AN EVALUATION OF HEALTH PLANNING IN THE MOUNT ROGERS AND NEW RIVER VALLEY PLANNING DISTRICTS

by

Kenneth David Whittington

Major paper submitted to the Graduate Faculty of the Virginia Polytechnic Institute and State University in partial fulfillment of the requirements for the degree of

MASTER OF URBAN AND REGIONAL PLANNING

APPROVED:

Robert G. Dyck, Chairman

Alan W. Steiss

John W. Dickey

May, 1976

Blacksburg, Virginia

ACKNOWLEDGEMENTS

The success of this paper is attributed to the cooperative efforts of the staff members of the Mount Rogers and the New River Valley Planning Districts. I would like to thank Mr. Jack Lee and Dr. Diane Valla of the Mount Rogers Planning District Commission and Mr. Gordon Dixon and Mr. David Nunley of the New River Valley Planning District Commission.

A note of special thanks is extended to the committee members: Dr. Robert G. Dyck, Chairman; Dr. Alan W. Steiss, and Dr. John W. Dickey.

TABLE OF CONTENTS

Page

ACKNOWLEDGEMENTS ii

LIST OF FIGURES v

CHAPTER I. INTRODUCTION 1

CHAPTER II. A REVIEW OF HEALTH PLANNING ACTIVITIES . . . 5

Federal Health Planning Legislation 5

Health Planning in Virginia 7

CHAPTER III. DETERMINATION OF CRITERIA 14

Determination of Submeasures 17

Lack of Conflict 17

Intergovernmental Agreements 19

Functional Integration 20

Communication 21

Elimination of Duplicated Efforts 21

Consensus of Values 22

Effect of Personalities 23

CHAPTER IV. APPLICATION OF CRITERIA 25

Health Planning in the Mount Rogers Planning District 25

Lack of Conflict 27

Intergovernmental Agreements 27

Functional Integration 29

Communication 30

Elimination of Duplicated Efforts 31

Consensus of Values 31

Effect of Personalities 32

Health Planning in the New River Valley Planning District 34

Lack of Conflict 35

Intergovernmental Agreements 36

Functional Integration 36

Communication 37

Elimination of Duplicated Efforts 38

Consensus of Values 38

Effect of Personalities 39

Page

CHAPTER V. CONCLUSIONS AND RECOMMENDATIONS 43

Conclusions 43
Lack of Conflict 43
Intergovernmental Agreements 43
Functional Integration 44
Communication 44
Elimination of Duplicated Efforts 44
Consensus of Values 45
Effect of Personalities 45

Recommendations 46
Recommendation 1 46
Recommendation 2 47
Recommendation 3 49
Recommendation 4 51

FOOTNOTES 53

BIBLIOGRAPHY 55

ABSTRACT

LIST OF FIGURES

Page

FIGURE 1. Virginia Health Service Area Boundaries (5) as submitted by Governor Godwin to HEW. 10

FIGURE 2. Virginia Health Service Area Boundaries (7) as Recommended by State "B" Agencies. 11

FIGURE 3. Virginia Health Service Boundaries (6) as Approved by HEW. 12

CHAPTER I

INTRODUCTION

This paper is an evaluation of the health planning activities in the Mount Rogers and the New River Valley Planning District Commissions. The underlying hypothesis is that health planning in Virginia has not developed into an activity that has achieved its full potential. This topic should be of concern to those who are interested in or occupationally related to the delivery of health services from both the public and private sector. It is intended to suggest ways of improving health planning practices which would result in a better health care system. Even though regional health planning is a relatively recent activity in Virginia, the evaluation seems timely due to new federal legislation establishing new approaches to health planning and the role of health in the "urban crisis."

The evaluation process begins with an examination of the federal legislation which established substate health planning, The Comprehensive Health Planning Act of 1966. The intent and provisions of this and subsequent acts are discussed along with the organizational structure of the relevant state and substate health planning agencies. The most recent federal legislation regarding substate health planning is The National Health Planning and Resource Development Act of 1974. The previous Act of 1966 serves as a basis for the 1974 Act. There is a "building block" type of relationship because the most recent legislation relies on the experience that emerged under the 1966 Act.

An evaluation procedure requires the determination of criteria that measures the performance of a given activity. The use of criteria is important in guaging the success of an activity in achieving established goals and objectives. A criterion has been developed by which to evaluate regional health planning in Virginia. That criterion is cooperation. It is expressed in the intent and purpose of federal legislation that establishes substate health planning, The Comprehensive Health Planning Act of 1966 and The National Health Planning and Resource Development Act of 1974. In addition, the Hahn Commission Reports called for the coordination of jurisdictions in dealing with areawide problems.

Cooperation is not the only criterion that can be used to evaluate health planning. Other criteria include efficiency, economy, etc. However, the present method to obtain a "better" health care system is cooperative effort and there is an interrelatedness between cooperation and other criteria. Therefore, if a greater degree of cooperation can be established, it is entirely possible that other criteria, such as efficiency and economy, can be maximized.

Cooperation is a criterion that is too vague to evaluate in a general way. It has been broken down into component measures which include: (1) lack of conflict, (2) intergovernmental agreements, (3) functional integration, (4) communication, (5) amount of duplicated efforts, (6) values that influence the actions of dominant groups and individuals, and (7) effect of personalities. The measurers are then applied to the regional health planning activities in the Mount

Rogers and the New River Valley Planning Districts. Both planning districts are relatively similar in geographic size, population and budget. In 1973, the Mount Rogers Planning District had a population of 163,200, a total budget of $229,313 and included 6 counties, 2 cities and 3 towns. In that same year, the New River Valley Planning District had a population of 119,000, a total budget of $265,240 and included 4 counties, 1 city and 3 towns. Both planning districts are rural jurisdictions, located in southwestern Virginia.

In the analysis procedure, it is necessary to explore the differences between cooperation and coordination. The health planning activities in the Mount Rodgers Planning District is cooperative while the health planning activities in the New River Valley Planning District is coordinative. Cooperation is defined by the author as two or more jurisdictions working together to reduce the magnitude of a common problem. Coordination is defined by the author as the establishment of an organization in such a way to avoid conflict. See Figure 1 for a concise description of each style.

The evaluation procedure provides the basis to make recommendations to increase cooperation and coordination. The recommendations consist of: (1) incorporating health planning into a human resources program, (2) integrating the health planning body into the structure of the planning district commission, (3) providing for greater representation in the health planning organization, and (4) assuring adequate financial support for health planning activities in the planning district.

TABLE 1

DESCRIPTION OF TRANSACTIVE AND TRADITIONAL PLANNING

Transactive Planning	Traditional Planning
Establishment of an interactive process	"Top-down" planning
Planning with people	Planning for people
Conflict identification and management	Conflict avoidance
Plans not necessary	No little plans or plans that result in controversy
Networking of functions with stress placed on linkages	Separation of functions
Process results in interfaces	The plan(s) provide the interfaces
Dynamics emphasized	Structure emphasized
Cooperation on numerous areas	Coordination on select areas
Two-way communication	One-way communication
Duplicated efforts are self discovered through networking	Duplicated efforts discovered in plans

CHAPTER II

A REVIEW OF HEALTH PLANNING ACTIVITIES

Federal Health Planning Legislation

The poor quality of health services in the U.S. relative to the nation's affluence, became a national issue by the 1960's and is still of great concern. Problems of rising hospital and physician charges, uneven quality of care, manpower shortages, duplications of effort, and outmoded facilities are some of the most familiar. Many health consumers, governmental officials and administrators have declared that the health care and delivery systems in the United States are approaching a crisis situation

As a result of the growing concern, a national program of comprehensive health planning was established with the passage of P.L. 89-749, the Comprehensive Health Planning and Public Health Services Amendment of 1966. The intent of the law was to:

> encourage planning for health services, health personnel, health facilities and the environment by the states and by the local communities on a regional basis. Its purpose was to promote and assure the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living.[1]

The legislation has five major provisions: (1) for formula grants for comprehensive health planning at the state level, (2) grants for comprehensive areawide health planning, (3) grants for training health planners, (4) formula grants to states for public health services, and (5) project grants for health services development. In addition, the

legislation called for a state agency and regional health councils. The functions of the state agency, the 314(a) Agency, include the composition of a state plan which would include the projects of high priority received from the areawide councils and the administration of federal funds for new services and projects in that state. The purpose of the areawide health councils, the 314(b) Agency, is to establish regional policies, review health care facility construction, act as an implementation tool for federal money, to inventory existing health services and facilities, and to determine certificates of need.

