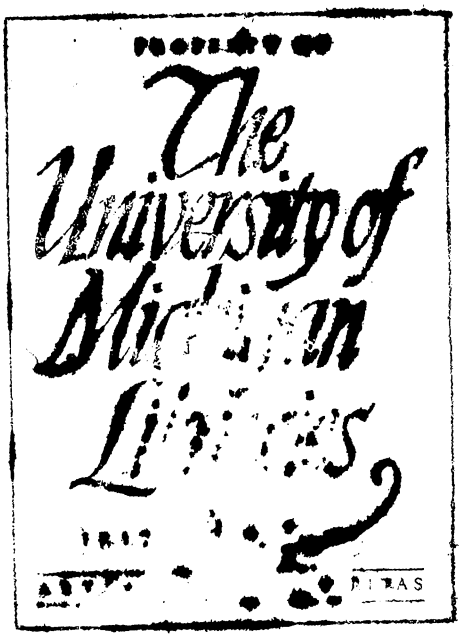
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THE ORGANIZATIONAL DEVELOPMENT OF TWO COMPREHENSIVE HEALTH PLANNING AREAWIDE AGENCIES: A LONGITUDINAL, COMPARATIVE CASE STUDY ON SELECTED VARIABLES

by

DANIEL G. ZAVELA, M.P.H.

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Regional Planning at the School of Natural Resources,

The University of Michigan

1974

Graduate Committee:

Stewart D. Marquis Jr., Chairman
Dr. Philip M. Gregg
Dr. Joseph L. Falkson
Dr. Don P. Haefner

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ABSTRACT

The author studied the organizational development of two area-wide comprehensive health planning agencies, the Southeastern Michigan Comprehensive Health Planning Council and the Mid-Ohio Health Planning Federation. Data were collected by means of a structured interview with a representative of each agency's staff. The interview questions were focused on board member representation, agency funding, jurisdiction, staff recruitment, existence of state enabling legislation, relationships with selected agencies, and agency decisions. When the data from the two agencies were compared with each other and with the author's experiences in a California CHP agency, the result was that each region evidenced a set of political/economic forces which was reflected in the board member representation and which shaped the agency's planning priorities via the local funding arrangements. Setting national performance standards for CHP agencies and the merger of all CHP and COG (public regional planning) agencies are both cautioned against based upon the analysis of data collected in this investigation. Future research topics are suggested.

ACKNOWLEDGEMENTS

My sincerest thanks goes to Darrell Montonaro, M.P.H. who greatly assisted me by collecting data and documents from the Mid-Ohio Health Planning Federation. The kind assistance of Dr. Robert N. Grosse, Professor of Health Planning at the University of Michigan School of Public Health, is also acknowledged for providing documents and historical/experiential information about the Southeastern Michigan Comprehensive Health Planning Council. I am indebted to the Southeastern Michigan Comprehensive Health Planning Council staff, Eugene C. Goeller, Associate Executive Director, in particular, and to the staff of the Mid-Ohio Health Planning Federation, especially Grant A. Drennen, Associate Director, for their kind cooperation in permitting access to many of their documents and their frank and courteous responses to the author's interview questions. Michael T. Savino, Health Grants Coordinator at the State of California Comprehensive Health Planning Agency in the Department of Health, receives my thanks for promptly and thoroughly answering my questions regarding 314b agency funding trends in California. I have great appreciation for the guidance given me by members of my thesis committee and for their personal interest in my investigation.

INTRODUCTION

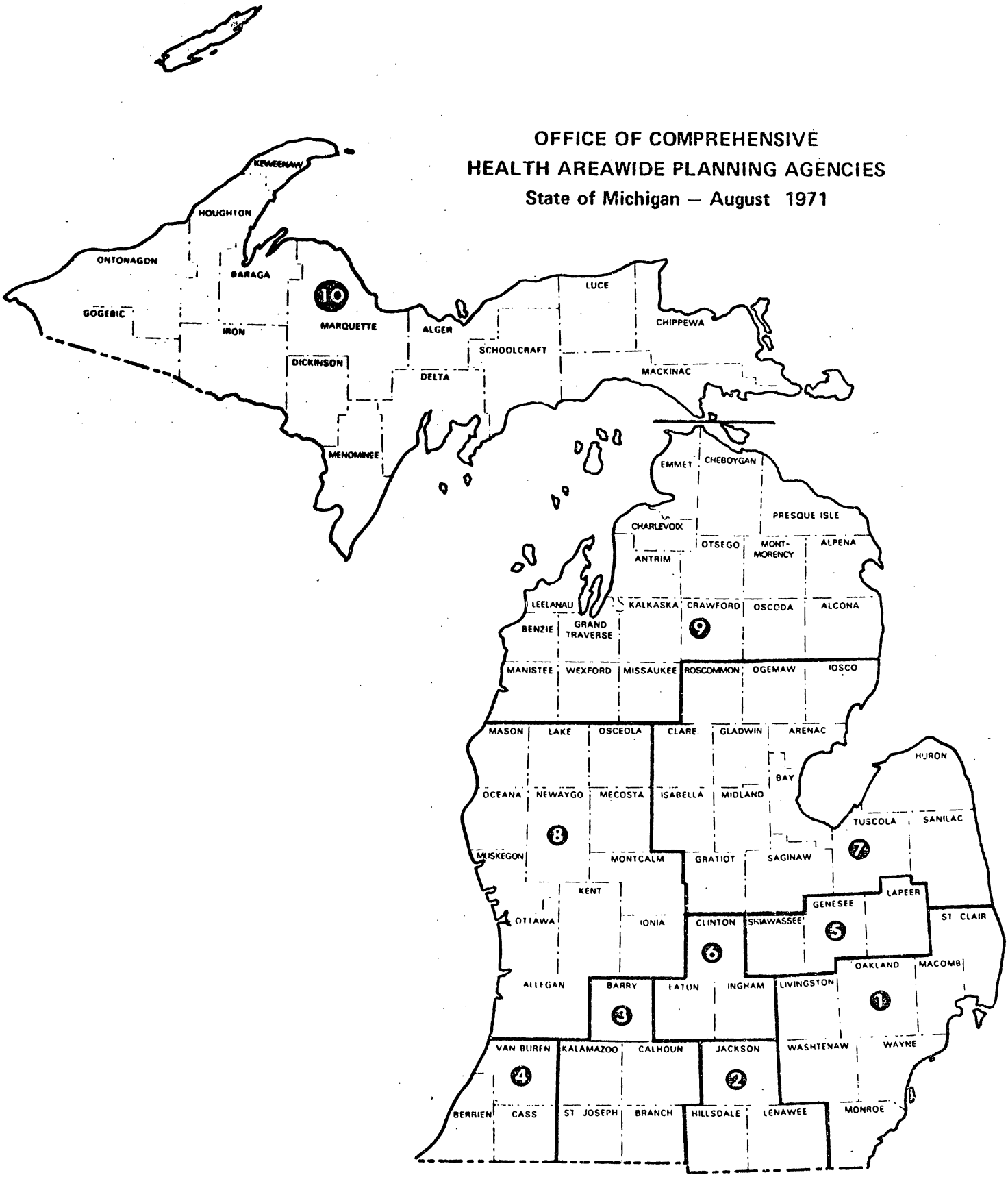
Purpose of the Investigation

> "The language of legislation is a lifeless potentiality, a skeleton devoid of flesh and muscle. High-minded statements of purpose must be interpreted and implemented by human beings, each with his own hopes, beliefs, suspicions, and fears. At best, the law provides a structure of incentives and prohibitions which recognizes the motivations of all affected parties, and modifies or uses them to bring about a desired public objective." (Arndt, 1972)

The focus of this paper is a comparative description of the agency profiles of two organizations, the Southeastern Michigan Comprehensive Health Planning Council and the Mid-Ohio Health Planning Federation,[1] both of which have been receiving areawide planning grant funds from the U.S. Public Health Service under P.L. 89-749, Section 314b, "The Partnership for Health Act". In this investigation the author sought to discover what were the active political and organizational forces which affected the development and the subsequent operation of each agency and whether or not these forces were the same in each case. The impacts of possible determinants of the planning process itself, such as sources of agency funds, agency jurisdiction, board member representation, and staff recruitment, were analyzed in order to gauge their relative importance.

1/ See Figures 1 & 2 for a geographic description of the agencies' respective regions.

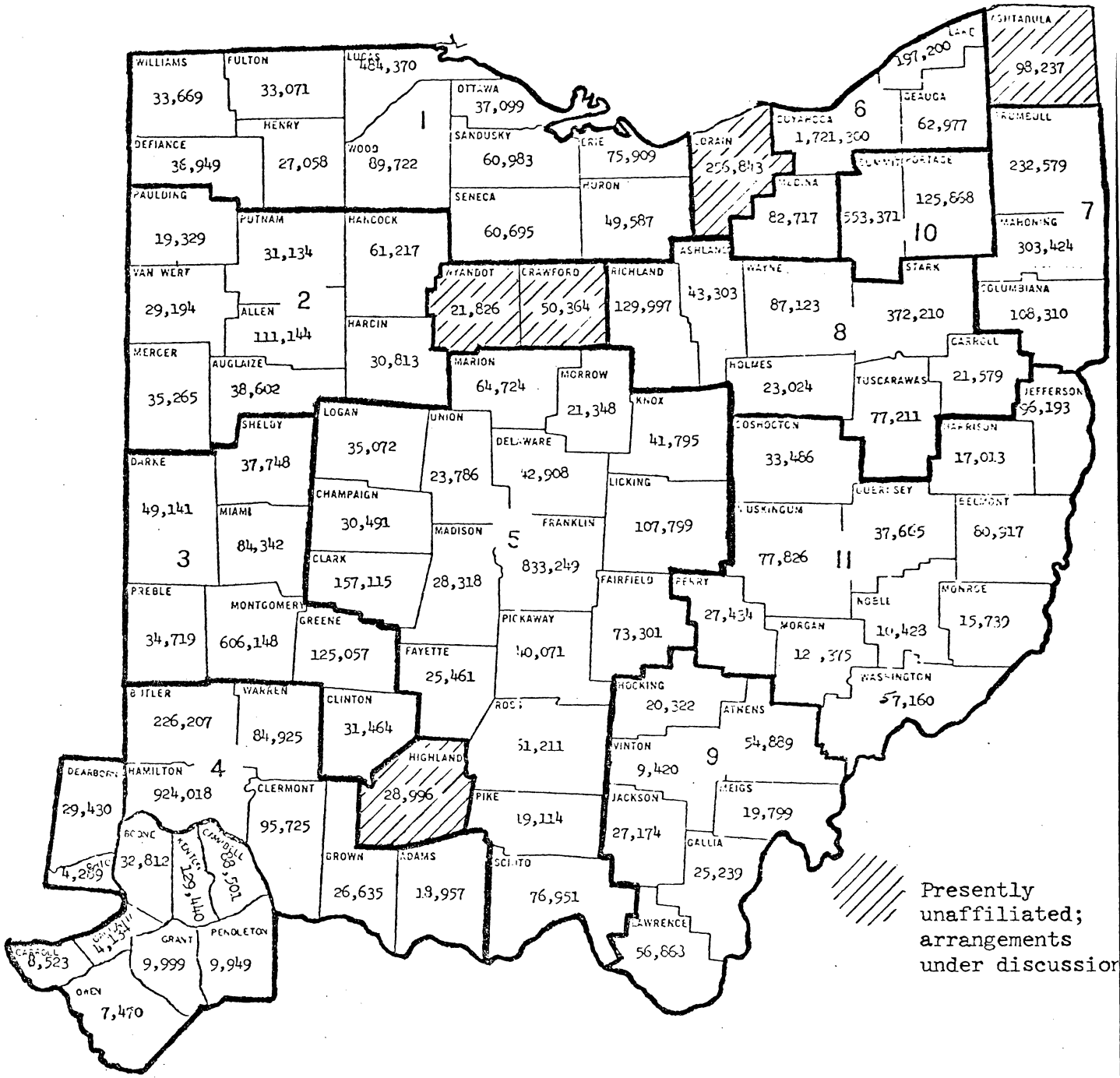
Figure 1. - Michigan Areawide Comprehensive Health Planning Agencies



