 16 providers, and 6 nonvoting members who represent the 6 area-wide agencies.

Attendance at the 8 council meetings held between December 1970 and September 1972 averaged 25, of which 13 were consumers. The consumers represented a majority at four meetings.

Maryland has demonstrated its belief in the need for comprehensive health planning by being one of the first States to appropriate and grant State funds to support and develop both the State agency and areawide agencies. During fiscal years 1970-72, Maryland provided \$307,000 to the State agency and \$245,000 in matching grants to the areawide agencies. In fiscal year 1972, over 55 percent of the State CHP agency funds came from the State.

An executive and five planning committees (plan development, environmental, health services and facilities, health manpower, and areawide development) consisting of advisory council members have been formed to assist the council in carrying out its functions. One staff member is assigned as liaison to each committee. Information was generally not available on attendance at committee meetings. Providers represent a majority on the health services and facilities and the health manpower committees and consumers on the other committees. Information on the status of the planning committees follows.

- The recently organized plan development committee will be responsible for providing more effective council input into development of a State health plan.
- The environmental committee primarily has been identifying State environmental health problems, but its progress has been impeded by insufficient manpower.

- The health services and facilities committee, the advisory council's most active committee, has been involved in numerous studies and projects and in specific certificate of need decisions made by the agency. It has participated in developing plans for (1) State health facilities, (2) chronic kidney disease facilities and services, and (3) a State emergency medical system. It has also participated in preparing a position paper on health maintenance organizations.
- The health manpower committee has been relatively inactive because of poor attendance at meetings by members and insufficient staff support.
- The areawide development committee was initially formed to help organize areawide agencies. Because of the complexities and detailed work involved, however, this was handled by the agency staff. The committee is now working on refining and improving the relationship between the State and areawide agencies.

Activities

Plan development

Maryland State CHP agency activities can best be described as reactive-type planning (i.e., reacting to problems brought to its attention) while trying to establish a planning process which will result in developing and documenting a health plan.

Its decision to finally develop a written plan, after being operational for more than 4 years, appears to have resulted from pressure by the State legislature and the HEW regional office.

The agency contracted with the Johns Hopkins University School of Hygiene and Public Health to evaluate the plans and planning processes of other health planning agencies and to recommend a method for developing a health plan. The contract also provided for evaluating the usefulness of existing data.

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In an October 1972 report, the university recommended developing a plan in three phases over 2 years. Phase 1 would develop a State policy plan, setting forth strategies to meet health needs over a 10- to-15 year period, and would take about 1 year. Phase 2 would develop areawide comprehensive health plans. Phase 3 would develop an action document which would set program and budget priorities to meet the goals and objectives in the State's long-range policy plan and the areawide medium-range plans.

The plan development committee studied the report and recommended to the advisory council that the agency implement the recommendation, using the university group. The council concurred, and at December 31, 1972, negotiations were underway between the agency and the university to carry out phase 1.

We were advised subsequent to the completion of our fieldwork that the university group was proceeding with the contracted plan development program and that it was expected that the 2-year target for developing a plan would be met.

Control functions

Maryland's certificate of need legislation is actually a requirement for licensure and became effective on July 1, 1970. This law required that licenses to open newly created hospitals or non-profit-related institutions, such as nursing homes, or to continue hospitals or non-profit-related institutions which have relocated their services shall not be issued unless they comply with the comprehensive health plan requirements for the area where the facility is to be located. The law was amended in 1972 to cover proprietary as well as non-profit-related institutions.

Under the Maryland law, areawide CHP agencies or other designated agencies are responsible for reviewing proposed health facility projects and making recommendations to the State CHP agency. The designated agencies include the State's two HEW-approved areawide CHP agencies, a health planning agency funded by the Appalachian Regional Commission, and other State-funded health planning agencies. The State agency makes final decisions on all projects after initial areawide agency review and recommendation, except

for one county where it performs the function because no agency has been designated to cover that county.

Although the State CHP agency has not developed a plan showing the State's need for facilities, manpower, and services, it has published a document containing broad policies, principles, and guidelines for the people of Maryland.

As of February 1973, plans were underway to revise and expand the document so it could serve as the health services and facilities part of the proposed State health plan.

We have been informed that one staff person generally performs the State's responsibilities for reviewing and commenting on proposed health programs and that no procedures exist for this review. However, he generally discusses the applications with other staff members, personnel from within the department of health and mental hygiene, and others as considered appropriate. If the situation warrants, an application may be presented to the appropriate advisory council committee. The agency does not maintain statistics on the number of applications reviewed and commented upon. The agency's files on review and comment actions were incomplete because the agency did not always keep copies of applications or its comments on them.

OHIO STATE CHP AGENCY

Organization

The Ohio department of health is the designated State CHP agency. CHP functions are carried out by the office of comprehensive health planning within the office of the department director. As of February 1973 the agency had a professional staff of 15--an increase of 10 from June 1971. State CHP officials explained that the State government's low salary structure and the lack of a personnel classification for planners had caused problems in hiring staff.

The State advisory council comprises 20 consumers and 19 providers of health care. Our analysis of the advisory council meetings held from May 1968 to October 1972 showed that consumers constituted a majority at only 4 of the 17 meetings. Attendance averaged 27, 15 providers and 12 consumers. A steering committee appointed by the advisory

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council was concerned over the low attendance and the fact that providers constituted a majority at most meetings. One reason given for the low consumer attendance is that many cannot afford the cost.

The advisory council has 8 planning committees and task forces with memberships ranging from 6 to 23 persons. Meetings for each group have ranged from 1 to 15 since 1968. The council in January 1973 authorized use of two more planning committees, a health facilities committee, and an alcoholism committee.