The setting for health planning established by The Comprehensive Health Planning Act of 1966 is now undergoing change with the passage of The National Health Planning and Resource Development Act of 1974, passed by the 93rd Congress. The Act calls for the designation of Health Service Areas (HSA's) (a rearrangement of the areawide health planning boundaries) by the Governor of each state. However, in a review of existing literature, Congress intended to "make maximum use of the existing areawide Comprehensive Health Planning agencies in the transaction to an ultimate development of the Health System Agency, and to build on the expertise and work already done by the existing agencies."[2] Evidence of this is found in the March 25, 1975 edition of the "Federal Register."

In addition, a number of national priorities were established to direct the future health planning organizations. They are as follows:

1. Provision of primary care services for medically underserved populations.

2. Development of multi-institutional health systems for coordination or consolidation of the institutional health services.

3. Development of medical group practices, especially those that are in conjunction with the institutional health services.

4. Training and increased utilization of physician assistants, especially nurse-clinicians.

5. Development of multi-institutional arrangement for assuring of support services.

6. Promotion of activities to improve the quality of health services.

7. Development of health institutions with the capacity to provide intensive, acute general and extended care.

8. Promotion of activities for the prevention of disease, including the area of nutritional and environmental factors.

9. Adoption of uniform cost accounting, simplified reimbursement and utilization reporting systems.

10. Development of effective methods of educating the general public concerning proper personal health care.[3]

Health Planning in Virginia

The managing and planning structure of the health programs in Virginia is three-tiered: the subarea council, the HSA and the state council. The subarea councils may be located either within the structure of the planning district commission or set up under separate quasi-public auspices within the same regional jurisdiction as that of the planning district commission. Their anticipated functions are to include identifying local health problems within a planning framework developed by the HSA, developing plans and priorities,

maintaining a local constituency, raising money from local sources, and reviewing and commenting on local health care projects.

The intermediate tier of the program is the HSA itself. The anticipated functions of the HSA are to work with the subarea councils in the development of a unified budget and policies, to establish administrative and management policies for HSA operation, to coordinate and supervise staff activities and subareas, to develop and implement a health education plan, and finally to make a consistent and continuous effort to identify problems, determine needs and relative priorities for the improvement of the health care system.

The final tier, the State Health Council, will retain most of the functions mandated under the 1966 Act; namely, the collection and dissemination of information and statistics for health planning, and assistance to regional agencies. It is expected to build on what has already been achieved, relying on experience and expertise.

The Department of Health, Education and Welfare mandated a number of guidelines that must be met for the approval of boundaries. USA's will serve a population between 500,000 and 3,000,000 and each SMSA will be included in its entirety within an HSA unless, in either case, a waiver is granted. Health Service Agencies will also be based upon a geographic region "appropriate for the effective planning and development of health services."[4] Factors to be considered include functional economic areas, state boundaries, time and distance, costs factors, health services utilization and referral patterns, special population characteristics and the coverage of major prepayment plans and Health Maintenance Organizations.

Non-metropolitan areas are to be given special consideration concerning the HSA designation process. Such factors as travel time, economic and/or geographic barriers are to be minimized. Ideally, each HSA should include a center that provides highly specialized health services and the HSA boundary designation should be coordinated with the Professional Standards Review Organization (PSRO) boundaries, existing regional planning areas and state planning and administrative areas. Finally, the Governor should consult with the chief executive officer of all health-related agencies.

The delineation of HSA boundaries was a controversial issue in Virginia.[5] The designation process that Governor Godwin proposed was five Health Service Areas which would be congruent with the Professional Standards Review Organization. PSRO's are medical review bodies for localities and were established in June, 1974. The justification for this porposal is that the law states that the HSA's and the PSRO's be closely coordinated (see Figure 2).

On the other hand, the areawide health councils, the 314(b) agencies, recommended the establishment of seven HSA's. Their arguments centered around the desire to localize health planning in that the health problems in Southwest Virginia are different in type and quantity from those in Central Virginia (see Figure 3).

The Department of Health, Education and Welfare approved six HSA's. The approved plan is very similar to the Governor's proposal except for one change. HEW ordered one interstate area in which Scott and Washington counties are joined with several Tennessee counties (see Figure 4).

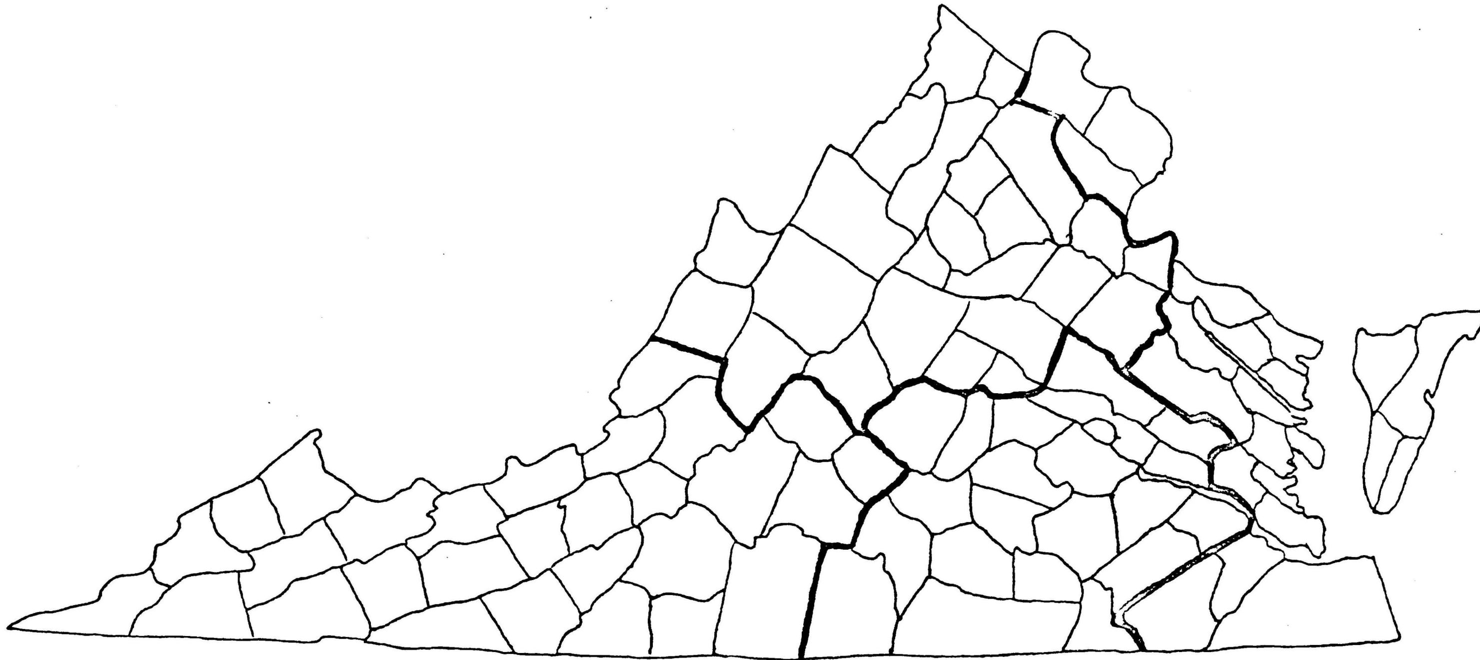

FIGURE 1. Virginia Health Service Area Boundaries (5) as submitted by Governor Godwin to HEW.