Area 1 - CHP Council of Southeastern Michigan

Figure 2. - Ohio Areawide Comprehensive Health Planning Agencies

OHIO AREAWIDE COMPREHENSIVE HEALTH PLANNING AGENCIES



1 - Health Planning Association of Northwest Ohio
2 - Comprehensive Health Planning Association of Greater Ottawa Valley
3 - Health Planning Council of the Greater Miami Valley
4 - Health Planning Association of the Central Ohio River Valley
5 - Mid-Ohio Health Planning Federation
6 - Metropolitan Health Planning Corporation
7 - Mahoning Valley Health Planning Association
8 - Seven County Health Planning Council
9 - Ohio Valley Health Services Foundation, Inc.
10 - Summit-Portage County Comprehensive Health Planning Agenc
11 - Southeastern Ohio Health Planning Association

Office of Comprehensive Health Planning
Ohio Department of Health
3/15/72

As the quote at the beginning of this section suggests, the author also had a broader purpose in mind, beyond a comparative organizational study of two health planning agencies, at the start of this inquiry. The Partnership for Health Act is a unique piece of legislation in that the ideals upon which it is based, in particular, "to assure comprehensive health services of high quality for every person [in this country]," via a comprehensive health planning approach, were not and are not presently subscribed to by many health care providers nor by the general populace. The private/public battle over establishing an individual citizen's "right" to health care will be waged for many years to come because of the political, economic, and administrative labyrinthian complexities of this issue. Beyond this contest are questions which are just as knotty, such as, "What are the components of comprehensive health services?", and, "What methodology should be used for measuring the quality of health care?"

Assuming that the problems mentioned above are solvable in the near future, for indeed field experiments are now being conducted to ascertain the actual utility of physician group practices, satellite clinics (as part of an acute hospital), prepaid health maintenance organizations (HMO's), physician peer review systems etc., we are left with the problem of interpreting and actualizing the phrase, "comprehensive planning for health."

The author has spent two years as a health planning assistant

for a 314b areawide agency in Sacramento, California and there observed the regional and State agency planning philosophies promoted between 1970 and 1972. The author has also conducted an exploratory survey of 314b planning agencies in the State of Michigan which was concerned primarily with how each agency perceived its health care advocate role, if any, and the contrast of these perceptions with the images of potentiality for areawide CHP agencies envisioned by selected health education faculty members at the University of Michigan School of Public Health. These activities, along with readings, course work and conversations with faculty members here at the University of Michigan, have impressed upon the author the lack of general agreement and in particular the lack of direction by the Federal Government concerning what health planning could and should be.

If the reader thinks that comprehensive health planning as a national program is idealistic, vague, ambiguous, ill-defined, and, perhaps, is operating either ahead or possibly behind its time, he/she is probably right. However, some persons have made normative statements in writing concerning under what organizational structures and toward which objectives 314b areawide agencies should operate. Obviously, experience and retrospective studies of these agencies will provide evidence against which the wisdom of these suggestions may be realistically evaluated. In the short run, an interested individual could study the forces - political and economic - which have guided the development of some selected 314b agencies and in turn compare

this data with the assumptions made by those who offer normative suggestions as to what the structure of a 314b agency should be and toward what end or objectives it should operate.

It is the author's intent to reply to some of those who have prescribed general solutions to the problems of 314b areawide agencies. The author has collected comparable longitudinal data on the development of two functioning 314b agencies and in this paper discusses those factors which appear to influence each agency's planning priorities and their status in the communities which they serve.

The next section will detail the methodology used in the collection of data on the development and operation of the 314b areawide agencies which were studied.

Methodology

The data in this study were primarily collected by means of a structured interview with a professional staff person at each of the 314b agencies' respective offices in Detroit and Columbus. The questions asked in these interviews are presented on the pages which immediately follow. In addition to presenting the answers to these questions in Parts I & II, the author has included a timetable of significant events, called "Chronological Development," for each agency to aid the reader's understanding of the data.

Additional information was obtained from printed documents such as 314b grant applications, areawide CHP project reports, historical sketches of the agencies, grant proposal review decisions, progress reports, and planning procedure manuals. Also, Dr. Robert N. Grosse, a faculty member at the U of M School of Public Health assisted the author by providing documents of the types mentioned above and by relating historical and experiential information.

In general the variables of interest to the author were catagorized as follows:

1. Board Member Representation;
2. Agency Funding Sources;
3. Agency Jurisdiction;
4. Academic and Professional Background of Staff;
5. Existence of Enabling Legislation;
6. Agency Decisions Which Have Been Made;
7. Relationship of the Agency with Selected Organizations.

The frame of reference with the author used to organize the data collected by the structed interview with agency staff members and by documents provided by them was that of the major events in the organization and development of a "typical" 314b CHP agency. The author viewed those steps as occurring in the following sequence:

1. Nucleus of Community Interest Formed around the Issue of Establishing a 314b CHP Agency;
2. Writing the Initial 314b Grant Request;
3. The CHP Agency's Constitutional Period --- First 1 to 2 Years;

4. The Operational Period --- the Agency Begins Planning for the Region;

5. Results of the CHP Process --- Planning Decisions.

The data are presented in Parts I & II in a question and answer format. There is in each part a discussion of the data which outlines the structure/process organizational profile of the agency.

Interview Questions

for

Staff Members

of

The Comprehensive Health Planning Council
of Southeastern Michigan

and

The Mid-Ohio Health Planning Federation

Variables Selected for Study

A. Group Formed with Initial Interest in Preparing CHP 314b Grant Request

1. Who (which individual) actually wrote the initial CHP 314b grant request? What organization was this individual with at the time?

2. What organizations did the members of the CHP agency founding group represent?

3. What was the initial 314b grantee organization?

4. Was there any contest over what should be the initial 314b grantee organization? If yes, who was involved in this contest and what organizations did these persons represent?

B. Constitutional Period

1. Who was on the search committee which selected the executive director; what organizations did these people represent?

2. What are the qualifications and background of the executive director?

3. What was the consumer/provider ratio agreed upon by the CHP agency board of directors? What was the basis of this decision, i.e., were Federal guidelines (minimum 51% consumers) adopted outright without any resistance or was a compromise between two (or more) interest groups necessary?

4. What organizations were initially represented on the board of directors? Was there any organization which desired representation, but which was purposefully excluded?

5. What was the funding base of the CHP agency, i.e., where did the agency's money come from during the organizational period - first 1 to 2 years of the agency's existence?

6. What is the jurisdiction of the CHP 314b areawide agency:

   a. Is the span of control assumed by the agency regional only, i.e., does the areawide agency claim jurisdiction over county and city health planning or are there counterpart organizations at these levels?

   b. Are health facilities, health services, mental health, mental retardation, and environmental quality program planning viewed by the CHP agency as being within their jurisdiction, or has the agency contracted, delegated or

relinquished (and/or not accepted) responsibility in these areas?

B. 6. c. Are there any specific areas of "health planning" which the 314b agency sees as state or national rather than regional responsibilities?

d. Are there any areas of overlapping responsibility between the CHP agency and other organizations at the regional level?

C. Operational Period

1. What is the background (previous work experience and formal educational training) of each of the professional staff members?

2. Has there been any change in the initial funding pattern of the agency following the constitutional period? If yes, what are the reasons for this change?

3. Has the State passed any enabling legislation for CHP 314b areawide agencies in regard to the regulation of health facilities construction, the funding of the 314b agency, environmental quality, etc.?

4. In general how could the 314b areawide agency's planning methodology be characterized?

5. How could the relationship of the 314b agency with the area's COG (council of government or regional planning commission), medical societies, health departments, and hospital planning council(s) be characterized now?

6. What health planning decisions and/or studies have been made during the operational period of the CHP 314b agency?

PART I: THE COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN

Table 1. - Chronological Development, Comprehensive Health Planning Council of Southeastern Michigan

Date	Event
April, 1968	Meeting Called by Dr. Rice (former State Health Officer) at Wayne State University, McGregor Center, for the Purpose of Developing Cooperative Efforts between SEMCOG and UHO
January 20, 1969	First Formal Meeting of AHOC; Accepted "Agreement of Comprehensive Areawide Health Planning for Southeastern Michigan between UHO and SEMCOG"
January, 1969	Grant Request Submitted to State CHP 314a Agency and to HEW, Regional Office, Chicago
July, 1969	GDAHC Grantee Organization for CHP 314b Areawide Grant by HEW, Public Health Service (effective date of grant, 6-1-69) - AHOC Policy Making Body for CHP 314b Organization; Organizational Grant Period
August, 1969	Gene Siberry Left GDAHC; William McNary New Director of GDAHC
March 30, 1970	Organizational Representation of Members on the Board of Trustees Agreed Upon at Formal AHOC Meeting
April 16, 1970	60/40 Consumer/Provider Ratio for Representation on the Board of Trustees and for Representation on the General Membership Agreed Upon at Formal AHOC Meeting; Medical Society Representatives Dissenting
September 1, 1970	Contract with GDAHC (to November, 1971) for Health Facilities Planning; Amount of Contract, $240,274.
September, 1970	Executive Search Committee Offers Terence E. Carroll CHP Executive Director Position
September 11, 1970	Proposal for Operational (Planning) 314b Grant Submitted to State 314a Agency; William McNary, Project Director

Table 1. - Chronological Development, Comprehensive Health Planning Council of Southeastern Michigan

Date	Event
September 15, 1970	Contract with SEMCOG (to August, 1971) for Environmental Quality Planning; Amount of Contract, $60,000.
September 18, 1970	Proposal for Operational (Planning) 314b Grant Submitted to HEW, Regional Office, Chicago
December 1, 1970	Intended Start of 314b CHP Operational Grant; Award of Grant Delayed Due to the Objections by Physicians Representing the Medical Societies Concerning the 60/40 Consumer/Provider Ratio for the CHP 414b Agency Board of Trustees
December, 1970	Terence E. Carroll Becomes Executive Director of S.E. Michigan CHP Council
January 20, 1971	Medical Society Representatives Agree to a 55/45 Consumer/Provider Ratio Compromise for the CHP Council Board of Trustees
February, 1971	Public Health Service, HEW Region V, Approves CHP 314b Grant Application
April, 1971	Award of Operation 314b Grant by HEW, Public Health Service
August 8, 1972	Act No.256, Public Acts of 1972, Approved by Governor, Establishes Certification of Need for Health Facilities Construction or Conversion, Addition to or Modernization; Authority Delegated to State Department of Public Health

Variables Under Study

Comprehensive Health Planning Council of Southeastern Michigan

The question and answer format below was used during a structured interview with a staff representative of the agency and other outside resource persons.

A. Group Formed with Initial Interest in Preparing CHP 314b Grant Request

1. Who (which individual) actually wrote the initial CHP 314b grant request? What organization was this individual with at the time?