Some committees have been inactive or underused because of a shortage of professional staff to provide technical assistance and because of their inability to find committee members able to devote the necessary time to the committees. For example, the health manpower committee was active from November 1969 through March 1971 but became inactive for lack of staff assistance and a chairman. The health facilities committee, established in September 1970, had not been activated as of February 1973 for the same reasons. In January 1973 the State advisory council decided to use the Ohio Hill-Burton agency advisory council as its health facilities committee.

Through fiscal year 1972, the State has spent about \$1,418,000 for comprehensive health planning, of which it provided about \$186,000 and the Federal Government, \$1,232,000.

Activities

Plan development

The State CHP agency has had significant problems in developing an effective planning process, assessing health needs, and developing and implementing a State health plan. The reasons for these problems include insufficient volunteer participation on the committees, insufficient staff to assist the committees, and lack of a requirement that the areawide agencies develop comprehensive health plans for use in developing a State plan. As of February 1973, the State agency had completed or drafted only four of eight components of the environmental segment of a plan.

The State CHP agency staff advised us that, from November 1967 until early 1970, the State agency was working on organizing the advisory council and establishing areawide agencies. The initial effort to describe a planning process was made during the fall of 1969. In May 1970 a formal statement entitled "Comprehensive Health Planning in Ohio" was published, which identified a process basing development of a State-wide comprehensive health plan on direct inputs from the areawide agencies. Also, during May 1970, the State agency issued another document which identified the components of a State health plan, including:

- Broad health goals.
- Identification of the distribution of the population, major health problems and needs, and environmental hazards.
- Inventories of existing health services, manpower, and facilities.
- A statement of short- and long-range health objectives to meet health needs related to prevention, detection, diagnosis, care and treatment, extended care services, and rehabilitation.
- A list of priorities for accomplishing objectives.
- A schedule for plan implementation, including recommended legislation, public and voluntary organizational responsibilities and financing, and procedures for evaluating accomplishments and updating the plan.

The State CHP staff advised us that the areawide agencies objected strongly to efforts to develop State and areawide plans because they believed they were not yet ready for such planning.

After a February 1971 meeting with State CHP officials, the 11 areawide agencies tried to list and document areawide health problems by priority, and 10 of them submitted information to the State agency during April and May 1971. The State agency made an initial review of the information and considered it unacceptable because there had been no

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real involvement of the area's consumers of health services. One areawide agency had canvassed area providers to obtain information on priority health needs. The State staff also determined that three other areawide agencies had provided inadequate documentation or data and requested additional information, which two of them submitted.

The staff compiled and divided this information by general topics (environment, manpower, mental health and retardation, and health services and facilities) and distributed it to either State advisory council committees or another State agency for review and translation into recommendations for State-wide health priorities.

The environmental health committee compared the information with plans it had developed or was developing and concluded that the information was consistent with its own plans. Because the health manpower committee was inactive, the information was not reviewed. The mental health and retardation information was referred to the State department of mental hygiene and correction (now the department of mental health and mental retardation), which took exception to the information, indicating that the priorities identified by the areawide agencies were not valid. Because there was no active health services and facilities committee, an ad hoc committee was established. This committee noted a lack of supportive documentation and data and attempted to develop and obtain adequate documentation. It apparently was not successful because of insufficient staff support and was disbanded in June 1972.

The CHP staff advised us that the State agency did not specifically demand adequate documentation and data from the areawide agencies before it worked with the information submitted during the spring of 1971 because the State agency had made a commitment to work with the areawide agencies' information as submitted.

The State and areawide agencies met again in March 1972, and agreed that the areawide agencies would define and document areas of concern and assess problems. From May through July 1972, 10 areawide agencies submitted their problem assessments, and in September 1972, 1 submitted its assessment. State-wide problem areas identified were

housing, a lack of certificate of need legislation, and financing of medical costs for the indigent.

Other than trying to use the information supplied by the areawide agencies, the committees, except the environmental health committee, have been unsuccessful in their efforts to develop a State plan.

The environmental health committee has been active in identifying State-wide health needs and assessing available resources. By using task forces, it completed two formal segments of the environmental health plan for air quality and solid waste and developed initial draft reports dealing with housing and water quality.

The advisory council approved the solid waste segment in July 1971 and transmitted the identified priorities to the office of the director of health, but no action had been taken as of February 1973 primarily because, according to the present director, the State was attempting to establish a task force on environmental problems and a status quo was maintained until the task force functions were clarified. The air quality segment was approved by the advisory council in January 1972 and transmitted to the director in February 1972, but he had taken no action as of February 1973.

A draft report on water quality was developed using information previously collected at the State level and from areawide priority information submitted by the areawide agencies during the spring of 1971, approved by the advisory council in January 1973, and sent to the areawide agencies for review and comment. A draft report on housing priorities was approved by the advisory council in January 1973 and sent to the areawide agencies for review and comment.

The agency has decided to use plans developed by other State agencies, such as the State Hill-Burton plan, as inputs to development of a State health plan because (1) it has not had active health services and facilities committees to develop those segments of a State health plan and (2) the recent passage of Public Law 92-603 (see p. 21) forced action on developing a facilities plan for use in assessing the need for health facilities.

Control functions

The State CHP agency's control function has generally been that of review and comment because Ohio had not adopted certificate of need legislation. The responsibilities are divided between another office of the department of health (department reviewer) and the office of comprehensive health planning.

The department reviewer is responsible for coordinating comments required by Office of Management and Budget Circular A-95, and the office of comprehensive health planning is responsible for comments required through other mechanisms. We found that neither the department reviewer nor the office of comprehensive health planning was properly organized to carry out the review and comment function.

The department reviewer informed us that he prepared comments on applications received through the A-95 process based on the input from an environmental engineer and his own knowledge. He stated that he assumed the State agency helped to prepare such applications as requests for Hill-Burton funds and therefore its comments were not necessary.

The reviewer said he would not comment unfavorably on applications for Federal funds because he lacked definitive criteria (i.e., a State comprehensive health plan) to support such decisions. A similar operating practice was confirmed by CHP officials.