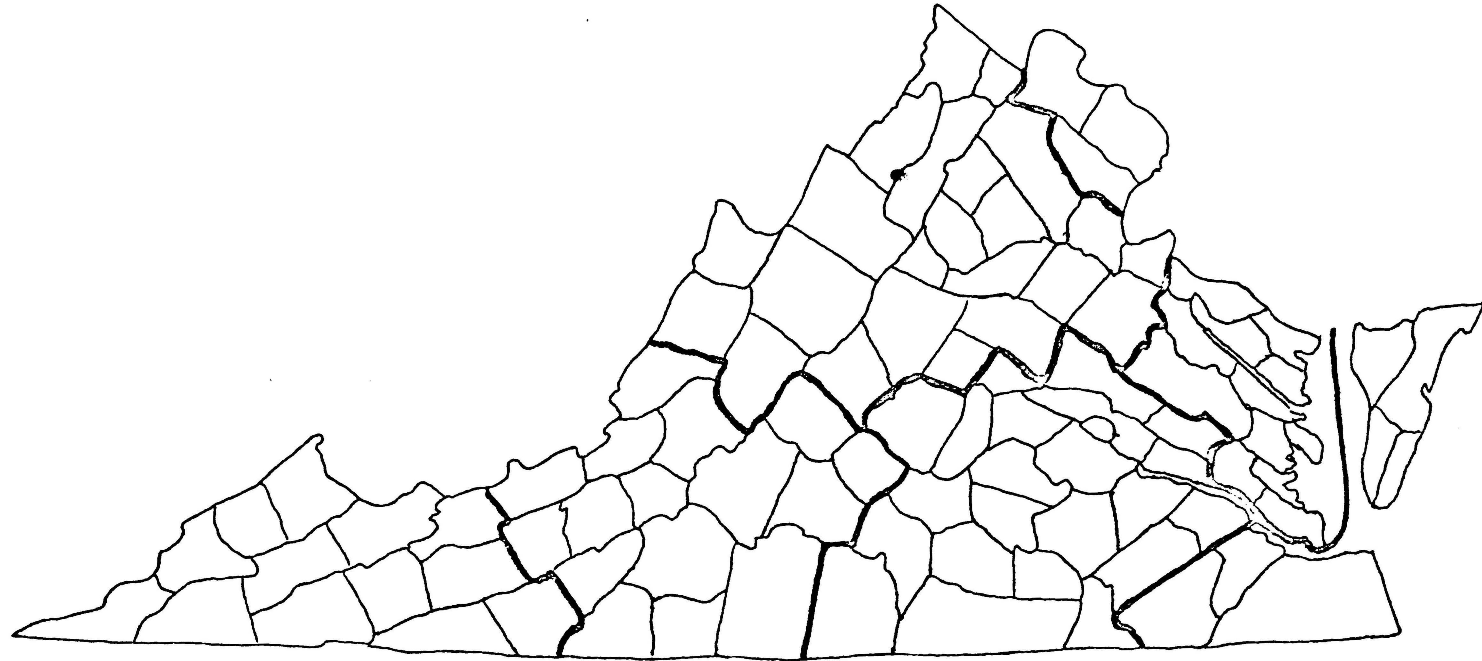

FIGURE 2. Virginia Health Service Area Boundaries (7) as Recommended by State "B" Agencies.

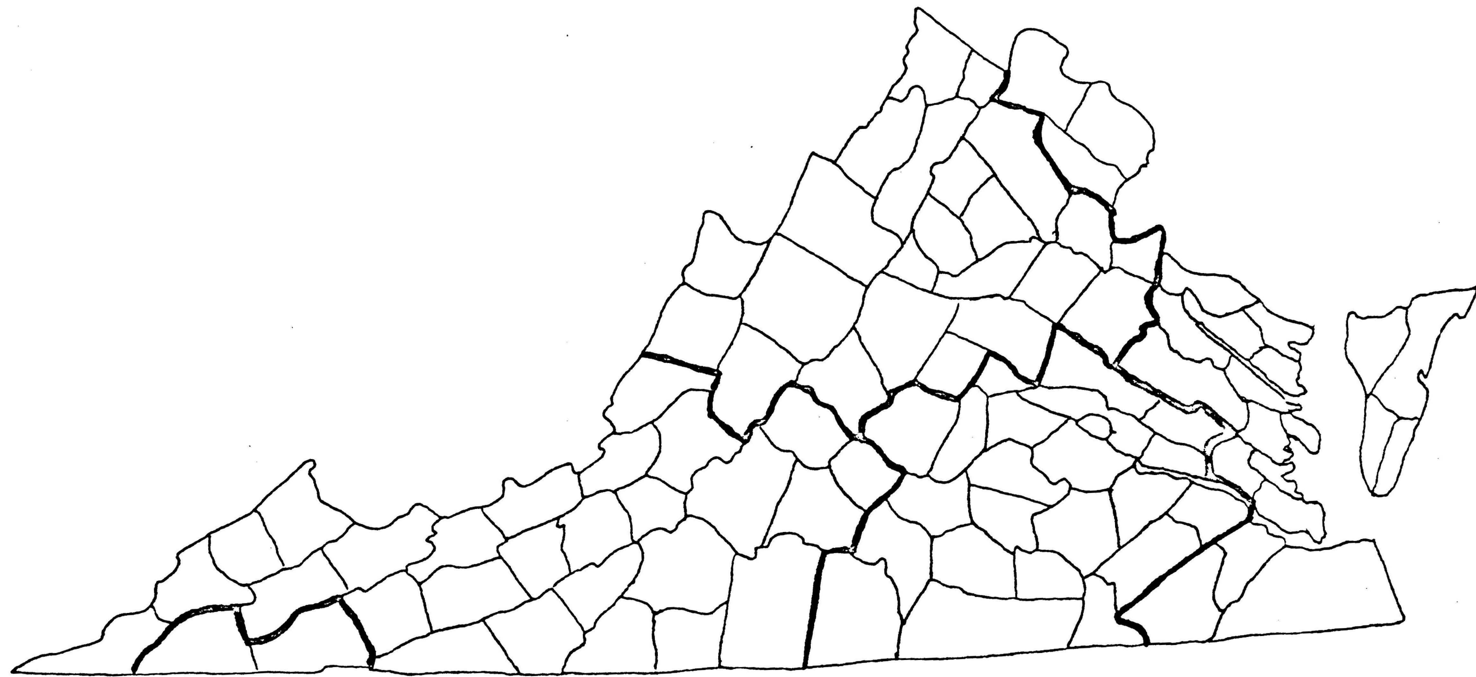

FIGURE 3. Virginia Health Service Boundaries (6) as Approved by HEW.

Many planners have argued that the regional planning body should house the comprehensive health planning body. In Virginia, the planning district commission, whose establishment was recommended by the Hahn Commission, is the appropriate organization to carry out regional planning activities. Planning district commissions were created to cope with regional problems such as those occurring in the health field. This arrangement maximizes public and political integration along with maximizing public sector influence. In addition, there is a presence of a long term focus, a regional-bounded scope and there are explicit goals, objectives and priorities based on analyzed resources and local potentials. Finally, there exists an unspoken mandate of elected representatives on public regional councils to provide some influence over health costs, accountability and objective evaluations. However, seventy-four percent of the areawide Comprehensive Health Planning agencies were created as private organizations. The Health Council in the New River Valley region is a public organization while the 314(b) agency of the Mount Rogers region is nonprofit and private.

CHAPTER III

DETERMINATION OF CRITERIA

To evaluate a program, a criterion or set of criteria is needed which adequately measures the performance of the program in achieving its original intent. One appropriate criterion to evaluate health planning in Virginia is cooperation, based on the expressed intent of relevant federal health planning legislation and the importance of cooperation found in the Hahn Commission Reports.

Cooperation is defined for purposes of this paper as the joint effort of two or more parties to reduce the magnitude of common problems. A willingness to interact is implied which is usually induced by the importance of the problem, planning requirements under federal grant-in-aid programs, and/or requirements to receive many federal and state funds. Most cooperative efforts are based on structural arrangements such as a planning district commission. Historically in Virginia, PDC's were based on certain federal and state incentives.

The criterion of cooperation can be derived from The Comprehensive Health Planning Act of 1966 and The National Health Planning and Resource Development Act of 1974. It is stated in the description of the intent and purpose of the 1966 Act that the accomplishment of providing every person with the best health care possible "depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations."[6] In addition, HEW only approves those State

plans that "provide for encouraging cooperative efforts among governmental or nongovernmental agencies, organizations and groups concerned with health services."[7] Cooperation remains an important criterion with the passage of the National Health Planning and Resource Development Act of 1974 since the intent of both laws are similar and the latter act deals mainly with the reorganization of health planning councils.