Gene Siberry, Executive Director, Greater Detroit Area Hospital Council, wrote the initial CHP 314b grant request in the late fall of 1968. The Areawide Health Operating Committee (AHOC) was an "unofficial," volunteer, policy making body whose 27 members represented the region's population. The goal of this body was, "to emerge with a recommendation that is acceptable to the various groups concerned about health in the southeastern Michigan community." AHOC's first formal meeting was on January 20, 1969, at which the "Agreement of Comprehensive Areawide Health Planning for Southeastern Michigan between the United Health Organization (UHO) and the Southeast Michigan Council of Governments (SEMCOG)" was accepted.

A. 2. What organizations did AHOC's members represent?

AHOC's membership was established, "on the basis of (1) geography, (2) population, (3) professional representation, and (4) consumer representation." The membership included medical society representatives (physicians), health department personnel (health officers), labor union officials (UAW, AFL-CIO), city/county government officials (Detroit/Wayne County), the automobile companies (General Motors, Ford, Chrysler), a medical school dean, businessmen, United Foundation representatives, school of public health faculty members, optometrists, hospital administrators, and consumers (see Appendix A for additional detail).

3. What was the initial 314b grantee organization?

The Greater Detroit Area Hospital Council (GDAHC) became the grantee organization for the U.S. Public Health Service 314b areawide planning grant, effective as of June 1, 1969. The Areawide Health Operating Committee (AHOC) became the policy making body by informal agreement. GDAHC's staff was split in two on order to manage the responsibilities of the 314b grant.

4. Was there any contest over what should be the initial 314b grantee organization? If yes, who was involved in this contest and what organizations did these persons represent?

With the passage of P.L. 89-749 ("The Partnership for Health")

by the U.S. Congress in November, 1966, three organizations, the Greater Detroit Area Hospital Council (GDAHC), the United Health Organization (UHO), and the Southeastern Michigan Council of Governments (SEMCOG) each began movement toward converting their respective potential for 314b areawide agency status into reality. Early on, GDAHC dropped out of this contest in part because it was, "fearful of diluting its facility - programming responsibilities and feared dilution of community support."

SEMCOG had received a grant from HUD, "to assist in the development of a permanent CHP agency." UHO was an organization of private provider interests, primarily hospitals. These two organizations blocked each other's movement toward the 314b CHP grant until the State of Michigan 314a Agency called the two sides together at McGregor Center on the Wayne State University campus in Detroit, "to cooperate [with each other] or lose the State Health Department's authorization necessary for federal funding."

The 27 member Areawide Health Operating Committee was the result of the negotiations which took place between these two groups in the summer and early fall of 1968. As has been mentioned, AHOC became the policy making body for the initial 314b CHP grant (see Appendices B and C for further historical details).

B. Constitutional Period

1. Who was on the search committee which selected the executive director; what organizations did these people represent?

The intent of this question was not to investigate the individuals who were involved in the selection of the executive director of the 314b agency but, rather, to ascertain whether or not this process had been controlled by any one particular interest group. The Council's Executive Committee (see Appendix D for details on the method used for selecting members) served as the Executive Search Committee. The search committee had a balanced representation of consumer and provider interests. Under the leadership of Myron E. Wegman, M.D., Dean of the University of Michigan School of Public Health, Committee Chairman and President of the Council, an atmosphere of compromise and cooperation was maintained during the selection of a candidate for the executive director position.

2. What are the qualifications and background of the executive director?

Terence E. Carroll, Executive Director, has completed academic work at the B.A. and M.A. level. His prior work experience includes the position of Director of the National Institute of Rehabilitation and Health (United Mine Workers), executive at a life insurance company, a former credit union employee, work with the automobile companies, and Curator of the Detroit Historical Museum.

B. 3. What was the consumer/provider ratio agreed upon by the CHP agency board of directors? What was the basis of this decision, i.e., were Federal guidelines (minimum 51% consumers) adopted outright without any resistance or was a compromise between two (or more) interest groups necessary?

The consumer members of AHOC, who were primarily from labor unions and disadvantaged groups, initially opted for a 100 percent consumer member board of trustees and general membership. In April, 1970, the membership voted for a 60/40 consumer/provider ratio as the standard guideline for the Council. Health care provider groups, primarily physicians, expressed great displeasure over this proposed rule. Under the patient and continuous mediation efforts of Dr. Myron Wegman, Council Chairman and Dr. Robert N. Grosse (both on the staff of the University of Michigan School of Public Health), a compromise was reached in January, 1971, with a 55/45 consumer/provider ratio for the Board of Trustees and a 60/40 ratio for the General Membership having been adopted.

4. What organizations were initially represented on the Board of Trustees? Was there any organization which desired representation, but which was purposefully excluded?

The membership list of the first Board of Trustees is presented in Appendix E. The occupation or affiliation of each member is specified. According to the Council's staff there was no attempt to systematically exclude anyone from membership on the Council. Dr. Robert Grosse did point out to the author that it was unfortunate that no effort was made to recruit members from the police, firemen, school educators and other

groups which have contact with the provision of health services/information while carrying out their daily work activities. Note that SEMCOG is not on the Board nor the General Membership.

B. 5. What was the funding base of the CHP agency, i.e., where did the agency's money come from during the organizational period - first 1 to 2 years of the agency's existence?

The author had difficulty in obtaining budget data on the CHP Council of Southeastern Michigan for the two-year period 1969 to 1970 (and for comparison purposes budgets and budget estimates for 1971 to 1975); however, the data obtained are sufficiently detailed to indicate the Council's general sources of revenue and some possible trends in funding patterns (see Table 2 - CHP Council of Southeastern Michigan Funding Sources, 1970).

Since budget data had been deleted from the available copies of the grant applications of the CHP Council of Southeastern Michigan and since the author was not permitted access to the agency's files[1], it was possible only to obtain pieces of information via interviews and to reconstruct a probable budget request to HEW in 1970 as presented in Table 2. The main failing of this reconstructed data is that, based on a total budget of $600,000 for 12 months, approximately $100,000 is

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1/ The author was told by Dr. Robert Grosse that the Council's budget was in a constant state of flux; and since the author was neither an accountant nor with the GAO, it is understandable that the agency wished to retain the confidentiality of their files.

Table 2. - Funding Sources 1970, CHP Council of Southeastern Michigan

Source of Funds	Dollars
Federal Government	300,000
State of Michigan	0
Counties (via SEMCOG)	40,000 (est.)
United Foundation (via UHO)	111,000
Blue Cross	28,000
Area Hospitals ($.75 per bed)	6,000
Blue Shield	6,000 (est.)
Podiatry Association	250
Nurses Association	250 (est.)
Other Insurance Companies	750 (est.)
Miscellaneous	4,000 (est.)
In-Kind Contributions (eg. meeting rooms from medical society)	11,000 (est.)
Unaccounted (remainder of local share of $600,000 total budget)	100,000
TOTAL	600,000

(est.) estimates representing probable figures based upon information obtained in interviews with CHP agency personnel and with U of M School of Public Health faculty member, Dr. Robert N. Grosse

unaccounted for. The dollar amounts with "(est.)" following the figures are known sources of funds but unknown amounts contributed; thus, the estimates represent probable figures based on information obtained in interviews with CHP agency personnel and with U of M School of Public Health staff members. All other figures are based on stated amounts in pledge letters included in the 1970 grant application to HEW. Technically, these figures represent the transition point between the organizational (constitutional period) and the planning (operational) phase. A comparison of these figures with 1973 data (in Section C, Question 2) will illustrate some changes in the funding sources of the agency. It is also probable that the Federal Government's share of the budget did not equal $300,000 for twelve months; thus, reducing the amount of local matching monies needed.

Table 2 does show that there were no State monies in the budget; contribution from counties, the United Foundation, Blue Cross/Shield, and the area's hospitals made up the bulk of the local share. A summary of expenditures based on this budget, which was included in a copy of the 1970 314b grant application, is reproduced in Appendix F. The one item of note is that $300,000 have been allocated to "Contracts." The significance of this entry will be discussed in Section B, Question 6b.

B. 6. What is the jurisdiction of the CHP 314b areawide agency:

B. 6. a. Is the span of control assumed by the agency regional only, i.e., does the areawide agency claim jurisdiction over county and city health planning or are there counterpart organizations at these levels?

There are no county nor city comprehensive health planning counterparts to the regional CHP agency; and there does not appear, at this time, to be any trend toward organizing such agencies.

b. Are health facilities, health services, mental health, mental retardation, and environmental quality program planning viewed by the CHP agency as being within their jurisdiction, or has the agency contracted, delegated or relinquished (and/or not accepted) responsibility in these areas?

Under the State of Michigan, Public Act 54 passed in 1963, "Community Mental Health Services Legislation," each of the counties in the region have established Community Mental Health Services Boards, "to coordinate existing services, plan and establish new programs for the treatment of people with emotional problems, and for the prevention of mental illness." The CHP Council's role has been described as that of a coordinating agency, i.e., "to share common problems and to discuss jointly how each county board should relate with neighboring county boards and with the CHP Council."

The Council's approach to services and facilities for the mentally retarded is not specifically defined in their 1970-1975 planning grant application. It appears that the Council will rely heavily upon reports from the Michigan

Department of Public Health.

Appendix F - Summary Budget for CHP Council fo Southeastern Michigan, 1970, has an item labelled "Contracts" which has been allocated $300,374; this is one half of the total agency budget for 1970. Appendices G and H are contracts entered into by the CHP Council with the Greater Detroit Area Hospital Council and the Southeastern Michigan Council of Governments, respectively. The GDAHC contract was in the amount of $240,374 for a wide range of activities from health facility inventory, services utilization and patient origin data to, "evaluation of hospital proposals for modernization, expansion, mergers, replacement and new construction." In this latter case, hospital facility proposals are sent first to GDAHC, evaluated by GDAHC and a recommendation is presented to the CHP Council's Board of Trustees. The GDAHC recommendation is evaluated by the CHP Council's standing Health Facilities Committee only when and if the Board of Trustees deems it necessary.

The $60,000 contract with SEMCOG (see Appendix H) entered into by the CHP Council called for the establishment of a "high level task force" to develop a set of papers beginning with the elements, i.e., the goals and objectives, of a regional environmental health planning program and continuing through finding solutions to specific environmental problems and demonstrating the implementation of these solutions. Also, SEMCOG was to help the CHP Council in de-

veloping a data bank, primarily based on census data. The Council did propose the organization of a committee on environmental health in the near future for the purpose of building upon this work contracted with SEMCOG.

Health services was seen as within the purview of the CHP Council rather than being GDAHC's responsibility; however, the author is not able to see the distinction between hospital services and personal health services as defined by GDAHC.

B. 6. c. Are there any specific areas of "health planning" which the 314b agency sees as state or national rather than regional responsibilities?

The author was told by a CHP Council staff member that the area of health insurance was a national (i.e., federal) issue rather than a regional health planning responsibility.

d. Are there any areas of overlapping responsibility between the CHP agency and other organizations at the regional level?

The major areas of overlapping responsibility with both GDAHC and SEMCOG and the contractual arrangements with each which were negotiated to eliminate duplication of effort and to enhance the development of potential cooperation between the CHP Council and each of these organizations, have been cited in the answer to Question 6b. Other organizations which have health planning responsibilities for a

geographic area similar to the Council's have agreed to share relevant information and to coordinate their efforts. These agreements are informal and the amount of actual co-operation from each, such as Regional Medical Programs (RMP), the Michigan Hospital Service and Michigan Medical Service (Blue Cross/Shield), the Commission on Professional and Hospital Activities (PAS and MAP studies), and Model Cities and the Office of Economic Opportunity (OEO), is open to question.