Also, the State clearinghouse (State agency designated to coordinate comments) has not established procedures clearly designating the Federal program responsibilities for each State agency; i.e., health projects to be reviewed by the department of health. As a result, certain health projects were not submitted to the department for review and comment, primarily Office of Economic Opportunity projects for medical services, drug abuse, and family planning.

The office of comprehensive health planning does not review or comment on all health projects within its responsibility and is not even aware of responsibilities to review certain projects. It does not maintain complete records on the review and comment function and we could not clearly establish the extent of its effort.

We were informed that before June 1972 the office could not make valid determinations of need in performing its review and comment function due to inadequate criteria and insufficient professional staff. No State-wide comprehensive health plan existed which could have been used as criteria. In addition, insufficient staff prevented the agency from using all existing criteria, such as other State plans, or developing criteria on its own.

CALIFORNIA AREAWIDE AGENCIES

San Diego

Organization

The Comprehensive Health Planning Association of Imperial, Riverside, and San Diego Counties is a private non-profit corporation which served only San Diego County when it was first federally funded in July 1968. The agency expanded to Imperial County in November 1968 and to Riverside County in January 1972 and now serves about 1.9 million people.

In October 1972 the San Diego agency had about 690 volunteers, representing about 175 organizations, participating on an areawide board of directors, 3 county boards, 21 committees, 9 task forces, and a public hearing panel. The agency had a total staff of 35, of which 17 were professionals. Even though this agency had the second largest staff of the six areawide agencies we reviewed, both staff and volunteers believed they had insufficient staff to assist the planning committees.

Management of the San Diego CHP agency is vested in a 75-member board of directors and a 21-member executive committee. Between July 1971 and September 1972, 12 board meetings were held. Consumers were in the majority at only three, even though they represented a majority on the board.

Agency planning is carried out by a planning division composed of the following committees: community health, services and facilities, social health, environmental health, and manpower education and utilization. In addition, a public hearing panel was established in August 1972 to review grants and health facility construction

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applications, and a quality of care committee ascertains whether hospitals seeking the agency's approval meet professional standards.

Each planning committee comprises several subcommittees and task forces, but many of them are inactive or meet irregularly because of insufficient volunteer participation and staff support.

- The community health committee was totally concerned with review and comment on proposed health projects until the public hearing panel was established. The committee is being reoriented to planning for community health needs.
- The services and facilities committee has been concerned entirely with review and approval of health facility applications and has not done any planning. An inventory of health facilities and services provided by these facilities has been compiled. This committee is being reoriented to health facility planning.
- The social health committee plans for such areas as developmental disabilities (such as mental health), alcoholism, drug abuse, and aging. Its first meeting was in March 1972, and its early emphasis will be on inventorying resources and identifying gaps, overlaps, and deficiencies in services. Although some subcommittees and task forces in this committee have been quite active (some gaps in the delivery of services have been identified), others have been inactive because of insufficient volunteers and staff support.
- The environmental health committee has several task forces involved in environmental planning. Although the committee has not established a priority of needs, it has obtained several environmental improvements in the area. Volunteers were of the opinion that much more could be done with additional staff support and volunteer participation.
- The manpower education and utilization committee is actually a joint effort of the CHP agency and the

regional medical program. The committee has inventoried available health manpower in San Diego and Imperial Counties; surveyed education requirements for medical personnel except doctors, and reviewed the operations of a physical therapy department of an area hospital. The committee has identified, through the experience of the committee members, the health needs of the area and has established the high cost of health manpower services as its top priority.

The San Diego agency has also had difficulty raising the local matching funds required by HEW. The sources of the approximately \$200,000 the agency raised in 1972 were: United Community Services, \$46,000; State and local governments, \$72,000; fees from applicants for facilities reviews, \$7,500; and the remainder from miscellaneous small cash and in-kind contributions.

Several agency officials, including the director, advised us that fund-raising activities required more staff time than any other activity. The director said that some contributors had pressured his agency for certain actions and in at least one instance had reduced their contribution when the agency did not yield to the pressure. One reason for the fund-raising problems has been the lack of support, financial and otherwise, from the local governments in two of the three counties in the planning area.

Plan development

In developing its March 1972 areawide plan, the San Diego agency used information gathered through special studies and discussions with community organizations and private citizens.

Staff and volunteers told us that a poor data base had substantially hampered the agency's ability to identify health problems, their causes and magnitude, and available resources. Data to develop the plan was obtained from about 60 organizations.

The March 1972 plan listed 47 goals for improving health status, such as "To improve communicable disease control with effective areawide programs of immunizations." The agency, however, did not establish any priorities of

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goals to be achieved. In June 1972 the San Diego agency developed 11 areawide priorities for 1973; 4 directed to improving the health of the community and 7 pertaining to agency support activities, such as maintaining a favorable image.

The executive director told us that the agency would update its plan in 1973 and, in doing so, would show health goals of highest priority to give the agency a more concrete sense of direction.

In addition to developing an areawide plan, the agency has made numerous studies. These include an inventory of available health manpower in the area, adequacy and use of health resources in Imperial County, and a comprehensive study of health needs in a major low-income area of San Diego.

Volunteers with whom we discussed the agency's planning effort believed that the agency had not identified priority health needs and said that the agency performed many disjointed and not necessarily important projects. They concurred that volunteer involvement was necessary to obtain community commitment to health planning but that volunteers made the decisionmaking process cumbersome and slow. The volunteers said they

- had inadequate time to understand problems and issues about the delivery of health services,
- often spent more effort protecting their individual interests than constructively seeking improvements in the health care delivery system,
- were insufficiently oriented to planning methods, and
- individually possessed valuable opinions but were indecisive in groups.

The volunteers believed that the agency staff had not given them sufficient direction to overcome these weaknesses, but they recognized that existing staffing was not sufficient to provide such guidance.