Another piece of federal legislation indicating that cooperation is an appropriate criterion is the Project Notification and Review System. Regional clearinghouses are established and its role is to receive notification from prospective applicants, identify appropriate state and local agencies that might have programs affected by the proposed project, conduct their own evaluation and send the clearinghouse's comments to the federal funding agency. The Advisory Commission on Intergovernmental Relations has stated that by using the clearinghouse for areawide functional planning instead of separate regional agencies, presumably coordination of the plans and integration with or into comprehensive plans would be facilitated.

Additional evidence that supports the use of cooperation as the evaluative criterion, especially in Virginia, is a report entitled "Metropolitan Virginia: A Program for Action." To deal with escalating urban problems such as those occurring in the health care systems, the Virginia General Assembly created the Virginia Metropolitan Areas Study Commission. The Commission was composed of fifteen members, all appointed by Governor Mills E. Godwin, Jr. and was chaired by Dr. T. Marshall Hahn, President of Virginia Polytechnic Institute and State University.

The Commission was to focus on increasing intergovernmental cooperation and to provide a means so that the state could play a more assertive role in dealing with the "urban crisis" and other problems of a regional perspective such as inadequate health care systems. The Commission made a number of recommendations including the division of the state into planning districts, better structured and better financed than the scattered regional planning commissions.

In granting the authority to local governments to form planning district commissions, the General Assembly identified the need for locally-based, regional agencies to address problems of a multi-jurisdictional nature. The General Assembly recognized that community development problems were areawide by defining the purpose of the planning district commission as the promotion of "the orderly and efficient development of the physical, social, and economic elements of the district by planning and encouraging the assisting governmental subdivisions to plan for the future."[8]

Planning district commissions were established so that local governments could plan cooperatively for areawide development and arrive at joint agreement for providing services. This objective is reflected in the types of services offered by the planning district commissions. Coordination and intergovernmental affairs programs are implicit in all planning activities but are also undertaken by the commissions as separate work programs. These include the Project Review and Notification System (A-95), development of intergovernmental agreements, providing state and federal program information and acting as a liason between the localities and the funding agency.

By using the clearinghouse for areawide health planning instead of separate regional agencies, presumably coordination of those plans and integration with comprehensive plans would be facilitated. Moreover, the pooling of federal areawide planning funds could enable the clearinghouse to develop both a common planning staff and a project review staff paid for with federal dollars. These staff economies could produce better plans, more effective reviews, and faster processing of applications.

Determination of Submeasures

The criterion of cooperation is too vague to evaluate functional programs. Therefore, cooperation is divided into a number of components that can be measured more easily. The component parts include: (1) lack of conflict; (2) intergovernment agreements; (3) functional integration; (4) communication; (5) elimination of duplicated efforts; (6) consensus of values; and (7) effect of personalities. Many of the measures are self explanatory; however, a brief discussion of how each relates to cooperation is included.

Lack of Conflict

Conflict is a natural phenomena that can be beneficial or disadvantageous depending upon its degree and its resolution. Conflict has been classified into three modes of confrontation, which are power play, bargaining, and collaboration.[9]

In the power play situation, the actions are unilateral. All of the power technicians' resources are unleased against the opponents to aim on given issues or long-range programs. No quarter is given,

no compromises are made when power can overcome and win all of the immediate goals for the powers protagonists.

In bargaining classification, each side admits the power position of the other. Each recognizes that the restraints inherent in the other's power position will not permit one side or the other to achieve the total control desired by each. Each assumes that neither party will emerge satisfied from the confrontation, but that both, through negotiation, will establish a power parity. Consequently, each side can get something it does not have at the start, or more of something it needs or wants. Usually, in order to gain one thing, each side must give up something which to them is a lesser importance. The "game" is to maneuver shrewdly, using whatever tactics they can to get the maximum from the other side by giving up as little as possible.

Finally, both sides accept that their own needs and fulfillment are best served in the long run by putting the preservation of the organization's task-goal energies ahead of them. They accept the opponent's problems to be as important and meaningful as their own and therefore worthy of equitable solution. It is thought that the energies of the concerted effort of those working jointly put to work creatively for the betterment of the organization can achieve more for them individually in the long run in terms of security, benefits and personal satisfactions than using the energies of their separate powers to try to dominate the opposition for the immediate, and perhaps, the lesser rewards.

Power play is the least desirable in terms of multijurisdictional cooperation. Generally, aggressive and hostile feelings exist between those locked in the power struggle, shutting off communication and interaction. At the other extreme is collaboration where these very little conflict. While, on the surface, collaboration seems to be the ideal situation, there is a good deal of value in conflict. First, conflict processes which are institutionalized function as preventive measures against more destructive outcomes. Essentially it diffuses of more serious conflict. Second, the conflict process can stimulate a search for new facts and solutions or lead to the clarification of facts. Third, conflictive situations may increase a group's cohesion and performance. Therefore, conflict may be a prerequisite of coordination.

Intergovernmental Agreements

Intergovernmental agreements are a "hard" indication of cooperation. It can be assumed that the participants have recognized its value of a teamwork approach in dealing with common problems on a regional scale.

There are a number of variables that must be given attention in the opinion of the author, when considering intergovernmental agreement. First is the number of agreements dealing, either directly or indirectly, with a functional area. Second is the type of agreement. This includes such factors as the amount of participation of each member, how easily the agreement is abolished and if the agreement concerns one functional area or a number of these. Third, the significance of the agreement must be measured. It should be

determined if the agreement is effectively contributing to problem resolution and if there is a good working relationship among the jurisdictions.

Functional Integration

A coordinated health planning system relies on the degree to which it has become integrated with other functional planning areas and its relation to other health-related programs. It depends on an awareness of what is going on in other areas of community development and the ability to relate health goals and actions with those of other activities. For example, transportation and land use planners should be called upon for aid in anticipating where population will be spatially distributed and what kind of transportation networks are likely to develop. Both are vital considerations in locating new hospitals and other health facilities as well as in anticipating other changes that might affect aspects of the health profile. As bridges between the various health interests represented in comprehensive health planning and other functional planning programs, cooperative efforts are more easily established.

A coordinative health planning effort also requires the active participation of the other health agents who are concerned with health care. While the various public and private health organizations may have different objectives and carry on an assortment of activities, they are related to accomplishing a general health goal, that of providing the best health care possible. Therefore, the 314(b) agency should become an integral part of health related activities.[10]

Some amount of integration is necessary because of the requirements of determining the Certificate of Need and the role of the A-95 Review Process. However, this degree of integration should be regarded as minimal for very little planning can emerge from these efforts.

The successful operation of a regional planning body depends on the degree of support and interest obtained from those concerned with the health field. This requires a continuing information and educational program.

Communication

Communications can be divided into direct and indirect methods or techniques. The direct approach utilizes the more personal or individualized method of communication. These include telephone calls, personal visits and personalized replies to inquiries. The indirect approach is a better method to reach a larger segment of society. The weekly, biweekly or monthly newspaper, newsletter, and radio, among others, are used in this approach.

Not only is it important for the health planning body to participate in some form of communication with the agents of health planning, but the agents must also communicate with the 314(b) organization. The importance of communication as a measure of cooperation depends on the kind, direct and indirect, and frequency of two-way communication with the health agents. One-way communication omits the transactive quality necessary for a cooperative approach to problem solving.

Elimination of Duplicated Efforts

Another measure of coordination is organization success in reducing or eliminating the duplication of effort. In a functional

area such as health care, there are numerous organizations that deal with only a single health-related facet. This situation can result in an overlap of delivery services that wastes time, effort and money. In an ideal cooperative situation, each dollar spent would provide a certain amount of health care not yet provided. For example, three independent nutritional programs catering to the same population in a certain jurisdiction is not as economical or efficient as a coordinated one where there is no overlap in jurisdiction and/or effort.

Consensus of Values

Values, essentially, are attitudes for or against an event or phenomenon, based on the belief that it benefits or penalizes some individual, group or institution. A consensus of values is important in the context that regional and local organizations attempt to maximize a common value or set of values. The difference among value sets on a policy-making board can have a significant effect on cooperation. The strength of commitment to the value (its priority) and the role of a particular person or group in the decision-making process are important factors in the relation of values to cooperation.

There are few planning policy decisions which do not involve value judgments. In the course of making recommendations based on technical coordination, the planner is also making value judgments. Consequently, the formulation of planning policy is often accompanied by conflict. The relevant decision-making body, in this case the local health planning organizations, must ultimately decide how or if they should act on an issue or a planner's recommendation.