C. Operational Period

1. What is the background (previous work experience and formal educational training) of each of the professional staff members?

The background and current position of each of the professional staff members is summarized in Table 3. The purpose for asking this question was to assess the range of experience available and to discover any concentration of talents in a particular academic area or profession and to later relate this information to the focus of the Council's work activities.

2. Has there been any change in the initial funding pattern of the agency following the constitutional period? If yes, what are the reasons for this change?

The author was not permitted to copy fiscal information on the agency's current budget. During an interview with an agency staff person, enough information was gathered verbally to com-

Table 3. - Professional Staff -- Positions and Background, CHP Council of Southeastern Michigan

Name	Position	Academic Degree(s)	Prior Work Experience
Terence E. Carroll	Executive Director	B.A. Liberal Arts M.A. History	Voluntary Health Agency, Life Ins. Co. Executive, Credit Union, Employee - Automobile Companies, Curator - Detroit Historical Museum
George C. Allen	Deputy Executive Director	B.A. Business Ad. M.H.A. Hospital Ad.	Hospital Administrator, Health Mgmt. Consultant
Eugene C. Goeller	Associate Executive Director	B.S. Business Ad. M.P.H. Health Adm.	State Mental Health Agency, State Health Agency, Hosp. Planning Council
Thomas H. Cranshaw	Associate Executive Director	B.A. Economics M.B.A. Hospital Ad.	Administrative Resident, Hospital Administration
H. Michael Cannon	Director, Publications & P. R.	B.A. English	Voluntary Health Agency
Rosemary Holland	Director Planning (III)	Bachelor of Philosophy in Social Wk Master of Social Work	Private Social Agency Field Placement, Detroit Common Councilman, Field Placement - Civil Rights Agency, School Teacher, Caseworker - Florence Crittenton Home

Table 3. - Professional Staff -- Positions and Background, CHP Council of Southeastern Michigan

Name	Position	Academic Degree(s)	Prior Work Experience
Juanita Godley	Director Planning (III)	B.S. & R.N. U of M M.S. Public Hlth. Nursing	Public Health
L. Loukopoulos	Director Planning (III)	B.S. Physics M.A. Math.	Mgmt. Systems Analyst-Civil Rights Agency, County Planning Commission, W.S.U. Center for Urban Studies
Ruben Flores	Director Planning	M.A. Social Work	Summer Placement-SEMCOG, Tool Company-Salesman

pare the 1970 budget with the 1973 budget and to detect some changes in the funding pattern of this 314b agency (see Appendix I for detailed fiscal information).

The total agency budget has grown from $600,000 per 12 month-year to $880,000: these figures include 50% Federal financing. The HEW regional office has made a ruling that as of April, 1973, the Federal Government will increase its portion of the 314b CHP agencies' budget from 50% up to 75%; this would mean that the local share in the near future could be as small as 25% of the areawide agency's budget.

The other observed trends in agency funding are as follows:

a. The State of Michigan did not contribute any funds to areawide CHP agencies in 1970 and does not now in 1973;

b. The counties' contribution has increased from $40,000 (est. 1970) to $60,000 in 1973;

c. United Foundation, via United Health Organization, gave $111,000 in 1970 and now provides $130,000 to CHP;

d. Blue Cross contributed $28,000 in 1970; $80,000 in 1973;

e. The area hospitals gave $6,000 in 1970 and gave $20,000 in 1973;

f. Blue Shield pledged $6,000 (est. 1970) and now contributes $25,000;

g. The other insurance companies currently contribute less than $1,000 as they did in 1970;

h. The cash contributions from health provider professional associations has decreased from $500 each (est. in 1970 from the Podiatry Assn. and the Nursing Assn.) to zero in 1973. The Wayne County Medical Society continues to make in-kind contributions such as meeting room spaces.

It is evident that the base of financial support for the CHP Council of Southeastern Michigan has not expanded beyond what

it was in 1970[2].

C. 3. Has the State passed any enabling legislation for CHP 314b areawide agencies in regard to the regulation of health facilities construction, the funding of the 314b agency, environmental quality, etc.?

The State of Michigan has not passed any legislation which would increase the funding base of 314b areawide agencies, impose additional planning or administrative requirements upon the 314b agencies, nor increase the agencies' regulatory power. A bill was passed in August of 1972, House Bill No. 4949 (Act No. 256, Public Acts of 1972) which requires "certificates of need" for new construction as well as conversion, addition or modernization of health facilities, effective April 1, 1973. The State Department of Public Health was authorized to establish a "State Health Facilities Commission" to administer this act. Areawide 314b CHP Councils could be consulted as to their views on a particular application, but the agency's comments were not to be binding on the State Health Facilities Commission nor would the CHP Council be reimbursed by the State for the time and money spent on the review of health facilities proposals. Also, a companion piece of legislation was passed at that time (August, 1972) which limited the discretionary power of Blue Cross to refuse payment to health facilities which failed to receive planning agency approval prior to construction (see

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2/ The City of Detroit contributed $5,000 this year; it is not known whether or not a contribution was made in 1970.

Appendices J and K).

C. 4. In general how could the 314b areawide agency's planning methodology be characterized?

The CHP Council of Southeastern Michigan primarily relies upon a set of standing committees as their approach to planning for health (see Appendix L for committee structure). It has been pointed out that there does not now exist county CHP councils; therefore, there are not county counterparts to these regional committees. It should also be noted that the committees do not directly relate to the Board of Trustees nor does the Board always work through its committees. According to the agency staff, planning committees may make direct decisions/recommendations, bypassing the Board of Trustees, if not more than one quarter of the committee is dissenting at the time of the vote. Incoming information, on the other hand, such as a health facilities proposal review report from the Greater Detroit Area Hospital Council is received first by the Board of Trustees; the Health Facilities Committee does not review GDAHC recommendations unless asked to by the Board. The contracts which the Council has had with GDAHC and SEMCOG were mentioned earlier (Section 6, Question 6b.). Staff has said that the Council has not drafted any master plans for health care with specific recommendations, such as where health facilities should be located.

5. How could the relationship of the 314b agency with GDAHC, SEMCOG, the Wayne County Medical Society and the area Health De-

partments be characterized now?

GDAHC continues to have a contract ($255,000/12 months) with the CHP Council of Southeastern Michigan to provide health facilities planning data to the CHP agency. It has been stated by the Council staff that this relationship will continue until 1977.

The contract with SEMCOG for environmental health planning data was concluded in August, 1971. Staff has indicated that SEMCOG does not currently have the desire which it once had to be the 314b grantee organization.

The Wayne County Medical Society was involved in a conflict situation in 1970 with the consumer members of the Council over what the consumer/provider ratio on the Board of Trustees would be. This argument was settled by January, 1971. Although the medical society does not provide a cash contribution to the Council, it does presently provide in-kind services.

The county health departments did originally endorse the formation of the CHP Council and have appointed representatives to the General Membership and to the Board of Trustees.

C. 6. What health planning decisions and/or studies have been made during the operational period of the CHP 314b agency?

The main activity of the CHP Council appears to be the review of and comment on grant proposals (to State and Federal agencies), health facility proposals in particular. Appendix M contains a status report on the action taken (or not taken) by the CHP Council of Southeastern Michigan on proposals submitted to the agency for review. This status report was selected as an illustrative example because the data is fairly complete. The Council did turn down or sometimes ask agencies to rewrite their proposals rather than "rubber stamping" them. However, the correlation does not appear to be high between the Council's recommendations and the actions of the funding sources. This is primarily a reacting function on the Council's part since it is not generating nor soliciting proposals.

One of the products of the Council's twelve month contract with SEMCOG was an inventory of environmental health/quality legislation. Printed in March, 1973, this document is entitled, "The Southeast Michigan Environmental Legislation Handbook."

Currently, the Council is involved in the activities of the Detroit Emergency Medical Services Committee, following a survey of emergency rooms in the area's hospitals by GDAHC. The CHP Council is attempting to develop a number of regional ad hoc committees to work on this problem and to ultimately design an emergency medical services system for the region. The apparent availability of Federal and private foundation

money will assist this effort.

Discussion

The preceding section detailed specific factual information about the development of the Comprehensive Health Planning Council of Southeastern Michigan; the intent here will be to synthesize the information presented thus far into a general profile of the agency. Some caveats are necessary. The reader is cautioned not to interpret the author's remarks as criticisms of the Council. It is difficult to assemble some externally selected structural and organizational process elements of an agency into an overall picture of how the agency "typically" functions because the analysis may be viewed as either too superficial or too critical depending upon the background and biases of the reader. In addition it should be remembered that agencies do change over time; so that the descriptive statements made now may or may not be true in the future, eg. one year hence.

There are subtle nuances in an agency's operation which are known usually only by those who have experienced with the staff the organization's growing pains, and who are familiar with the personalities and politics involved. Thus, this approach should not be interpreted as an historical study; but, rather, as stated above, this section is a profile of the Comprehensive Health Planning Council of Southeastern Michigan which has been constructed for the purpose of comparison with the operation of the Mid-Ohio Health Planning Federation.

An examination of how the membership composition of the Board of Trustees was determined provides much insight about the political and economic substructure of the Comprehensive Health Planning Council of Southeastern Michigan. As was pointed out in the preceding section, initially there was a contest between SEMCOG, a voluntary association of county and city governments, and UHO, a United Foundation sponsored association of private health care providers (primarily hospitals) over which organization would be the 314b grantee organization. This was the first of three major blocks which held back the establishment of an operating CHP areawide agency. This initial problem was "solved" by the development, at the insistence of the state 314b agency, of a compromise organization, the Areawide Health Operating Committee (AHOC), which included strong United Auto Worker (UAW) representation. The other two major organizational problems were the establishment of an adequate funding base for the proposed 314b areawide agency and securing the cooperation of the area's physicians.

In the latter case, a crisis situation developed when labor and inner-city poor representatives argued on behalf of having 100% consumer membership on the Council. The actual consumer/provider ratio which was first agreed upon by membership vote was 60/40 percent. After much debate and protest on the part of the physicians and other provider groups, notably the nursing home administrators and podiatrists, which held up the 314b operational grant approval from HEW, the consumer/provider ratio was revised to 55/45 percent.

The third major difficulty which had to be overcome was that of se-

curing adequate sources of local funding to match the Federal dollars which were to be 50% of the agency's budget. Not only was the 314b grantee candidate required to raise the dollar amount of local matching money (50% of the agency's total budget), but also the sources of these local funds had to reflect "broad based community support." The United Foundation and the Blue Cross/Shield Insurance Company contributed most of the monies which made up the local share. According to Dr. Robert N. Grosse, faculty member at the University of Michigan School of Public Health, contributions from county and city governments were solicited on the basis that SEMCOG would receive a contract with the 314b agency for environmental health activities; the amount of this contract was to be in excess of the total city/county contribution. One practical reason for securing SEMCOG's support was that SEMCOG was the A-95 Clearinghouse for Federal grant requests. In like manner the Greater Detroit Area Hospital Council, which had been largely supported by the United Foundation, was to receive a contract for health facilities planning from the areawide agency.

The reader should see that issues concerning funding and agency jurisdiction were entwined in this case. Another comment concerning the development of the organization and funding should be made at this point. The initial 314b grantee organization was GDAHC; the staff was split in two to handle the additional responsibilities. The current staff of the CHP Council has a strong hospital administration background due to the retention of these persons. As a final note, the author found that the State of Michigan has not passed any enabling legislation which would increase the funding

base of the areawide agency, impose additional planning/administrative requirements, nor increase the 314b agency's regulatory power.