Control functions

The San Diego agency has review and approval authority under California's certificate of need legislation for health facility construction in the area. The health services and facilities segment of the areawide comprehensive health plan contains criteria for these reviews.

The procedures for performing these reviews and review and comment on grant applications are basically to assign the applications to appropriate committees to review. Public hearings are then held, and the agency board of directors makes the final decision.

The agency did not disapprove any applications requesting review and comment or review and approval during 1972, but most approvals contained recommendations for changes.

San Francisco

Organization

The Bay Area Comprehensive Health Planning Council is a private nonprofit corporation organized to serve nine counties in the San Francisco Bay area and about 4.6 million people.

The areawide agency, a federation of county councils, has a board of directors (council) which manages agency affairs. The council has 49 members, of whom 26 are consumers. The council does have broad geographical, social, economic, and ethnic representation. However, more than half the consumer representatives are businessmen or educators, and there is very little local government participation.

Attendance at the 18 board meetings held in 1971 and 1972 averaged 25 and consumers constituted majorities at 8 of them.

Because a substantial part of the work is carried out at the county level under the bay area federation concept, we examined three county councils and found that consumers were in the majority at 16 of 28 meetings they held in 1971

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and 1972. Most of the consumer council members in these three counties had professional occupations.

At the time of our fieldwork, the agency had a professional staff of 24, nine at the areawide level and 15 in the county units. Of the nine areawide staff members, only one was with the agency before 1972.

The Bay Area Comprehensive Health Planning Council has an executive committee and five standing committees: plan expansion, review and comment, finance, bylaws, and personnel. Providers are in the majority on only one of these committees. Attendance at meetings of four committees (two did not meet) during 1972 averaged about 50 percent and about half of those attending were consumers.

The three affiliated county CHP units reviewed had planning and administrative committees similar to those of the areawide agency. In two counties consumers and providers were about equally represented at committee meetings. However, in the other county provider attendance predominated; average attendance at meetings of one committee was 7 to 1 in favor of providers and only 13 of 53 committee meetings held during 1972 had consumer majorities.

Although the agency believes it has insufficient overall funds to effectively carry out its planning responsibilities, it has not had any particular problem obtaining local funds to match the available Federal funds. The local funds are obtained primarily from the county governments in the planning area, reimbursement through a State tax for facilities reviews, and the United Fund. For example, the proposed 1973 budget of \$1.142 million provides for \$475,000 from HEW and \$667,000 in local matching funds. Contributions of \$236,000 are expected from the county governments, \$115,000 in reimbursement from the State for facilities reviews, and \$120,000 from the United Fund. Only \$65,000 is expected from private health organizations, and the remainder primarily from other private donors.

Plan development

The bay area CHP agency submitted its first plan to its board of directors in May 1972. The board never approved its recommendations for planning, apparently because some

recommendations on social issues were highly controversial. Four of the nine counties affiliated with the CHP agency had also completed first-draft plans, and the remaining five had completed segments of plans. By June 1972 each county unit had also completed health facilities plans. These plans were combined and submitted to the State agency as an areawide facilities plan.

The areawide agency's staff, all except one hired after April 1972, consider the May 1972 plan good for background information but too general for action recommendations.

At the time of our fieldwork, the bay area agency was involved in an estimated 2-year process of developing a health systems plan. In October 1972 it established the plan expansion and review committee with an initial purpose of developing goals and policies to guide development of the plan. The 10 goals and 72 policy statements adopted by the board in January 1973 basically expanded three main areas identified in the agency's May 1972 health plan--social issues related to health, delivery of health services, and environmental plans.

The system plan will set forth service requirements by geographic area and provide recommendations for providers, consumers, legislators, and governmental agencies.

Control functions

The bay area CHP agency has established formal procedures and criteria for its review and comment and review and approval responsibilities, including approval of facility construction under the State's certificate of need legislation. The agency also assisted the State CHP agency in drafting review and comment guidelines for all areawide CHP agencies in the State. The procedures the agency follows depend on the scope and impact of the project being reviewed.

Of the nine State and areawide agencies reviewed, the bay area agency appeared to be the most active and had the most systemized procedures for carrying out these responsibilities.

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MARYLAND AREAWIDE AGENCIES

Baltimore

Organization

Maryland created the Baltimore Regional Planning Council in 1963 to, among other functions, develop a general development plan for the Baltimore metropolitan area. In July 1968 the council was designated as the CHP agency for the Baltimore area and was placed within the State department of planning in February 1972. The agency serves about 2.1 million people in the city of Baltimore and five adjacent counties.

The governing body consists of 26 members; 24 elected officials or members of State and local government agencies and 2 private citizens. It is assisted by eight advisory councils, including the citizens health council.

Members of various provider and consumer organizations elect the delegates to the citizens health council.

Under the council's bylaws, the citizens health council should be comprised of 30 delegates with a majority of consumers. As of December 1972, the citizens health council consisted of 26 delegates; 13 providers, 13 consumers, and 4 vacancies. Consequently, at that time, the council did not have the required consumer majority. According to the agency's deputy director, additional consumer delegates were elected to the citizens health council subsequent to the completion of our fieldwork and, as of October 1973, it had a consumer majority.

Our analysis of nine council meetings held from January through October 1972 showed that consumers were never in the majority. The average attendance at these meetings consisted of nine providers and seven consumers.

The citizens health council is assisted by a CHP staff and several committees and panels. The staff at December 1972 included eight full-time and four part-time professionals and three clerical members.

The agency also has seven problem-solving and four service committees and 12 provider panels. The problem-solving committees have been created for the following areas, designated by the citizens health council as priorities: plan development, long-term care, mental health, emergency medical services, coalitions and networks (coordination with provider and community groups), project review, and environmental health. All but the environmental health committee were active as of December 1972, and it was inactive because of insufficient staff support. All the active problem-solving committees had provider majorities except the coalitions and networks and project review committees.