Most regional health goals concern improving health conditions of the region and providing the best comprehensive health care. However, due to the various sets of value judgments, there may not be any one way of establishing or implementing policies or programs. Even though value sets are individual, many authors have classified groups by their values. For instance, health planning organizations are composed of consumers and providers. Other classifications include elected officials, planners, special interest groups, government, and the public. Other classifications are available, however, an individual's value set determines his behavior and role in the planning process.

Effect of Personalities

To enhance coordination in human service delivery, the individual staff members must be both the actor and target of the interaction. The study of personality deals with the individual as a system of needs, feelings, attitudes, deficiencies and roles. These elements combine to determine an individual's behavior in a social milieu.

The individual places greater emphasis on ambition and the appropriateness of the job to his personality than does the organization. Each individual makes unique demands of his job depending on the composite of his needs. To the extent that there is congruence of aims, norms and personality, the organization is efficient and the workers are satisfied.[11]

However, in many instances the personality of the staff member and the demands required in the daily operations of the organization are not congruent. The individual may attempt to change the

organizational structure and the pertinent responsibilities. In an organization such as the planning district commission, organizational change can be easily undertaken for there are very few rules regarding an uniform structure.

The members on the governing body are just as important as the staff members. Political Influence by Edward Banfield illustrates this point. Where leaders emerge who have the support of their peers and the political situation is characteristic of the machine politics of Chicago, Banfield states that the role of planning is to assemble data that justifies and supports privately-made proposals. Therefore, the dominant personalities of the staff or governing body may manipulate the organizational structure, purpose and operations of the organization to satisfy personal needs, attitudes and motivations.

CHAPTER IV

APPLICATION OF CRITERIA

The health planning efforts in the Mount Rogers and the New River Valley Planning Districts have been selected for evaluation. They are relatively similar in their rural character, approximate geographic size, population and budget. The evaluation facilitates the identification of common problems which may be applied to health planning in Virginia.

Health Planning in the Mount Rogers Planning District

The 314(b) agency of the Mount Rogers Planning District was established in a great deal of controversy. When the legislation mandated the organization of areawide Comprehensive Health Planning councils, a debate began concerning the position of the 314(b) agency in the administrative structure of the planning district commission. The basic issue revolved around whether the 314(b) agency should be a voluntary, non-profit, private organization or a public one housed in the planning district commission. The actors involved in the debate were the Mayor of Wytheville, the President of the 314(b) agency, and the Executive Director of the Mount Rogers Planning District Commission. The major and the President of the 314(b) Agnecy favored the private organization and the Executive Director of the PDR wanted the 314(b) agency to be integrated within the planning district commission.

Available information indicates that there was a good deal of conflict among these personalities. This is not to diminish the importance of the decision concerning the structural position of the 314(b) agency, but the controversy grew with conflicts over who would be authorized to sign checks, who the health planner would report to and the amount of the health planner's pay. The subject of many sub-controversies seemed to have little relative importance to the main issue. It appears that the three individuals had a very strong ambition and complete satisfaction was more desirable than compromise. The situation ended with the formation of the voluntary, private organization and with the PDC Director leaving the Mount Rogers Planning District Commission.

The 314(b) agency was formally recognized by the planning district commission approximately two years ago but before that time, the lack of health planning in that region caused a number of adverse effects. Because of the late development of the 314(b) organization, it was not eligible for federal funds. As a result, the organization does not carry out any health planning activities other than the determining of certificate of need. In additiona, the conflict has caused the delay of a number of health-related projects that had to receive approval from the 314(b) organization. Mr. Jack N. Lee, the present Executive Director, stated that health clinics could have otherwise already been constructed in Wytheville and Washington Counties. At the present, the clinics are still not completed. Another example concerns the Wytheville Community College's desire to initiate an Emergency Medical Technician's Training Program using money from an

Appalachian Regional Commission Grant. The Department of Health, Education and Welfare would not approve the ARC grant because the Mount Rogers region did not have a health plan. Finally, the controversy did not reflect well on either organization. It alienated many governmental officials, the public and others interested in health care and regional planning activities.

Lack of Conflict

At the present, the 314(b) organization is attempting to cope with a number of problems. The group has reorganized to meet federal guidelines regarding participation requirements. It has become a more representative body but by no means does it represent the health related interests of the entire region. There is also a problem regarding jurisdiction under the new HSA legislation. It is not definite whether Washington County, Scott County and the City of Bristol will be represented in Virginia or Tennessee HSA's. Finally, it appears that no one has assumed a strong leadership role in the 314(b) agency. Although it functions to determine certification of need, the agency is inactive in other areas of health planning and management.

Intergovernmental Agreements

The absence of a health planning effort by the 314(b) organization did not stifle others from engaging in other coordinating, health related activities. The Southwest Virginia Health Consortium is a regional organization that covers only part of the planning district, including the counties of Smyth and Washington and the City of Bristol. It was begun through the actions of three local community colleges; Virginia Highlands, Mountain Empire and Southwest Virginia. This group

brings together all health and human resource agencies to find out what the human resource needs are in the field of continuing education and proposes and implements plans to provide them.

Another recently initiated council is the Human Resources Roudtable. Such fields as mental health, education, welfare, and family services have been represented. Dr. Diane Valla, the Human Resources planner for the Mount Rogers Planning District Commission, was instrumental in starting the Roundtable sessions which are held monthly. The idea of bringing representatives of these agencies together grew out of the realization that many agencies are not fully aware of the resources and activities of other similar agencies. The concept of getting together to exchange ideas and insights have been unanimously endorsed. Such areas as possible overlap, shared responsibilities, methods of implementing programs and the availability of mutually beneficial resources are discussed.

The Mount Rogers Planning District Commission has recognized the importance of the Human Resources Roundtable. At its March meeting, the Mount Rogers Planning District Commission Executive Committee went on record as supporting the formation of the roundtable group and invited the group to consider becoming an advisory council to the Mount Rogers Planning District Commission. The Executive Committee also expressed a willingness to amend its by-laws to accommodate the Human Resources Roundtable.

Dr. Valla is paid out of annual local contributions and the funds from the Appalachian Regional Commission. Her functions include acting as a liaison between the planning district commission and the various

health-related agencies; to provide information to local governments regarding health-related programs and funding, to provide and establish contacts with representatives of federal and state agencies that provide money for health projects and facilities; to know and provide information regarding state and federal legislation concerning health planning; and to coordinate, by function of being the regional clearinghouse, the local health programs. In addition, Dr. Valla is working with the 314(b) agency so that it can assume a more responsible role.

Functional Integration

There is a high degree of functional integration in the Mount Rogers region both in relating health planning to other functional areas and in the participation of health-realted organizations. The approach of the Mount Rogers Planning District Commission in dealing with social needs was establishing Human Resources planning instead of treating each component of Human Resources independently. The Human Resources program at MRPDC includes Health, Mental Health, Emergency Medical Services and Health and Child Development. The involvement of a single planner in these various areas fosters a perspective that is integrating all social needs. Also, the importance of relating health and other social areas to physical planning is recognized by the Human Resources planner and the Executive Director which facilitates the integration process.

Many health-related organizations, both public and private, participate in the health planning process. The Human Resources Roundtable is the medium used for participation. Among the

organizations that have participated at roundtable sessions include:

> Southwestern State Hospital, local and regional Welfare offices, community action programs, mental health and mental retardation service agencies, community colleges, Mount Rogers Governmental Cooperative, local governments, Information and Referral of Washington County, Department of Vocational Rehabilitation, Southwest Virginia Health Consortium, RMCA, Mt. Rogers Alcohol Safety Action Program, Southwest Virginia Training Center, Appalachian Commission Office of Special Programs, ministerial associations, VPI&SU Extension Service, Southwest Virginia Manpower Planning Council, alcohol and substance abuse agencies, Legal Aid, Virginia Appalachian Education Cooperative, libraries and public health.[12]

The importance of the Human Resources Roundtable's role in functional integration is greatly enhanced with the Roundtable becoming an advisory committee to the planning district commission.