The decisions (planning output) made by the Comprehensive Health Planning Council of Southeastern Michigan are primarily concerned with the review of health care service demonstration projects requesting Federal monies and health facilities proposals generated by outside groups. It may be helpful for the reader's understanding to now briefly review the major steps in processing a health facility proposal, eg. for construction of a 50 bed wing of an acute hospital. The proposal, written most likely by a hospital planning consultant, would be sent out to the State Health Facilities Commission for review, and a non-binding review of and comment on the proposal would then be requested of the 314b CHP Council. Since the CHP Council of Southeastern Michigan does not have local (county) council counterparts, the proposal would be sent to and reviewed by GDAHC who in turn would send their comments and recommendations directly to the CHP Board of Trustees for their review. The CHP's decision would then be sent back to the State. Note that the CHP Council's Health Facilities Committee does not review the recommendation of GDAHC unless the CHP Board of Trustees makes a special request that this review be done through the Committee.

In terms of the Council's current activities, SEMCOG has completed, as part of their contract with the CHP agency, a handbook on environmental legislation, "The Southeast Michigan Environmental Legislation Handbook." Also, the Council is involved in the activities of the Detroit Emergency Medical Services Committee which the 314b

agency sees as of potential benefit to the entire region. Outside of the planning services which the Council contracts for, the agency's main health planning approach is to rely on standing committees for the development of solutions to the health care needs of the region.

Part II details the structure and operation of the Mid-Ohio Health Planning Federation as was done with the CHP Council of Southeast Michigan in Part I. A comparison of the operation of these two CHP 314b Councils and some parallel observations on CHP activities in California, the Sacramento region in particular, is presented in Part III.

Sources

"Planning Grant Application, December 1, 1970, through November 30, 1975," Comprehensive Health Planning Council of Southeastern Michigan, William S. McNary, Acting Director, 921 Penobscot Building, Detroit.

"Comprehensive Health Planning In Southeastern Michigan, A Tenuous Partnership" (unpublished), James P. Ardnt, Program in Health Planning, School of Public Health, University of Michigan, December 11, 1972.

"Status Report on Grant Proposals Submitted to CHPC-SEM, January - December, 1972," Comprehensive Health Planning Council of Southeastern Michigan, 1300 Book Building, Detroit.

"Statement of Revenues and Expenditures and Statement of Program Expenditures, Five Months Ended April 30, 1973," Comprehensive Health Planning Council of Southeastern Michigan, 1300 Book Building, Detroit.

Personal Interview with Robert N. Grosse, Ph.D., Health Planning Department, School of Public Health, University of Michigan, July 2, 1973.

Personal Interview with Eugene C. Goeller, Associate Executive Director, CHP Council of Southeastern Michigan, 1300 Book Building, Detroit, July 6, 1973.

PART II: THE MID-OHIO HEALTH PLANNING FEDERATION

Table 4. - Chronological Development, Mid-Ohio Health Planning Federation

Date	Event
1945	The Columbus Hospital Federation Founded "to Coordinate the Planning and Financing of Hospitals in Columbus and Franklin County and to Perform Related Services to the Community;" Delbert L. Pugh, Executive Director
1962	Federation Developed a Prototype Areawide Health Facilities Planning Council under Hill-Burton Health Facilities Planning Grant, Public Health Service, HEW; Operational Territory Was 38 Counties in Ohio
July, 1968	Federation Received 314b Planning Grant (P.L. 89-749) under the Partnership for Health Act, 1966; Area Included 17 Counties; Delbert L. Pugh Retained as Executive Director
September, 1969	Code of Regulations Adopted; Organization's Name Changed to the Mid-Ohio Health Planning Federation; Consumer/Provider Ratio Set at 51%/49% --- Minimum HEW Consumer/ Provider Ratio
June 1, 1970	Federation Received 314b Operational Grant from Public Health Service, HEW
April, 1972	"Health Planning Procedures Manual," Prepared by Mid-Ohio HPF, Includes the Details of Planning Responsibilities of County Councils

Variables Under Study

The Mid-Ohio Health Planning Federation

The question and answer format below was used during a structured interview with staff representatives of the agency.

A. Group Formed with Initial Interest in Preparing CHP 314b Grant Request

1. Who (which individual) actually wrote the initial CHP 314b grant request? What organization was this individual with at the time?

Edward Lentz, a staff member of the Columbus Hospital Federation, wrote the first successful[1] 314b areawide grant application which was submitted to the U.S. Public Health Service, HEW. Mr. Lentz is now Deputy Director of Medical Care Administration at the Ohio State Health Department.

2. What organization did the members of the Columbus Hospital Federation represent?

"In the beginning, there was representation of many community organizations, and the Code of Regulations spelled out that hospital representatives were to be in the majority of Board Members. As the organization developed, membership on the

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1/ Angelo Vivino, another staff member at the Columbus Hospital Federation, drafted the first 314b grant application to HEW. It was not accepted. It had been written "in their usual format which was always successful"; the staff was "very surprised" when this application was not accepted.

Board shifted to individuals selected because of community leadership rather than individuals selected by other organizations. Since that time the Board has had representation of medicine, hospital administration, hospital trustees, and laymen from all segments of the community" (Drennen, see Appendix N).

A. 3. What was the initial 314b grantee organization?

In 1968 the Columbus Hospital Federation, with Delbert L. Pugh as Executive Director, became the initial 314b grantee organization. Appendix N contains a brief history of the organization by Grant Drennen.

4. Was there any contest over what would be the initial 314b grantee organization? If yes, who was involved in this contest and what organizations did these persons represent?

According to the staff persons interviewed, soon after the "Partnership for Health" legislation (P.L. 89-749) was passed in 1966, the HEW regional office requested the United Foundation to make application for a 314b areawide grant. This was based on the "federal philosophy which said that the regional office should find some responsible, volunteer health agency within each region and approach them to submit a 314b grant request to get the ball rolling."

The United Foundation (United Community Council) did not want to particularly be involved in comprehensive health planning

at the agency level; and since the Columbus Hospital Federation already had all the "top lay people" on their board, there was no desire nor reason for a confrontation; thus, the UF did not submit a grant request to HEW.

The Columbus Hospital Federation felt that they had already been engaged in comprehensive health planning; and thus, it was they that took the initiative and drafted a 314b grant request in 1967 in order to avoid the development of an organization parallel to theirs. No other organization challenged their grant request.

B. Constitutional Period

1. Who was on the search committee which selected the executive director; what organizations did these people represent?

There was no search committee because the Executive Director of the Columbus Hospital Federation, Delbert L. Pugh, became the Executive Director of the Mid-Ohio Planning Federation when the former organization received the 314b areawide grant.

2. What are the qualifications and background of the executive director?

Delbert L. Pugh, Executive Director, has completed three years of college education and has audited graduate level courses; in addition he completed the Boy Scouts of America Community Organization Program (which has been called "the toughest com-

munity organization school in the country"). Mr. Pugh has 28 years of experience in health planning and was with the Columbus Hospital Federation since its inception.

B. 3. What was the consumer/provider ratio agreed upon by the CHP agency board of directors? What was the basis of this decision, i.e., were Federal guidelines (minimum 51% consumer) adopted outright without any resistance or was a compromise between two (or more) interest groups necessary?

The Mid-Ohio Health Planning Federation has not adopted any specific consumer/provider ratio guidelines other than the legal Federal minimum (51% consumers minimum, 49% providers maximum).

4. What organizations were initially represented on the Board of Trustees? Was there any organization which desired representation, but which was purposefully excluded?

As was mentioned in the answer to Question A.2., the representation on the 55 member Board of Trustees was not/is not based on organizational affiliation but on "community leadership" (see Appendix O for the Board of Trustees membership list). Representation on the Board is also determined, in part, by county residence. The counties are allocated seats on the Board of Trustees each according to their population; every county has at least one representative. Five of the seats on the Board of Trustees are at large positions for which persons are nominated by the Board (see Appendix P - Code of Regulations). The role of the county councils will be detailed in the answer to Question 6a.

B. 5. What was the funding base of the CHP agency, i.e., where did the agency's money come from during the organizational period - first 1 to 2 years of the agency's existence?

From 1945 until 1962, the Columbus Hospital Federation was funded primarily by contributions from hospitals and from concerned businessmen, eg. F & R Lazarus Company and Wolfe Associates, both in Columbus. In 1962 the Columbus Hospital Federation became an areawide health facilities planning organization covering 35 counties in Ohio ("about 44% of the land area of Ohio," according to Grant Drennen) under a Hill-Burton planning grant. In 1968 the Columbus Hospital Federation became the Mid-Ohio Health Planning Federation upon receipt of a 314b grant from the U.S. Public Health Service, HEW. As a condition of the grant, the Federation had to show evidence of community support through the diversity of its local funding pledges. Thus, the Federation began to solicit monies from other sources. These sources will be detailed in the answer to Question C.2.

6. What is the jurisdiction of the CHP 314b areawide agency:

a. Is the span of control assumed by the agency regional only, i.e., does the areawide agency claim jurisdiction over city and county health planning or are there counterpart organizations at these levels?

Each county in the region has its own local health planning council which operates with a mix of standing committees and problem-oriented task forces (eg. the Emergency Medical Services Task Force of Pike County). Membership on the county

councils is open to anyone who is interested; each council has a board of at least 15 members[2], a minimum of 8 of these persons must be consumers.

The county councils have their own membership rules. Those elected to the board of directors are usually persons who have worked hard on the councils' committees; these people in turn may be nominated to positions on the regional Federation Board of Trustees if they "exhibit leadership." Not everyone who is on a county council committee is on the board of directors; these positions "have to be earned" (see Appendix Q - Sample By-Laws for County Health Planning Councils).

Most county councils rely upon the regional office for staff services.

B. 6. b. Are health facilities, health services, mental health, mental retardation, and environmental quality program planning viewed by the CHP agency as being within their jurisdiction, or has the agency contracted, delegated, or relinquished (and/or not accepted) responsibility in these areas?

The Federation has not relinquished, delegated, nor contracted their responsibilities, all of which they view as public health activities, to any other organization.

c. Are there any specific areas of "health planning" which the

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2/ There is no maximum; some county councils have up to 100 members on their boards.

314b agency sees as state or national rather than regional responsibilities?

At this time the author does not know of any specific areas of health planning that the staff of the Mid-Ohio Health Planning Federation consider to be state or national rather than regional responsibilities.

B. 6. d. Are there areas of overlapping responsibility between the CHP agency and other organizations at the regional level?

It has been pointed out that the 314b areawide agency in this case once was the Hill-Burton areawide health facilities planning agency; therefore, there is no jurisdictional problem with regard to health facilities and services planning.

"All counties within the Federation's planning area are formally organized and affiliated with a 648 Mental Health and Mental Retardation Board and a 169 Mental Retardation Board. The 107th General Assembly of Ohio passed under the provisions of amended House Bill No. 648 and amended Senate Bill No. 169 that Boards be organized by the county or a program community. The 169 Board is located in each county serving as the focal point for mental retardation training services. The 648 Mental Health and Mental Retardation Boards serve a population base of 50,000 or more. Ten such Boards serve the Federation's planning area, five of which are multi-county in structure and five singular county structured. The 648 Board is responsible for the provision of clinical type services for the emotionally disturbed and mentally retarded."