Although it believes it has insufficient overall funds to carry out as fully as expected its planning responsibilities, the Baltimore agency has not had any problems raising the local funds required to match available Federal funds, as it receives most of its non-Federal funds from the State and local governments. For example, the health planning budget for June 1972 through January 1973 provided for \$105,000 from the State and local governments and \$51,000 from the State CHP agency.

Plan development

According to the agency's 5-year work plan, the region's health needs are still being quantified. The plan also states that, although the region's health resources are second to none in the Nation, gaps are evident and the region lacks an effective system to link these resources so that more comprehensive care can be delivered more effectively and efficiently. The initial focus of areawide health planning, therefore, has been described by the agency as improving the delivery of services by achieving a linked system of resources responsive to community need, direction, and support.

According to the agency's director for health planning, the region's most pressing health need is primary care service, which is described as first-contact care and is provided through ambulatory care facilities, such as physicians' offices, general or specialty outpatient clinics, and hospital emergency rooms. The agency's initial planning for

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primary care was directed toward (1) home services and long-term care for chronically ill and elderly persons, (2) transportation access to health facilities, and (3) reducing the demands on emergency departments for treatment of nonurgent cases. Currently the agency's effort in the primary care area is directed toward assisting community groups in planning and developing ambulatory care centers in areas having shortages of such care and identifying alternative systems for delivering primary care. The coalitions and networks committee has been designated as the focal point for planning to meet the region's needs for primary care.

Other priority health needs the agency identified are emergency medical care, long-term care, mental health (including alcoholism and drug abuse), and environmental health. The problem-solving committee created for each of these areas is responsible for identifying the needs in each area.

The agency has also compiled inventories of the health care facilities and environmental resources (State and local organizations concerned with environmental matters) in its region and, assisted by a private consulting firm, obtained detailed information on the capability of 24 hospitals in the region to provide emergency medical care.

The agency's general approach to planning involves identifying and assessing health problems, determining their causes, and proposing interim and long-range solutions and alternatives.

In some priority areas, developing alternatives to an existing method of care is the specific objective of the agency's current planning. For example, the long-term-care committee is charged with developing alternatives to long-term institutional care to enable individuals, especially the elderly, chronically ill, and disabled, to maintain themselves in home or community settings. Another committee is concentrating on alternative systems for delivering primary care, but the alternatives in these areas had not been quantified at the completion of our work.

A health plan was developed as part of a 5-year general development plan and was adopted by the agency's governing

body in December 1972. The agency's health council did not formally approve the health segment because, according to an agency official, the council thought it was not specific enough. The agency staff described this health segment as its first-generation comprehensive health plan.

The health plan identified 11 broad objectives for improving the area's health care delivery system and 29 obstacles to be overcome. The plan includes some limited statistical data relating to the region's health status, access of certain residents to health care, use of emergency services, and number of general and psychiatric hospital beds in the region. It also states, however, that the region's health needs are still being quantified, and it does not have detailed data on the region's needs for medical facilities.

According to the deputy director for health planning, future efforts of the agency's plan development committee will be directed toward updating the health plan. The anticipated approach for periodic updating is to develop information for subareas of the region to identify their existing resources and needs.

Control functions

In carrying out the review and comment function, the Baltimore agency uses various procedures and has not developed guidelines or criteria for performing the reviews. According to the staff director, the procedure followed in reviewing a proposal or project application depends on the nature of the proposal and the time allotted for its review.

The preferred procedure is to submit a health-related proposal to the appropriate problem-solving committee, and thereby use the expertise of the committee members. However, the use of this procedure depends on the time allotted for the review. Another procedure is to present the proposed project to the citizens health council and governing body. Time allotted for the review often prohibits use of this procedure, and normally it is used only when the project is controversial. A third procedure limits the review responsibility to selected staff members and is normally followed when time allotted for the review is short.

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The staff director attributed the lack of a standard procedure to the varying time periods allowed by Federal reporting requirements for reviews. He also advised us that the agency maintained no records of the number of proposals received for review and comment nor of agency comments.

To meet its responsibility under Maryland's certificate of need law, the agency established a project review committee and assigned one staff member to assist it. This committee is responsible for reviewing applications for new health facilities or changes in existing facilities and services and consists of seven consumers and five providers. The committee is assisted, when applicable, by a psychiatric technical review subcommittee of 12 providers which is assisted by a member of the agency staff who is also responsible for mental health planning.

The agency has developed criteria for health facility reviews, including guidelines listing items and questions the initiator of a health facility project should consider during planning and setting forth data requirements and conditions the applicant must meet. The agency uses the guidelines, along with additional criteria developed for certain types of projects, in evaluating proposed projects. As previously noted, the agency's December 1972 health plan did not include a segment on the area's health facility needs.

Salisbury¹

Organization

HEW approved the Health Planning Council of the Eastern Shore, Inc., a private nonprofit corporation, as an areawide CHP agency effective June 1971. The agency originally covered four counties but was expanded to nine in October 1971. The nine counties are basically rural and have a combined population of 258,000. At the time of our fieldwork,

¹The Health Planning Council of the Eastern Shore, Inc., moved its offices from Salisbury to Cambridge, Maryland, in 1973. To avoid confusion we have continued to refer to it as Salisbury.

the agency was operating under an organizational grant. However, it has since received a planning grant effective February 1, 1973.

The Salisbury agency's advisory council, which is actually the agency's decisionmaking body, consists of 30 consumers and 20 providers. Between July 1971 and October 1972, six council meetings were held and consumers represented a majority at five. Attendance has averaged about 50 percent of membership.

As of December 1972 the agency had a staff of three full-time and two temporary professionals.

The agency has an executive committee and four planning committees (review and comment, facilities and services, manpower, and goals and objectives). Each committee comprises members of the advisory council plus other volunteers and has a consumer majority except for services and facilities which has an equal number of consumers and providers.

--The review and comment committee is responsible for acting on decisions involving the State certificate of need legislation and reviewing and commenting on Federal health projects.