Communication

There also appears to be strong links of communication within the Mount Rogers planning district among health agents. There are two groups besides the 314(b) organization that deal with health, the Human Resources Roundtable and the Southwest Virginia Health Consortium. Both have effectively established an atmosphere conducive for discussion and interaction from a variety of perspectives. The 314(b) agency, the Southwest Virginia Health Consortium, and the MRPDC are invited and take an active role in the roundtable sessions. Each group distributes reports, minutes of meetings and like material to the others. Although both direct and indirect forms of communication are used, most of the communication methods used are direct and facilitate transactive, two-way interaction on a personal basis.

Elimination of Duplicated Efforts

The health planning efforts have not had a significant effect in eliminating the duplication of effort. The reasons for this is the relative inactive operations of the 314(b) organization and the recent establishment of the Human Resources Roundtable. However, through the initiation of the Roundtable, there is a good potential for reducing the amount of overlap in the health care system.

Consensus of Values

There are, of course, many value sets concerned with health planning. However, these are two dominant values that have a high priority. They are (1) to provide the best health care possible, and (2) coordination, itself. The Mount Rogers region has been economically and socially depressed for many years. This is evidenced by their inclusion into the Appalachian Regional Commission. Another characteristic of the area is that, in general, the population is relatively small and scattered. In addition, there is a common notion among Southwest Virginians that from the view of the state administrators, the state ends at Roanoke. This notion is fostered by the fact that Roanoke is the largest metropolitan area in southwestern Virginia and a great deal of the remaining area is rural. For these reasons, an adequate health system is a higher priority than many other functional areas and it took little action on the part of the planning district commission for action to be taken.

Coordination, itself, is a value of high priority not only characteristic of health planning but in many other activities. Due to the small population and its scattered form, it has been recognized

that there is strength in numbers. This is particularly true in applying for Federal and State grants. There is a predominant attitude of "you and me against the world" where cooperative activities are not only helpful but a necessity in providing more productive programs.

Effect of Personalities

The personalities of the people who are instrumental in the health planning effort have had a significant impact on the coordinative effort. A great deal of the success in cooperation can be attributed to the Executive Director, Mr. Lee and the Human Resources planner, Dr. Valla. Mr. Lee is a friendly, easy-going person that does not attempt to force ideas on people but is very effective in pointing out the advantages and disadvantages of a particular issue. He remains in constant contact with elected officials and the various groups and organizations. The relationship he has developed between the planning district commission and the other groups is based on a mutual trust. Dr. Valla is dedicated in aiding the region to help itself. This is exemplified by her efforts in starting the Human Resources Roundtable. Both individuals view themselves as having a secondary role in the decision-making process which facilitates the cooperative effort.

Figure 5 is a brief summary of the evaluation of the health planning process in the Mount Rogers Planning District. This approach to health planning is somewhat different than that of the New River Valley Planning District. There are inherent advantages in this approach which are discussed at the end of the chapter.

TABLE 2

SUMMARY OF HEALTH PLANNING IN THE MOUNT ROGERS PLANNING DISTRICT

Lack of Conflict	Few significant problems generating conflict, most pertain to the new HSA legislation.
Intergovernmental Agreements	There are 3 intergovernmental agreements--314(b) Agency, SWVHC, Human Resources Roundtable.
Functional Integration	Health planning is integrated by means of the Human Resources program, Human Resources Roundtable, determination of certificate of need and A-95 review process.
Communication	Well-established communication linkages, exchange of written documents, two-way communication.
Elimination of Duplicated Efforts	No significant effect on duplicated efforts due to recent initiation.
Consensus of Values	There is a consensus of values optimizing cooperation itself.
Effect of Personalities	Dominant personalities foster cooperative activities.

Health Planning in the New River Valley Planning District

The 314(b) organization in the New River Valley Planning District is the Health Council. It is a public organization associated with the New River Valley Planning District Commission (NRVPDC) and is the only health planning organization in the region. It is funded by the Department of Health, Education and Welfare and boasts of having the only Health Plan in Virginia.

There was a minimal amount of conflict concerning the establishment of the 314(b) agency. The NRVPDC was in favor of housing the 314(b) agency in the commission's organizational structure because it saw itself as being representatives of local governments which was conducting regional planning activities. Therefore, it seemed logical that the planning district commission should also conduct the areawide comprehensive health planning programs.

The NRVPDC worked very hard to become qualified to receive the responsibility of health planning because the regional administrator of HEW was opposed to designating health planning to public organizations. The NRVPDC wrote a number of letters to administrators in both the regional and federal offices of HEW and met with the regional administrator to discuss the situation. The HEW representative stated that the Health Council had to be autonomous and could not be a subsidiary advisory group to the Commission.

A compromise was finally agreed upon. The 314(b) agency would be a public organization, however, if the Health Council made a recommendation, they were free to forward it directly to HEW. The Health Council would also forward the recommendation to the planning

commission. The NRVPDC may also forward a recommendation to HEW that is contrary to the recommendation made by the Health Council but does not have the authority to change the findings of the Health Council.

Lack of Conflict

Since the establishment of the Health Council, there have been three situations involving some degree of conflict. The first is providing a doctor in Floyd County. There was an attempt to place a physician there using the National Health Service Corps which is a federally-funded program. However, a number of doctors were against the proposal, objecting to any form of socialized medicine. The second conflict arose from the question of whether the two rescue squads in Pulaski County should be merged. Each rescue squad wanted a designation of service areas whereas the administrators of the county favored a merger. The third conflict concerns indigent obstetrics. Many more "welfare babies" were being delivered at Radford Hospital than is characteristic of the population for that area. For example, most low income mothers who use the public health pre-natal service go to Radford Hospital to have their babies delivered because physicians in Montgomery County refuse to have them as patients.

These conflicts offer an interesting clue about the willingness of local health agents to cooperate. As of yet, none of these issues have been resolved. The doctor issue has been in a state of flux for over a year. It appears that the representative members on the Health Council do not share a cooperative spirit even on a relatively unimportant issue of merging two rescue squads.

Intergovernmental Agreements

There are several intergovernmental agreements concerning health planning other than the Health Council. The Area Agency on Aging is an organization which deals with the elderly. It was originally a concern of the Health Council but since then, it has been reorganized as a separate organization. Presently, the Area Agency on Aging is suffering from a lack of interest on the part of the local jurisdictions. The Alcohol Safety Program is a federally funded activity that concerns the problem of intoxicated motorists. The Health Council, Area Agency on Aging and the Alcohol Safety Program enjoy a relatively close working relationship even though each has assumed its own functional jurisdiction. There is a formal coordinative link among the three because they are housed within the planning district commission structure.

Functional Integration

Health planning is integrated with other functional activities through the A-95 Review Process and because it is part of the planning district commission. The planning commission has the responsibility of reviewing regional projects to make sure they conform to regional policies and goals. There is also an informal interaction that takes place among the functional areas where the health planner, Mr. David Nunley, may have an opportunity to comment on plans and projects that indirectly relate with health care.

Health planning is also integrated with other health agents. The determination of the Certificate of Need requires a minimal amount of integration. In addition, the Health Council has identified all

health agents of the region with which coordinative relationships are established. However, the Health Council suffers from a similar problem as the 314(b) agency in the MRPDC; it is not representative of all health agents in the region. In the New River Valley region, it appears that the health agents do not express a willingness to participate in the areawide comprehensive health planning process. This point is further explored later in the chapter.

Communication

There is a well established communication link between the Health Council and the NRVPDC. The health planner, Mr. David Nunley, attends all the meetings of the Health Council and its various committees. He, in turn, regularly contacts the Executive Director, Mr. Gordon Dixon, and keeps him abreast of what is happening in the health field. When there is a recommendation to be made, the Health Council usually forwards it directly to the planning district commission. Because of the autonomous structure of the Health Council, most questions and issues of a health-related nature are submitted directly to the Health Council by the local jurisdiction.

In addition, the Health Council refers copies of important reports, plans and like material to health organizations, public and private, that may have an interest. The Council may receive feedback from the materials if the organization takes the initiative. There is no formal means of receiving comments for it is assumed that most disagreements are represented in the Health Council.

Elimination of Duplicated Efforts

It is difficult to measure the Health Council's activities in attempting to eliminate the duplication of effort. The duplication of health-related efforts is not a primary or even a secondary concern of the Health Council. Health planning in the New River Valley Planning District Commission is oriented toward meeting state guidelines such as providing an adequate number of hospital beds based on Hill-Burton formulas. Issues concerning duplication of efforts have not been discussed by the Health Council.