The Planning Federation's philosophy toward mental health and mental retardation services is that they should be brought into "the mainstream of general medical and health

care" and that the planning for these services should be interlocked with the Federation's health planning activities. The Health Planning Federation has decided to implement this philosophy in the following manner:

> "To secure interlocking relationships locally and on an areawide basis, provisions will be made for the Chairman of the Mental Health Committee in each county, or the representative who may have been selected to serve on the County Health Planning Council, to automatically become a member of the Federation Areawide Committee. This representative will be responsible for guiding the general policies of the Federation and assisting the responsible groups to develop program and objectives in the seventeen-county area."

In the area of environmental quality planning, there are two other organizations which have responsibilities similar to that of the 314b areawide agency. The State of Ohio has an Environmental Protection Agency and each county has its County Regional Planning Commission both of which communicate with the Mid-Ohio Health Planning Federation and serve on each other's committees. The county regional planning commissions see health planning per se as "one small part of planning." On the other hand, the 314b agency has defined environmental health problems as those factors which are involved in illness or disease. This point of view will be further explained in the answer to Question C.6. At the present time, there does not appear to be any conflict among these agencies.

C. Operational Period

1. What is the background (previous work experience and formal educational training) of each of the professional staff members?

The background and current agency position of each of the professional staff members is summarized in Table 5. The purposes for asking this question were to assess the range of experience which these individuals have and to discover if there is any concentration of talents in a particular academic area or profession. Later in this paper this information is examined as an input to the Federation's planning activities.

2. Has there been any change in the initial funding pattern of the agency following the constitutional period? If yes, what are the reasons for this change?

It was stated in the answer to Question 5, Section B, that the Federation was attempting to broaden its fiscal base as one of the requirements of the 314b grant. Appendix R contains a listing of the Federation's sources of support for 1971-1972 (12 months) which appears to demonstrate that they have met this condition of their grant. On a percentage basis, the local matching funds have been raised from the following sources:

Hospitals	50%
Blue Cross	10%
Voluntary Agencies & Businesses	20%
Local Governments	20%
	100%

Table 5. - Professional Staff -- Positions and Background, Mid-Ohio Health Planning Federation

Name	Position	Academic Degree(s)	Prior Work Experience
Delbert L. Pugh	Executive Director	3 years college	28 Years - Health Planning
Grant A. Drennen	Associate Director	A.B.	16 Years - Health Planning
Donald Saathoff	Associate Director	M.B.A.	Hospital Administration
Clyde Gaston	Associate Director (Environ. Health)	M.A.	City and Regional Planning
Charles A. Turner	Director Environ. Health	M.A.	City and Regional Planning
K. Joseph Derek	Master Planner (Manpower)	M.B.A.	Registered Pharmacist
Angelo Vivano	Director Community Health Services	M.P.H.	Registered Sanatarian
Carl E. Lincke	Director Alcoholism Programs	M.B.A.	Hospital Administration
Al Dyckes	Emergency Health Services	M.A.	Education
Jack Kindig	Financing Health Care	M.B.A.	Hospital Administration
H. Keith Windley	Hospital Services	M.B.A.	Hospital Administration
Grace Kindig	Mental Health and Mental Retardation	M.A.	Public Health Nurse

Table 5. - Professional Staff -- Positions and Background, Mid-Ohio Health Planning Federation

Name	Position	Academic Degree(s)	Prior Work Experience
Frank Wilson	Facilities and Technical Services	M.E.	Civil Engineer
Tom Sommer	Appalachia Planner	A.B.	-
Mark Leisure	Academy of Medicine Liaison	B.S.	-
James Renick	Communications Director	A.B.	-
Laurene Smith	Outreach Health Planner	-	Model Cities Staff
Betty Willis	Outreach Health Planner	-	-

(-) indicates not ascertained or not applicable

The Federal Government has provided 51% ($260,000) of the total budget of $500,000. There is no anticipated change in this arrangement for the immediate future.

In order to attract sources of cash revenue beyond their traditional sources, the county councils have been asked to solicit contributions from community and business leaders. As "sustaining members" these persons donate $1000 or more on a yearly basis.

The method of calculating each county's share of the financial burden of supporting the Federation appears to have changed somewhat over time. In 1966 the Federation had organized itself into district committees of 10-14 county committees which represented the grass roots planning segment of the regional planning organization (see organization chart in Appendix N). The feeling of the Federation staff at that time was that, "the Districts should be able to support a full-time District Executive and the administrative overhead necessary to back him up with office staff;" therefore, each district was expected to contribute "double the District Executive's salary," i.e., $20,000 to $30,000 annually or $2000 to $3000 per year per county. At the present time the funding assessment per county is determined via rating the counties according to their "Buying Power Index."

The "Buying Power Index" is a measure of each county's ability to contribute which is calculated by an outside consulting

firm. Their calculations are primarily based upon estimates of the buying power of the community, some measures of the county's wealth, and the total population of the county. The seventeen counties are rated and each is assigned a percentage of the total budget which they should raise for the Federation. These are the current funding mechanisms. The Federation does not receive funds from the State of Ohio.

C. 3. Has the State of Ohio passed any enabling legislation for CHP 314b areawide agencies in regard to the regulation of health facilities construction, the funding of the 314b agency, environmental quality, etc.?

The State of Ohio has not passed any legislation which would increase the funding base of the 314b areawide agencies, impose additional planning or administrative requirements upon the 314b agencies, nor increase the agencies' regulatory power.

4. In general how could the 314b areawide agency's planning methodology be characterized?

The Mid-Ohio Health Planning Federation relies primarily upon a set of standing committees as their approach to planning for health. These committees have the following titles:

a. Health Services Committee (health care financing and community health care);

b. Environmental Health Committee;

c. Health Facilities Committee;

d. Mental Health/Retardation Committee;

e. Health Manpower Committee.

Several other approaches to planning for health have been proposed by the Federation staff; they include the following:

a. Planning Forums at the County Level - monthly breakfast meetings at which speakers would be invited to be on a discussion panel which would review current health issues;

b. Master Planning - development of regional and county plans which would specify the locations of future hospitals, satellite clinics, emergency equipment, etc.;

c. Problem Solving at the County Level - encouraging persons on county councils to be aware of their health care resources and problems in order to develop action plans to solve these problems.

C. 5. How could the relationship of the 314b agency with planning commissions, hospital planning councils, medical societies and health departments be characterized now?

As was mentioned earlier, there are no COG (Council of Government or Regional Planning Commission) type bodies in Ohio. The Federation does work with the county planning departments and with the State Environmental Protection Agency.

It has been also noted that the previous hospital planning council, the Columbus Hospital Federation, has metamorphosed into the Mid-Ohio Health Planning Federation. Therefore, there is no conflict nor overlapping responsibility in the area of health facilities planning.

The Federation has successfully promoted and maintained the support of the area's physicians. Physicians are recognized as the group which often controls and influences the delivery of health care and its quality and availability in a community.

Health departments in Ohio at the county level are often understaffed and underfinanced due to low population bases, low income level of the residents, etc. The role of the Mid-Ohio Health Planning Federation has been to "assist with the implementation of a statewide program to reorganize local health departments and to encourage expanded state financial support."

C. 6. What health planning decisions and/or studies have been made during the operational period of the CHP 314b agency?

One of the main activities of the Federation is the review of grant proposals. Appendix S presents a list of projects reviewed from July, 1971, to May, 1972. The proposals are not limited solely to health facilities construction projects but include a substantial number of proposals in the area of environmental health, specifically water quality. Also, emergency medical services appears to be another area which apparently has generated considerable community interest. Unfortunately, the Federation's recommendations and the outcomes of these proposals were not stated.

The publications listed in Appendix S generally fall into one of two categories, namely, hospital studies and health services inventories. The "Health Planning Procedures Manual" is especially noteworthy because of the philosophy which is stated therein:

> "The County Health Planning Council should advocate changes in health programs and stimulate the respon-

sible agencies to implement desirable changes."

Therefore, the Federation feels that if a county council "works right," its members will encourage a local area to become interested in a problem, motivate the people to work toward developing solutions to the problem, and assist local groups in drafting grant porposals and/or in securing local funding. This approach when implemented would definitely turn the process of project review into an active rather than a passive operation. Since the Federation has encouraged local persons and organizations to draft grant proposals, the staff feels that this is an active process at the present time rather than reactive.

Discussion

The preceding sections presented information related to the development of the Mid-Ohio Health Planning Federation as was done in Part I on the evolution of the Comprehensive Health Planning Council of Southeastern Michigan. The intent here also will be to construct a general profile of the agency, i.e., the Mid-Ohio HPF. The same caveats concerning the lack of intended criticism, the time-specific nature of the data, and the omission of biographic details on central political figures should be noted by the reader here as in Part I.

As in Part I, an examination of how the membership composition of the Board of Trustees was determined provides much insight about the political and economic substructure of this 314b areawide agency. The

representation on the Board of Trustees is based upon evidence of "community leadership" on the part of the nominees rather than the person's organizational affiliation. The philosophy behind this approach, then, is that the agency seeks out those persons who would have the greatest potential to contribute, i.e., the ability and desire to get something done. In general there are two routes by which a person could receive a nomination for membership on the Board of Trustees, the person could be a prominent individual in the community who has "contacts and influence" and/or the person could have worked hard and come up through the ranks. In the latter case the individual would have worked hard on a county planning council committee and was then elected to membership on one of the 17 county health planning council's board of directors. If in turn this person distinguished him-/herself at this level, the individual may be nominated to the regional CHP Board of Trustees. Thus, these positions "have to be earned" according to the manner in which persons are required to secure the membership(s).

As was implied in the complex organizational structure which was outlined above, the foundation of this CHP agency has existed for some time. In fact the CHP 314b agency formerly was the Columbus Hospital Federation, a Hill-Burton health facilities planning agency which has existed, with the same executive director, since 1945. Most of the other staff members were retained through the transition of the agency from health facilities planning to broader comprehensive health planning responsibilities.

Jurisdictional problems are minimal since there is no separate health

facilities planning organization; there are no COG or Regional Planning Commissions in the State; the health departments are generally understaffed, underfunded agencies, and at the moment the Federation has good working relationships with the individual county planning commissions and with the mental health and mental retardation planning boards.

The funding sources of the agency, as the reader would suspect, have primarily been hospitals. At the present time, hospitals still contribute approximately 50% of the local share. The Federal Government has told the Federation that it must broaden its fiscal base as evidence of community support. The Federation's primary method of achieving this end has been to ask the county councils to solicit contributions from community and business leaders. As "sustaining members" these persons donate $1,000 or more to the Federation annually.

The State of Ohio has not passed any legislation which would increase the funding base of the 314b areawide agencies, impose additional planning or administrative requirements upon the 314b agencies, nor increase the agencies' regulatory power. The State has not enacted any form of certification of need legislation for health care facilities.

The Federation has been active in the area of grant proposal review and in the publication of their work. The agency's publications from July, 1972, to May, 1972, could be generally classified into two categories, namely, hospital studies and health services inventories. One Publication, "Health Planning Procedures Manual" (1972), is es-

pecially noteworthy because of the philosophy which it promoted in regard to the expectations which the regional agency has of its county counterparts:

> "The County Health Planning Council should advocate changes in health programs and stimulate the responsible agencies to implement desirable changes."

Therefore, the grant proposal review process, according to the regional agency, should actually start with the county council recognizing a health problem and then motivating and assisting individuals to either draft grant proposals or develop sources of local funds to solve the problem. Thus, the grant proposal review process would be an active rather than a reactive process. The Federation's staff feels that they have made some progress in this area. Presently, the types of grant proposals which come before the Board of Trustees for review include many environmental health as well as health facilities and health care program proposals.