--The services and facilities committee is responsible for informing the agency of problems in effectively using existing facilities and services and needs for new or expanded facilities and services. It has been active in assessing the area's kidney dialysis needs and studying emergency care in a resort area.

--The manpower committee advises the agency on health manpower problems in the area. At the time of our fieldwork, it was studying alternative methods of alleviating the health manpower shortage in the area.

--The goals and objectives committee was not functional as of December 1972.

The agency is also forming councils in each of the nine counties.

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Raising local funds to match available Federal funds has not been a problem for the Salisbury agency as the State provides a large portion of the agency's local fund requirements. For example, the agency's budget for February 1973 through January 1974 provided for local matching funds of about \$58,400, of which \$43,900 will be obtained from the State, \$11,000 from the nine county governments, and \$3,500 from Blue Cross.

Plan development

At the time of our review, the Salisbury agency had been receiving Federal funding assistance for only about 1-1/2 years and had been involved primarily with organizing. The agency anticipated that during 1973 about 75 percent of its resources and time would be devoted to actual planning.

The planning method will be based on a level-of-care approach--primary, secondary (specialized), tertiary (highly specialized), and extended care--and is expected to identify needs, establish priorities, and select programs for implementation. The agency's advisory council will be responsible for organizing the planning, and subcommittees will be formed to direct day-by-day activities.

The agency's planning has consisted of several studies, including:

- Physician shortages in the area.
- Need for a kidney dialysis treatment center in the area.
- Health service needs in Ocean City because of the influx of tourists to this resort area.

The agency has also prepared profiles on each county in the planning area describing the character of the local community and providing data on county population and trends, physical environments and problems, socioeconomic descriptions and concerns, and infant birth and death rates.

The agency plans to complete the primary and secondary care segments of a comprehensive health plan by the end of

1974, with the tertiary and extended care segments to be completed later.

Control functions

The agency has not been active in reviewing and commenting on Federal health projects. At the time of our visit, it had received no applications for review for 6 months, apparently because there were no projects requiring review.

The agency has, however, been reviewing projects pursuant to the State's certificate of need legislation. The procedures are informal; applications are first reviewed by the staff and then by the review and comment committee which makes recommendations to the agency's advisory council. The State CHP agency makes the final decision.

The Salisbury agency has adopted and published guidelines for health facility development consisting merely of a list of items that the initiator of a health facility application should consider, such as a description of the services to be provided and the facility's benefit to the community. The agency has not determined the area's health facility needs.

OHIO AREAWIDE AGENCIES

Cambridge

Organization

The Southeastern Ohio Health Planning Association is a private nonprofit corporation funded by HEW since June 1, 1969, to perform comprehensive health planning in 11 Southeast Ohio counties having a population of 466,000.

The geographic area served by the Cambridge agency may be too fragmented for effective areawide health planning. The residents of the 11 counties have traditionally been served by 4 medical service areas, each centered in cities outside the planning area: 2 counties by Pittsburgh; 2 by Wheeling; 1 by Parkersburg, West Virginia; and 6 by Columbus, Ohio. The executive director of the agency stated that this fragmentation made it difficult to bring the 11

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counties together for planning and that the area must be redefined if his agency is to be successful.

The apparent reason for organizing the 11-county area was to have adequate population to support an areawide agency. HEW criteria for establishing a planning area state only that the area should be appropriate for comprehensive health planning and have sufficient population so that a full range of physical, mental, and environmental health services, facilities, and manpower (except for highly specialized resources) is available or can be made available within the area.

The agency board of trustees (council) consists of 34 consumers and 26 providers. Of 9 council meetings held since July 1971, consumers have represented a majority at 7, but total attendance averaged only 33 percent.

Initial plans called for the Cambridge agency to have facilities, services, and manpower committees, but they were never organized because the board of trustees was apparently reluctant to delegate any authority. In July 1972, more than 3 years after the agency was awarded its first grant, the board authorized the organization of personal health services and environmental health committees with memberships comprising council members plus other volunteers. The executive director advised us that the board's increasing workload and better understanding of its role in the planning process prompted its decision to authorize these two committees.

The environmental health committee first met in October 1972, at which time 9 of the 11 members authorized had been appointed.

The personal health services committee will deal with manpower services, facilities, and mental health. This committee had not met as of January 1973; six members had been appointed and five vacancies remained.

Raising local matching funds has been a major problem for the agency. As of February 1973, it had a professional staff of three. From June 1969 through January 1973, five professionals joined and left the agency. Problems in

obtaining local matching funds have caused this staff fluctuation since the agency's uncertain financial situation has discouraged prospective staff members. According to the executive director, the area economy is depressed and he has had to spend an inordinate amount of his time raising the required local funds.

The agency's budget justification for June 1972 through May 1973 shows that, of a local matching requirement of about \$79,000, over \$23,000 will be in-kind contributions (office space and personal services). The remaining funds are expected primarily from area hospitals (about \$17,000), Blue Cross and other insurance groups (\$10,000), and the 11 counties (\$28,000). However, local governments had pledged to pay only about \$10,000 of this \$28,000 and the agency has had considerable difficulty getting support, financial and otherwise, from them.

The executive director had previously spent 50 to 60 percent of his time in fund raising but at the time of our fieldwork was spending less than 50 percent. In addition, the sole function of one of the committees is to raise local funds, and the county councils devote considerable time to this.

Also, the agency has been threatened with withdrawal of local support because of its comments on proposed projects. One hospital discontinued financial contributions after receiving unfavorable comments from the agency on the proposed enlargement of the hospital.

Plan development

Because of the many problems the agency faces, it has done very little health planning, and that which is done is often directed to areas having available Federal funding, such as emergency medical services.

The agency had not developed a comprehensive health plan and, before HEW asked it to develop a plan by June 1973, had not contemplated developing one for several more years.