Consensus of Values

It appears that the providers of health care dominate the Health Council. The new HSA legislation calls for a partnership of providers and consumers. Mr. Nunley stated that this implies a senior partner and a junior partner. The providers have become the senior partner.

Certain characteristics of the region have allowed the providers easy access into their role. The local jurisdictions that compose the NRVPDC view themselves as independent, self-sufficient governments. While they are indeed independent and possibly self sufficient, this attitude that the local jurisdictions have assumed is very important in terms of establishing a cooperative relationship. Paraphrasing Mr. Nunley, a reason the local jurisdictions participate in the health planning process is to protect ones "turf" from an impingement of other similar organizations.

Another characteristic of the New River Valley Planning District is that health is not a high priority area. Consumer interest is very low unless an issue arises that directly affects a particular

segment of the public. After the issue is resolved, public interest falls to the level it was previously. The reason for this is not clear. Consumer representatives are not vocal in the Health Council and usually vote with the majority.

Finally, it seems as if health planning in the New River Valley Planning District is a "top-down" process, where the Health Council plans for the local jurisdictions instead of with them. This is suggested by Mr. Nunley's statement that no regional health planning organization would have been formed if not for the federal legislation that mandated it. Perhaps this is a result of jurisdictional protection and lack of total acceptance on the part of the local governments.

As the characteristics indicate, the providers of health care assumed the dominant role in the Health Council. The providers have a very high and continuous level of interest regarding Health Council decisions because of their occupation and they attend Health Council meetings much more frequently than consumers. The providers are very protective of this role as reflected in the process of providing Floyd County with a doctor.

Effect of Personalities

Due to the characterizations previously made about health planning in the New River Valley Planning District and because of the autonomous structure of the Health Council, it is also somewhat difficult to assess the effects of personalities. There are very good working relations between Mr. Nunley and Mr. Dixon which have benefitted the cooperative effort. Neither person has overbearing

ambition or other personal traits that hinders a cooperative effort. There does not seem to be an individual on the Health Council whose personality has significantly affected the cooperative aspect of areawide Comprehensive Health Planning.

This evaluation of health planning in the New River Valley Planning District and the Mount Rogers Planning District serves as a basis for the next chapter. Proposals are recommended that, hopefully, would promote a greater degree of cooperation. The recommendations are not directly aimed at the health planning activities in either planning district, but relate generally to health planning in Virginia.

Figure 6 is a brief summary of the evaluation of health planning in the New River Valley Planning District. There are two different methods of health planning in each planning district, and each enjoys advantages relative to the other.

The health planning process in the Mount Rogers Planning District is more representative of the various health agents of the region than the Health Council of the New River Valley Planning District. The Human Resources Roudtable includes the participation of nearly every aspect of health care: consumers, providers, elected officials, public and private organizations, educators, etc. In addition, a more integrated health planning process is enjoyed by the Mount Rogers Planning District. This can be attributed to the initiation of the Human Resources program where health-related information is more easily assembled and the inter-related concerns of health and other social services are easily identified.

TABLE 3

SUMMARY OF HEALTH PLANNING IN THE NEW RIVER VALLEY PLANNING DISTRICT

Lack of Conflict	There are three conflicting situations that have yet to be resolved.
Intergovernmental Agreements	There are 3 intergovernmental agreements--314(b) Agency, Alcohol Safety Program and Area Agency on Aging. Only 314(b) Agency concerned with coordination.
Functional Integration	Health planning is integrated by the determination of certificate of need and A-95 review process.
Communication	Well established links of communication however it tends to be one-way.
Elimination of Duplicated Efforts	Duplicated efforts are not an expressed concern of the Health Council.
Consensus of Values	Value sets of providers reflect the desire to maximize benefits to their group. Consumers are normally non-vocal but are occasionally aroused if an issue directly affects them.
Effect of Personalities	There are no dominant individuals that have affected the cooperative effort.

The health planning process in the New River Valley Planning District stresses long-run health planning which is evidenced by the formulation of the New River Valley Health Plan. This was made possible by adequate financing, which the 314(b) Agency in Mount Rogers does not have, and the desire on the part of the Health Council members to have a plan. It allows the Health Council to predict future needs on a much longer time span than the Human Resources Roundtable of the Mount Rogers Planning District. Also, the 314(b) Agency is incorporated into the planning district commission. This serves to formalize integration and communication by being a part of the planning commission's organizational structure and reduces the potential for conflict between the health planning body and the planning district commission.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

To provide a basis from which recommendations can be made it is necessary to determine the most favorable planning district as they relate to each subcriteria. It is possible, by using this method, to extract the benefits from each style of health planning, cooperative and coordinative, and formulate recommendations that maximize the benefits of each style.

Lack of Conflict

The health planning style of the Mount Rogers Planning District is the more successful method of minimizing conflict. The Human Resources Roudtable provides a medium for the active participation for all health agents and interested public. Since there are no requirements regarding representation, any group or individual may participate. It is also a group that is able to discuss all health-related issues. In addition, this style of planning has generated a consensus of values regarding cooperation itself. It can be attributed to the unique characteristics of Mount Rogers region.

Intergovernmental Agreements

The cooperative style of the Mount Rogers Planning District has generated more productive intergovernmental agreements. Although each planning district has the same number of intergovernmental agreements, the ones in the New River Valley Planning District have been established to carry out federally funded programs. The

intergovernmental agreements in the Mount Rogers Planning District, the Southwest Virginia Health Consortium and the Human Resources Roundtable have been established to provide a method to foster cooperation and to better the existing health care system.

Functional Integration

Both planning districts have been successful in integrating health planning. In the New River Valley Planning District Commission, the 314(b) Agnecy, the Health Council, is housed within the structure of the planning commission. In the Mount Rogers Planning District, a Human Resources program has been initiated which deals with all health-related areas of planning.

Communication

The Mount Rogers Planning District has achieved a greater degree of communication. The highly structured Health Council of the New River Valley Planning District Commission has one-way communication links while communications in the Mount Rogers Planning District is two-way. The establishment of the Human Resources Roundtable has fostered the two-way communication links because most of the health agents in the planning district, including the Planning Commission, the 314(b) Agnecy and the SWVHC, are represented and it is primarily a discussional group considering all social service problems.

Elimination of Duplicated Efforts

The health planning activities in the Mount Rogers Planning District has the greatest potential for eliminating duplicated efforts. Historically, neither planning district has concentrated its efforts

in this area. Duplicated efforts are not an expressed concern of the Health Council in the New River Valley Planning District. The Human Resources Roundtable is only recently established and is the reason for not considering this area yet. However, duplicated efforts is within the scope of the roundtable and will probably be addressed in the near future.

Consensus of Values

The health planning activities of the Mount Rogers Planning District creates a greater consensus of values. This is primarily attributed to the relatively unstructured organization of the Human Resources Roundtable and the unique characteristics of the region. The reinforcement of individual values which is characteristic of committee systems, generally does not take place in the Mount Rogers region. Local jurisdictions and health agents have also recognized that more productive activities can be undertaken on the regional level due to the scattered population and its depressed social and economic characteristics.

Effect of Personalities

Neither of the two styles of planning hinder the harmful effects of individuals with an overbearing ambition nor induce the benefits of individuals working for the good of the region. However, it must be mentioned that the coordinative approach taken by the Health Council of the New River Valley Planning District implies a structural method to avoid conflict. Since many conflicting situations involve the personality traits of individuals, the coordinative approach may be more successful in dealing with an individual's personality.

Recommendations

Recommendation 1

The Mount Rogers and New River Valley Planning Districts have integrated health planning differently in regard to other functional planning activities. The MRPDC has established a Human Resources program where health is one of a number of concerns. The NRVPDC has established separate committees dealing with different functional areas such as health and emergency medical services.