As their principal approach to planning for health, the Mid-Ohio Health Planning Federation relies primarily upon a set of standing committees. The approach is somewhat the same at the county level with the addition of ad hoc task forces which work on solutions to specifically identified problems, eg. poor water quality in a community.

Several other approaches to planning for health have been proposed for the future by the Federation staff; they include:

1. Planning Forums at the County Level - monthly breakfast meetings at which speakers would be invited to be a discussion panel which would review current health issues;

2. Master Planning - development of regional and county plans which would specify the locations of future hospitals, satellite clinics, emergency equipment, etc.;

3. Problem Solving at the County Level - encouraging persons on county councils to be aware of their health care resources and problems and to develop plans to solve these problems.

In Part III a comparison is made between the Mid-Ohio Health Planning Federation and the Comprehensive Health Planning Council of Southeastern Michigan highlighting their structural and organizational process differences and the importance of community support, in particular, sources of local matching funds. Some parallel observations on CHP activities in California are presented.

Sources

"A Case Study of An Operating Planning Agency: A Presentation, Institute for Staffs of Hospital Planning Agencies, Chicago," The Columbus Hospital Federation, 1666 E. Broad Street, Columbus, Ohio, December 12, 1966.

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"Health Planning Procedures Manual," The Mid-Ohio Health Planning Federation, 1666 E. Broad Street, Columbus, Ohio, April, 1972.

"Annual Report of Progress," The Mid-Ohio Health Planning Federation, 1666 E. Broad Street, Columbus, Ohio, June, 1972.

Personal Interview with Grant Drennen, Associate Director, Mid-Ohio Health Planning Federation, 1666 E. Broad Street, Columbus, Ohio, July, 1973.

PART III: COMPARISON OF THE CHP DEVELOPMENTAL PROCESS IN SOUTHEASTERN MICHIGAN AND IN MID-OHIO WITH SOME NOTES ON THE STATUS OF CHP IN CALIFORNIA

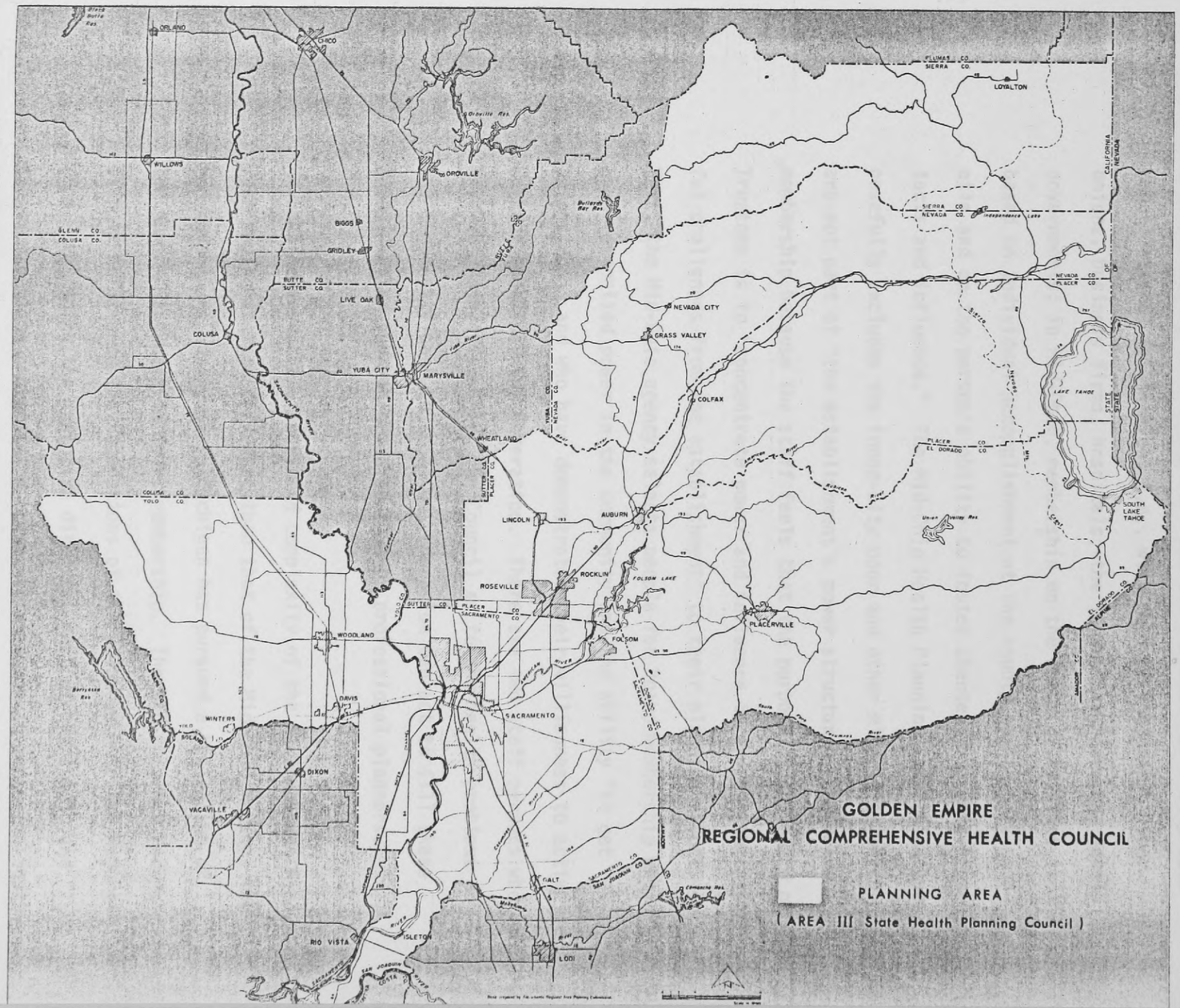
Board Membership - Southeastern Michigan, Mid-Ohio, Sacramento Region

In addition to comparing the structure and the organizational processes of the CHP Council of Southeastern Michigan with the Mid-Ohio Health Planning Federation, the author here presents some parallel information on the activities of the Golden Empire Comprehensive Health Council (Sacramento, California, region - see Figure 3). Appendix T contains an organizational chart of the Golden Empire Council. The author was on the staff of GECHC for two years as a health planning assistant (general planner).

There are enacted pieces of legislation in California permitting State financing of 314b areawide agencies and establishing regional health facility review procedures; this differs from the experiences of the Southeastern Michigan and Mid-Ohio CHP agencies and introduces benefits and problems which have not yet been grappled with by these latter agencies. This funding information may prove to be useful to the Michigan and Ohio 314b agencies and to other 314b areawide councils which are seeking methods of firming up their fiscal base and/or increasing the amount of regulatory power held by their agency for the purpose of implementing their planning decisions.

This author has attempted to demonstrate in Parts I and II that an examination of two factors, namely, the basic philosophy held by the staff and the methods which were used in the selection of board members, reveals much information about the political and economic substructure of the agency under study. Whereas in Southeastern Michi-

Figure 3. - Golden Empire Regional Comprehensive Health Council Planning Area


GOLDEN EMPIRE
REGIONAL COMPREHENSIVE HEALTH COUNCIL
PLANNING AREA
(AREA III State Health Planning Council)
ORLAND
CHICO
WILLOWS
OROVILLE
BIGGS
GRIDLEY
LIVE OAK
COLUSA
YUBA CITY
MARYSVILLE
WHEATLAND
LINCOLN
AUBURN
ROSEVILLE
ROCKLIN
FOLSOM
PLACERVILLE
WOODLAND
DAVIS
WINTERS
DIXON
VACAVILLE
SACRAMENTO
GALT
ISLETON
RIO VISTA
LODI
LOYALTON
NEVADA CITY
GRASS VALLEY
COLFAX
LAKE TAHOE
SOUTH LAKE TAHOE
GLENN CO
COLUSA CO
BUTTE CO
SUTTER CO
YUBA CO
NEVADA CO
PLUMAS CO
SIERRA CO
PLACER CO
EL DORADO CO
YOLO CO
SOLANO CO
SACRAMENTO CO
SAN JOAQUIN CO
AMADOR CO
CALIFORNIA
NEVADA

gan, membership on the Board of Trustees was based primarily upon organizational affiliation, i.e., with medical societies, labor unions, business firms, hospitals, the inner-city poor, and local governments; in Mid-Ohio, membership on the Board of Trustees is based on individual accomplishment at the county counterpart councils and on the person's ability to foster change, i.e., his "contacts and influence." The Mid-Ohio Health Planning Federation purposefully excludes the inner-city poor and other minorities which are not part of "the establishment's power structure" from Board membership because the staff feels that the purpose of the Board of Trustees is to "concentrate power and influence to prevent successful challenges from the establishment" to their planning effort. Thus, the Mid-Ohio agency selects people for Board membership who have recognized power in the community and the ability "to get things done" and who have demonstrated their willingness to actively work on behalf of the Federation. There are two staff persons who have the task of advising the Council as to the health problems of the inner-city poor so that the Federation can act to fill these needs, having been informed of them by professional planners.

Perhaps because the history and complexity of the Southeastern Michigan region is much different than that of the Mid-Ohio region, the CHP Council of Southeastern Michigan has pursued a "balancing of the powers" approach to Board membership. The Mid-Ohio CHP Federation is built upon the foundations of the Columbus Hospital Federation - retaining the executive director, most of his staff, and their established support and credibility in the region. The Southeastern Michigan Council was born out of the struggle of UHO, an as-

sociation of private health care providers (primarily hospitals) and SEMCOG[1], a council of governments entity, for control of the 314b grant. The Greater Detroit Area Hospital Council (GDAHC) did not actively seek the 314b areawide grant, even though their history closely paralleled that of the Columbus Hospital Federation, because they were "fearful of diluting [their] facility-programming responsibilities and feared dilution of community support." Note that GDAHC received its local financing primarily from the United Foundation. Neither GDAHC nor the CHP Council of Southeastern Michigan has developed county planning councils to date. Labor interests and representatives of the inner-city poor[2] have members on the Board of Trustees and have directly influenced the adoption of a 55/45 per cent consumer/provider ratio on the Board of Trustees and a 60/40 ratio for the General Membership.

In the Sacramento region, the Golden Empire Comprehensive Health Council was established primarily through the persistent efforts of the executive director of the United Crusade (United Foundation). Health care provider groups for the most part fought the development of a CHP agency. The Hospital Planning Council of Sacramento was a small organization, with one professional staff person, which was, according to the present CHP executive director, controlled by a group of hospital administrators and physicians who reviewed each

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1/ Neither UHO nor SEMCOG have since expressed any outward signs which would indicate a desire to take over the 314b agency role from the CHP Council of Southeastern Michigan.

2/ Representatives of "disadvantaged groups" make up 24% of the general membership of the Council.

other's projects in a favorable light while rejecting many other proposals drafted by "outsiders." Usually if an administrator knew that his health facility proposal was in danger of being rejected, he would decline to have it reviewed by the Hospital Planning Council since at that time he/she was not compelled to do so. Unfortunately, the original Board of Directors of GECHC was made up of health care providers who were interested in holding back the organization from trampling upon their interests and "professional volunteers" who were generally civic minded individuals whose main interest was in keeping the organization afloat by attending the meetings of the Board and its Committees. The Hospital Planning Council was merged with GECHC on the condition that one-half of the 314b agency's annual funding be a contract payment to the HPC for facility planning services.