The agency did prepare a list of health needs and sent it to the State CHP agency in April 1971 in response to the

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State's request for an identification of health needs by each areawide agency. The list was based on responses from the agency's county councils and, as such, was a list of needs on a county-by-county basis and was not arranged by areawide priorities.

In 1972 the Cambridge agency updated the list of health needs in response to a request from the State CHP agency. Using the same general process it used to develop the first list, the staff prepared a list of 15 areawide health problems but did not arrange them in areawide priorities.

Although the HEW requirement to develop a comprehensive health plan was received in September 1972, the agency still did not have a formal planning process as of February 1973. At its January 1973 meeting, the council was going to consider a process prepared by the executive director but consideration was deferred. This process consisted of participation and input from the county councils; area voluntary, professional, and governmental agencies; and the areawide council.

The agency's executive director admitted that the agency would need much additional technical assistance from the State CHP agency and HEW to complete the plan. He believes a need exists for CHP training programs for both staff and council members so that all concerned will better understand their roles.

Control

The Cambridge agency's control over the health care delivery system is limited to a review and comment function which it performs informally to provide project review by the consumer and provider volunteers on county and areawide levels.

The agency staff receives a project application, prepares a synopsis, and sends both documents to the county council that the project most concerns. The county council reviews the proposed project and notifies the areawide council of its conclusions. The areawide council provides the final review.

Staff input to the review and comment function is limited to preparing the project synopsis and, if county officials or the areawide council request it, to technical assistance. Staff input has been limited at times because of personnel turnover and limited technical capabilities of available staff.

The agency does not have an opportunity to review and comment on some projects, has not developed guidelines or criteria for performing the reviews, will not comment unfavorably on federally funded projects, and cannot always be independent.

- The agency's relationship with the metropolitan clearinghouses (agencies designated by the State to coordinate local agency comments on Federal projects) in its area has been poor, and these clearinghouses do not always send proposed health projects to it for review and comment. The clearinghouses have been contending for health planning responsibilities in sections of the area covered by the Cambridge agency.
- Although review and comment takes place at both the county and areawide level, neither levels appears to have adequate criteria for commenting on a project. The two counties we visited had no criteria. The areawide agency had only a checklist for evaluating projects, and it contained no method for determining project need in relation to areawide health care priorities.
- Federally funded projects have not received unfavorable comments because the agency believes the area needs so many things that any project it reviews would fit within the area's needs and unfavorable comments would cause the Federal dollars to be lost. The president of one council stated that, if an application was received, his council assumed it was needed.
- The agency has had some problems in attempting to perform objective and independent reviews of project applications. As stated previously, a hospital withdrew financial support because adverse comments were made on its project. In another case, the

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agency was reluctant to objectively comment on an environmental issue because the company involved was a major employer in the area and threatened that, if required to meet environmental pollution standards, it would move its plant.

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In discussing this report with State CHP officials, we were advised that the situation at the Cambridge agency had greatly improved since the completion of our fieldwork. They stated that the executive director had been replaced, attendance at board meetings has improved, relationships with other planning agencies had improved, its financial condition had improved some, and progress had been made in its planning activities.

Toledo

Organization

The Health Planning Association of Northwest Ohio is a private, nonprofit corporation funded by HEW since June 1, 1969, to perform comprehensive health planning in 11 northwest Ohio counties having 1 million people.

The 43-member board of trustees is the general governing and policymaking body of the agency. At the time of our review, the board comprised 22 consumers and 21 providers. Attendance at 8 board meetings during calendar year 1972 ranged from 14 to 23 and providers were in the majority at 6 meetings. Although the agency represents an 11-county area, 29 of the 43 members were from the Toledo area.

Only two areawide planning committees--environmental health and facilities and services--were operational at the time of our review. However, the latter was not established until May 1972.

The environmental health committee comprises 14 consumer and 12 provider volunteers. It has formed a standing subcommittee on solid waste problems and two task forces, one to review and comment on proposed health projects and one to determine areawide environmental health needs for the environmental health component of an areawide health plan.

The facilities and services committee comprises seven provider and six consumer volunteers and includes a migrant health planning subcommittee, a dental health subcommittee for three counties, and a kidney disease subcommittee which was established in December 1972. The committee is developing the facilities and services component of an areawide health plan.

There are also 11 county health planning committees, 1 for each county within the planning area. Two of these are inactive and a third convenes only when called upon to review and comment on proposed health projects in its county.

The 11 county committees are responsible for establishing their own planning committees for (1) facilities, (2) services, (3) manpower, (4) environmental health, (5) mental health, and (6) vocational and physical rehabilitation. According to the agency's executive director, each county committee is to participate actively in the development of an areawide plan. However, our visit to two counties indicated that little, if any, comprehensive health planning was actually being done and that county committee activities were oriented toward solving specific health problems and reviewing proposed health projects.

The agency has had significant problems raising local matching funds. Its budget for June 1, 1972, to May 31, 1973, shows a local matching requirement of about \$102,000. As of January 5, 1973, it had raised about \$77,500--\$14,700 from in-kind contributions, \$22,400 from area hospitals, \$13,600 from area private industries, \$15,800 from health insurance companies, and \$10,000 from one county government. The remainder was from the United Fund and various voluntary health associations. During the previous year 73 percent of the local funds collected were from hospitals, industries, and one county government. The executive director advised us that lack of local matching funds would cause the agency to reduce its next budget request to HEW to less than its current level.

One consequence of the fund-raising problems is the small staff. The Toledo agency has a professional staff of four--two are paid by the agency, one by the Ohio department of health, and the other by the department of health and the

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Economic Opportunity Planning Association of Greater Toledo (a Model Cities agency). The small staff cannot adequately assist the areawide and county committees, which results in a lack of comprehensive health planning by the volunteer committees and councils.