The recommendation to incorporate health planning into a Human Resources program would maximize a number of sub-criteria. First, conflict could be reduced. A broader perspective is achieved pertaining to social services in general. Subcommittees that relate to different aspects of health planning would be eliminated, fostering a concerted effort toward achieving a "better" health care system rather than maximizing a committee goal and creating conflicts among committees. Second, the quality of intergovernmental agreements may be increased. This is attributed to the broader perspective obtained in combining all social services rather than planning by singular functions. Third, the Human Resources program can be a superior type of organization in regards to functional integration. Not only does this arrangement use the A-95 Review Process, but it also relies on interrelationships with all health-related social services. Planning for a single function, such as health or emergency medical services, may discount or ignore these important relationships. Therefore, the Human Relations organization has a greater potential to be more comprehensive than singular functional planning. Fourth, communication should be

enhanced. Formal, direct communication links are established among social services and with physical planning operations due to the recognition of relationships among social services and other functional areas of planning. Fifth, duplicated efforts are more easily eliminated in the Human Resources program. Information regarding the existing delivery of social services can be obtained and synthesized in a larger perspective which facilitates the identification and eliminations of duplicated efforts. Sixth, the Human Resources program facilitates a concensus of values concerned with the provision of a better health care system. This discounts the reinforcement of individual values that is characteristic of the committee or singular functional planning method.

Recommendation 2

In both planning districts, the 314(b) Agency is an autonomous body able to formulate legislative policy with the planning district commission. The 314(b) Agency can send recommendations directly to HEW with or without the commission's approval. The significance of any disagreement that the planning district commission has with the 314(b) agency is determined by HEW. This minimizes the importance of the planning district commission to act on recommendations and policy-making made by the 314(b) Agency. It also generates an area of potential conflict.

This arrangement violates the conceptual reasons for the initiation of planning district commissions in Virginia. The planning district concept was initiated to establish a regional body consisting of local governments in the planning district boundary to solve common problems

such as inadequate health care. The State's enabling legislation states that the purpose of the planning district commission is to plan for social development along with physical development. In addition, the federal government called for regional planning district commissions to act as an agent to coordinate federal programs with the localities. Given the expressed intent and purpose of the planning district commission, it seems only proper that the health planning organization be a part of the commission on a level subservient to the commission along with other councils and commissions.

The argument may also be expanded to include hypothetical situations. For instance, if criminal justice planning were reorganized and received more funds, the Criminal Justice Committee could be established as an autonomous body, increasing the number of policy-making organizations and the potential conflict among them.

Through a unitary organizational structure with the planning district commission having the final approval of health-related policies and programs, a number of sub-criteria can be maximized. First, this recommendation can reduce conflict. Two independent planning and policy-making bodies greatly enhance the potential for conflict. Housing the health planning body within a planning district commission formalizes lines of authority which produces a structured organization that allows a cooperative effort. Second, a greater degree of functional integration may be achieved. Not only can the A-95 Review Process be utilized to review local projects as they relate to other functional planning areas, but other methods are available to achieve integration such as the representation of the health

planning body on a planning district commission. Third, the potential for transactive communication can also be increased. This can be attributed to the establishment of the interrelationships that result from housing the health planning body in a planning district commission.

Recommendation 3

Another recommendation that relates to the organizational structure of health planning involves the representation of the 314(b) agency or the future sub-area council. The Executive Director and Health Planner of both the Mount Rogers and the New River Valley Planning District Commissions responded that the 314(b) agency is not representative. This is an area of great concern to the HSA legislation. The exact number of subarea councils and representatives on the council has not yet been determined. In order to assure the greatest amount of cooperation, each planning district should have one subarea council located within the planning district commission organization. The state is developing a policy where public health services are becoming regionalized along the same boundaries as the planning district commissions instead of using county jurisdiction. Therefore, the planning district commissions should become the "building blocks" of the HSA.

In addition, there should be no upper limits imposed on the membership of the subarea council. However, those subarea councils having a large membership should have an executive committee to facilitate the ease of decision-making. The arguments sustaining this recommendation parallel those made calling for the establishment of the Human Resources organizational structures. The subarea council

can benefit from the participation from all those health-related organizations. There would be a greater base of support and more comprehensive information. Participation is essential for two reasons: (1) the subarea council is going to assume an advisory role to the HSA and (2) the final decision for the approval of a Certificate of Need is usually made on the basis of data presented to the Health Commissioner.

This recommendation also maximizes a number of sub-criteria. First, the potential of conflict would be reduced. The more health-related organizations and interested public citizens that are represented, a greater importance would be placed on achieving a better health care system. There is an assumption that there is strength in numbers. If the assumption is true, a policy-making organization with a large membership can be a valuable tool in the supression of conflict. Second, it is possible to obtain a greater degree of functional integration. Greater representation would allow the participation of all health-related organizations and individuals concerned with health planning. It would broaden the scope of health planning and would increase the participant's awareness of the importance of health planning. Third, greater representation could aid in the elimination of duplicated efforts. The increased representation of health agents on the health planning body would be accompanied by an increased awareness of what the other health agents are trying to accomplish. This is a very important aspect in eliminating duplicated efforts. Finally, greater representation can aid in creating a consensus of values. This is supported by the

assumption that there is strength in numbers and would serve to exert pressure to obtain conformity.

<u>Recommendation 4</u>

Subarea councils require adequate funding if they are to fulfill their responsibilities. A major reason for the lack of productivity of the 314(b) agency in the Mount Rogers Planning District Commission is the absence of funds. If subarea councils are not adequately financed, a similar situation can occur.

This is perhaps, one area where the state can directly participate. The Federal government is making block grants to the states replacing categorized grants. This is a part of the "New Federalism" where the Federal government is allowing the states a greater degree of control in the delivery of services and the establishment of programs. The block grants are an excellent source of revenue for the operation of subarea councils. However, the amount of money that is appropriated to the planning district for health planning purposes is a decision of the State Health Department.

This recommendation would also maximize certain sub-criteria. First, adequate financing would reduce the amount of conflict. Many conflicting situations concern financially-related factors such as the cost of formulating plans, planners' salaries and overhead expenses required in daily operations. Adequately financed health planning processes could reduce the number and magnitude of those conflicts. Second, adequate financing would allow more direct links of communication. A sizable portion of an organization's budget is

spent for the referral of reprints and documents to those interested. A limited budget is an obstacle to the establishment of communication links.

FOOTNOTES

[1]Comprehensive Health Planning and Public Health Services Amendment, 48 U.S.C., sec. 749 (1967).

[2]Robert G. Dyck and David L. Nunley, "Innovations Required to Deal with Issues in Health Services Area Designation: A Case Study in Southwest Virginia," paper presented at the 57th Annual Conference of the American Institute of Planners, San Antonio, Texas, 1975, p. 4.

[3]*Ibid.*, p. 3.

[4]*Ibid.*, p. 18.

[5]*Ibid.*, p. 5.

[6]Comprehensive Health Planning and Public Health Services Amendment, 48 U.S.C., sec. 749 (1967).

[7]*Ibid.*

[8]Virginia Metropolitan Areas Study Commission, "Metropolitan Virginia: A Program for Action," Richmond, 1967, p. 28.

[9]For further information regarding functional integration see "Public Regional Councils and Comprehensive Health Planning: A Partnership?" by Don Ardell in the *American Institute of Planners Journal*, vol. 36, p. 393-404.

[10]Robert Hogan, *Personality Theory* (Englewood Cliffs: Prentice Hall, 1976), p. 78.

[11]Allen Filley, *Interpersonal Conflict Resolution* (Madison: Scott, Foresman and Company, 1975), p. 15.

[12]"Agencies May Form Council," The Mount Rogers Planning District News, Spring 1976, p. 1.

AN EVALUATION OF HEALTH PLANNING IN THE MOUNT ROGERS AND NEW RIVER VALLEY PLANNING DISTRICTS

by

Kenneth David Whittington

(ABSTRACT)

The underlying hypothesis of this paper is that health planning in Virginia has not achieved its full potential. The health planning activities in the Mount Rogers and the New River Valley Planning Districts are evaluated using the criteria of cooperation. Although a number of criteria are appropriate for use in the evaluation procedure, cooperation is used because it is one of the present methods to achieve national health goals.

Cooperation is too general a term to be directly applied, so sub-criteria are determined to measure the cooperative effort. The sub-criteria include: (1) lack of conflict; (2) intergovernmental agreements; (3) functional integration; (4) communication; (5) elimination of duplicated efforts; (6) consensus of values; and (7) effect of personalities.

The discussion centers around the differences between the cooperative style of planning used in the Mount Rogers Planning District and the coordinative style of planning of the New River Valley Planning District. Recommendations are proposed to combine the benefits of both styles of planning.