The agency has had difficulty establishing relationships with some of the counties in the planning area, apparently because of insufficient staff to support its county committees and a lack of interest in health planning by some rural counties. The lack of interest is also evidenced by the fact that only one county government in the planning area contributes financially to the agency.

Plan development

The Toledo areawide agency has been oriented toward solving specific health problems by supporting individual health care projects as they are brought to its attention. The executive director stated that the agency took this approach to gain credibility and local support and because it did not have the capability to develop comprehensive health plans. He further stated that the agency's council and committees needed to be educated in their roles and responsibilities toward comprehensive health planning and required a period of learning in order to recognize the need and value of a comprehensive health plan.

About January 1972 the agency realized the need to develop a written comprehensive health plan for northwest Ohio and to redirect its efforts from one of problem reaction, because it was being overwhelmed with problems to solve. Further emphasis was added in September 1972, when officials of HEW Region V announced that all areawide agencies in Ohio would be required to develop comprehensive health plans by June 30, 1973.

The agency adopted a process for developing a health plan which includes (1) establishing objectives and local health goals, (2) identifying health problems, (3) inventorying resources, (4) assessing availability and use of health resources in relation to the problems, (5) determining priorities, and (6) developing a schedule for plan implementation.

The original organizational process for developing the plan provided for representation and input from interested agencies and groups. The organizational process was to begin by having areawide committees develop goals, needs, and other health plan components. These components were to be reviewed by the county planning committees, consumer groups, and other health and social planning agencies. On the basis of the responses from these groups, the areawide committees were to modify and revise their recommendations before submitting them to the council for approval.

The executive director told us the process was being modified somewhat since much of the plan will be written by the staff and supplied to the areawide committees as a tentative plan subject to review and revision. This was being done as a matter of expediency to have a health plan completed by July 1, 1973. By January, the staff and areawide committees had developed a statement of health goals and was seeking response from the various health groups.

One major problem in developing the health plan is the lack of data to adequately analyze health problems and identify needs. Some data sources have been identified, and information is being gathered on demographic data, health problem indicators, and vital statistics. We were told that information for such areas as nursing homes, ambulatory care centers, and care provided by private physicians, needed to identify health problems and establish priorities, was lacking. This lack of data has forced reliance on opinion.

Since the planning process provides for participation of areawide committees and county councils, plan development may be hampered because the agency has insufficient staff to assist these committees and councils which have not had good volunteer participation.

During a discussion of this report, agency officials said that, subsequent to the completion of our fieldwork, the agency issued parts of its health plan. Major segments to be completed include health manpower and mental health. We did not review the completed parts of the health plan.

Control functions

Ohio does not have certificate of need legislation, so the Toledo agency's control over the health care delivery system is generally limited to review and comment on specific Federal- and State-proposed health projects.

In December 1972 the agency adopted a formal procedure for review and comment at both county and areawide levels on proposed health projects. Projects applicable to a particular county are initially reviewed by that county's planning council. The appropriate areawide committee then conducts the primary review and comment at the areawide level. Generally, ad hoc committees, consisting of areawide committee members and invited specialists, conduct the reviews on projects concerning their area of expertise. The final authority for approval of comments rests with the areawide council. Before December 1972 the agency used similar, but informal, procedures.

The county councils concern themselves with the proposal's merits, goals, objectives, methods, financing, and evaluative procedures. Since no comprehensive health plan exists for the planning area, areawide committees must evaluate projects using existing sources of information or criteria. For example, to evaluate health facility projects, the agency uses the Ohio State Hill-Burton plan and its own data on hospital bed use and occupancy.

The executive director informed us that, although the agency published a statement of priorities in 1971 in response to a request from the State CHP agency (see p. 59), little faith could be placed in it and that the priorities were not an adequate basis for giving favorable or unfavorable comment on proposed projects.

The director also stated that often Federal priorities for which funds were available were not closely related to local needs. For example, Federal funds were currently available for emergency care programs and lead-poisoning research. Although these problem areas did not appear to have high priorities on the 1971 priority statement, the agency approved several emergency medical care programs and one grant to determine lead-poisoning hazards in rural and small urban areas.

PRINCIPAL OFFICIALS OF THE
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
RESPONSIBLE FOR ACTIVITIES
DISCUSSED IN THIS REPORT

	<u>Tenure of Office</u>	
	<u>From</u>	<u>To</u>
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Caspar W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
ASSISTANT SECRETARY FOR HEALTH:		
Charles C. Edwards	Apr. 1973	Present
Richard L. Seggel (acting)	Jan. 1973	Apr. 1973
Merlin K. DuVal, Jr.	July 1971	Dec. 1972
Roger O. Egeberg	July 1969	July 1971
ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION (note a):		
Harold O. Buzzell	May 1973	June 1973
David J. Sencer (acting)	Jan. 1973	May 1973
Vernon E. Wilson	July 1970	Dec. 1972
Joseph T. English	Jan. 1969	July 1970
ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION:		
Kenneth M. Endicott	Aug. 1973	Present
Robert J. Laur (acting)	July 1973	Aug. 1973

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	Tenure of Office	
	<u>From</u>	<u>To</u>
DIRECTOR, COMMUNITY HEALTH SERVICE (note b):		
Jordan J. Popkin	July 1971	Nov. 1971
John W. Cashman	Nov. 1968	July 1971
DIRECTOR, COMPREHENSIVE HEALTH PLANNING SERVICE:		
Eugene J. Rubel	Aug. 1973	Present
Robert P. Janes	Nov. 1971	July 1973

^aEffective July 1, 1973, this Administration was abolished and the Public Health Service was reorganized into six health agencies under the direction and control of the Assistant Secretary for Health. The Comprehensive Health Planning Service was placed in the Bureau of Health Resources Development, Health Resources Administration.

^bFrom the Administration's establishment in April 1968 until November 1971, the CHP program was administered by its Community Health Service. Beginning in November 1971, the program was administered by the newly created Comprehensive Health Planning Service of the Administration.

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