GECHC up until recently did not have the interest of, much less representation from, labor and the region's disadvantaged and minority groups. The Council's membership was primarily upper-middle class, white, professionals most of whom had been associated with the Hospital Planning Council. Three out of the six counties in the region had pre-existing health planning councils, each of which were directly answerable to their respective county board of supervisors. Consumer representation on the county councils and in turn on the regional council was based upon the person's willingness to serve with the proviso that the county board of supervisors approve the appointment.

The philosophy of GECHC, as voiced by the assistant director, was

that "any cooperation" on the part of the medical establishment, which he said was inherently conservative, could be considered to be progress for health planning. He viewed the existence of the Council as an achievement in and of itself.

The COG organization, which has been designated as the A-95 Clearinghouse for Federal grant proposals in GECHC's region, is called the Sacramento Regional Area Planning Commission (SRAPC). Although this body was minimally involved during the organizational phase of the 314b areawide agency, SRAPC has developed during the past two years a strong and consistant point of view that regional health planning activities should be subsumed under its operations. The accomodations made by GECHC to SRAPC's position will mentioned in the next section.

The next section will also illustrate the interrelationships between funding sources, area politics and the agency's planning philosophy and activities.

Sources of Funding and the Areawide Agency's Approach to Health Planning

Since 314b areawide health planning agencies are essentially private, non-profit corporations with quasi-public responsibilities, one of the most vexing problems that a CHP council executive director has is that of raising funds. The U.S. Public Health Service under P.L. 89-749 does provide at least 50% of the 314b areawide agency's budget; however, each of these Federal dollars must be matched

with local funds (including in-kind services). The difficulty of this task becomes readily apparent when one learns the fate of the executive director of the Los Angeles region 314b CHP agency (Southern California Comprehensive Health Planning Council) in 1971. After an audit by the GAO, this CHP agency which had been in existence two or three years was found to be $300,000.00 in debt to the U.S. Government; the executive director was dismissed, and the region was embroiled in a sea of political controversy. Some of the fallout from this particular situation will be discussed in the last section on the development of county councils. An executive director of a 314b areawide council must accomplish at least two distinct ends when seeking funding sources for the agency; they are as follows:

1. Develop stable sources of funds which will assure the existence of the agency over the long term;

2. Secure monies from a variety of local sources so as to meet the HEW condition of the 314b grant which states that the agency's funding pattern should show evidence of broad based community support.

The Southeastern Michigan 314b Council receives most of its local funds from the United Foundation[3] and from the Blue Cross/Shield Insurance Company. The Greater Detroit Area Hospital Council was heavily supported by these funding sources also. Not surprisingly, the Southeastern Michigan Council receives its funds from these organizations on the condition that approximately $250,000 dollars be channeled to GDAHC via a contract for the latter organization to

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3/ Technically, the CHP Council of Southeastern Michigan receives most of its local monies from UHO which in turn receives its monies from the United Foundation.

perform health facilities planning activities until 1977 (see Appendix G) for the 314b agency. The contributions from the city/county sources were solicited on the basis that SEMCOG would receive more funds back via a one-year environmental health planning contract (see Appendix H) than the governments had contributed. These methods of initiating funding support on the local level from a variety of sources are in this case expedient and practical; however, there are some obvious drawbacks in terms of planning and decision making responsibilities being delegated outside the agency. The wisdom of this approach will be tested in the long run by an evaluation of the agency's performance.

Since the Mid-Ohio Health Planning Federation evolved from the Columbus Hospital Federation, retaining most of the health facility planning staff members, one would expect that the funding sources and planning agenda of the Federation would be heavily health facilities oriented. This is indeed the situation. Fifty per cent of the local matching funds comes from hospitals; a much smaller percentage comes from the United Foundation and from the Blue Cross/Shield Insurance Companies. The Federation staff are now attempting to expand their fiscal base by asking the county planning councils to solicit contributions from businessmen, i.e., to have them become sustaining members by contributing $1000 or more on an annual basis.

It is interesting to note that the support from the region's hospitals has not diminished even though the organization has taken on the broader responsibilities in comprehensive planning for health;

this seems to contrast with the position stated by GDAHC that they would lose their community support if they were to take on 314b planning responsibilities. However, according to an associate director at the Mid-Ohio HPF, the Federation has not directed the focus of their planning activities away from health facilities and related physician's services because "70% of health care is provided in hospitals and the remaining 30% is given in private practitioners' offices." Certainly, because the staff has retained this planning philosophy, it should partially explain the loyalty of the area's hospitals and physicians in supporting the Federation. The author feels there are two other factors at work here which also increase the likelihood of continued community support for the Federation; these are the longevity of the organization, which was established in 1945, and the professionally recognized high quality of the agency's work.

The Federation has a predominance of staff personnel with hospital administration, academic, and work experience backgrounds which undoubtably strengthens the agency's ties with the area's hospitals. The backgrounds of those persons who staff the Southeastern Michigan Council are also primarily in hospital administration. The GECHC staff by comparison is small with only five professional staff persons, three of whom have public health backgrounds.

The hospitals' monetary contributions to the Golden Empire Comprehensive Health Council were retained through the transition period of merger with the Hospital Planning Council of Sacramento and the subsequent dissolution of the HPC. The service that the HPC had

provided to the hospitals in return for their support, exclusive of their health facility proposal review activities, was the collection and distribution of health facility utilization statistics[4]. GECHC continued this service but had some difficulty maintaining the quality and speed of the operation intra-office when the HPC secretary who performed this task left GECHC. Another more irritating and threatening nemesis, than the possibility of having their utilization reports either delayed or discontinued, befell the region's hospitals and nursing homes with the passage of AB 1340 (1969), California's health facility review legislation. At this point the contributions from health facilities were no longer a certainty. The resulting action by the State in passing additional legislation is discussed in the next section.

The other major sources of funds for GECHC were the contributions made by the county boards of supervisors. In this instance the Sacramento Regional Area Planning Commission, the COG agency, had the potential leverage to cripple GECHC by convincing the supervisors to withhold their funds. SRAPC has not as yet exercised this power; but, as the A-95 clearinghouse for Federal grant proposals, SRAPC did insist, however, that GECHC not engage in "duplicative environmental quality planning activities." It was decided that SRAPC and GECHC would form a joint committee on the environment for the purpose of environmental health/quality planning. The amount of interest in this project could be roughly gauged by the fact that

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4/ Monthly reports were prepared for nursing care type facilities and quarterly reports were prepared for acute hospitals. The information was provided on a voluntary basis.

nine months passed after the agreement was made before the first joint meeting was held. Environmental health planning is considered by most of the 314b CHP agencies in California to be a requirement of the Federal Government which the councils wish the Government would forget about because the CHP agencies feel other organizations, already established, are better qualified to do planning for environmental health.

As was suggested here and as is detailed in the next section, local funding is viewed by the 314b agencies in California as a large headache. The State Government is seen as being sympathetic and responsive to the plight of the 314b executive directors since the legislature has passed legislation which is intended to improve the funding situation for the 314b agencies.

State Enabling Legislation - Regulatory and Taxing Power for the 314b Agencies

The States of Ohio and Michigan have not passed any legislation which would increase the funding base of the 314b areawide agencies, impose additional planning or administrative requirements upon the 314b agencies, nor increase the agencies' regulatory power.

The State of Michigan has enacted legislation, effective April 1, 1973, requiring certification of need for health facility proposals involving "new construction or conversion of, addition to or modernization of health facilities" (see Appendix J). The State has created a "Health Facilities Commission" under the Michigan Department

of Public Health to administer this act. CHP 314b areawide agencies are consulted in an advisory capacity by the Commission and receive no reimbursement for their efforts.

In marked contrast to the Michigan law, California's health facilities planning regulations enacted in 1969 give the 314b areawide agencies regulatory responsibilities, i.e., public hearing on facility proposals, the determination of community need, and the collection of fees for their proposal services - up to $2000 (see Appendix U).

There were of course many problems which arose when the State of California delegated these weighty responsibilities to the regional CHP agencies; most of these agencies were just completing the organizational phase of their development. One of the first problems encountered was the forecasted reduction in contributions from health facilities due primarily to adverse decisions by CHP 314b agencies on the merits of some facility proposals which they reviewed. In response to this situation, the State of California and the California Hospital Association joined forces to draft legislation (AB 2222) which would impose a tax on hospitals ($4/bed) and on nursing home type facilities ($1/bed)[5] for the support of comprehensive health planning. But rather than have the funds collected by and/or sent directly to the 314b agencies, the State collected these monies as part of each facility's annual license fee. The

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5/ By comparison, the reader is reminded of the $.75/bed voluntary contribution requested by the CHP Council of Southeastern Michigan from hospitals (excluding nursing homes).

State, after deducting 6% of the total monies collected for administrative costs, allocated funds to each CHP region on the basis of a formula which included the following factors:

1. Population of the region;
2. Wealth of the region;
3. Amount of time, i.e., percentage of the agency's budget, spent on health facilities planning.

The reader should be able to anticipate the result. Each CHP areawide council to collect their share of the funds increased the amount of time they spent on health facilities planning to the detriment of other health planning concerns. There also was one other not so subtle trend started. The State felt a need to standardize health facility planning and review procedures used by 314b agencies across the State.

The first move in this direction was a proposal by the State of California to draft guidelines concerning the types of personnel who should be hired to do health facilities planning.

This proposal met stiff opposition and was shelved by the State. However, the State was successful in drafting and implementing a set of guidelines which specified the content of and date by which each CHP areawide agency would complete its health facilities plan.

In regard to implementing the health facility proposal review legislation itself, the State issued a document on May 11, 1973, the "California Health Facility Application Review Manual," the purpose

of which was stated as follows[6]:

> "This manual provides a framework which will allow all 314(b) areawide comprehensive health planning agencies to develop guidelines which will result in statewide, standardized procedures for the conduct of their responsibilities in accordance with Chapter 1451, Statutes 1969."

There were of course reasons for drafting a manual of this type[7]; the thing that was disturbing was the timing of the State - this document was prepared a full two years after the health facilities proposal review (certification of need) legislation had become effective. Are the staff members at the regional level required to completely revise their current review practices? The manual gives the following answer to this question, "No individual areawide agency may unilaterally change or modify these procedures in any way."

The author is not suggesting that a strong State 314a CHP agency is ipso facto a negative thing, but rather the reader is asked to note the consequences of both the assumption of regulatory power by 314b agencies and of the State financing of CHP areawide agencies. A possible consequence of increased State direction of the affairs of regional CHP councils has been illustrated in the preceding paragraph.

There was an expected further decrease in direct, voluntary local

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6/ The document is not included as an appendix due to its length (58 pages).

7/ The author knew of a situation in northern California in which an applicant was charged an additional $1000 for his proposal review because the staff considered it "controversial."

funding contributions to CHP 314b agencies as the traditional funding sources, namely, health care facilities were taxed by the State for the support of comprehensive health planning. The implications of this situation will be explored further in the conclusion of this paper.

A proposed extension of the trend toward State management of monies collected within CHP regions was written into Senate Bill No. 413[8] introduced by Senator Beilenson on March 12, 1973, and is now awaiting legislative action. Among its many provisions, this bill if enacted would raise the maximum fee charged for health facility review procedures conducted by the 314b areawide councils from $2000 to $5000, but these fees would be paid directly to the proposed Health Facilities Commission which would determine the reimbursement that the areawide council would receive.

As a final note here, the author was informed by the California State 314a Agency that the Federal Government will continue to provide 50% funding for CHP 314b areawide agencies; 75% funding will be provided for "economically depressed" regions. This differs from the 75% Federal funding which the author was told is now available by administrative decision by HEW Region V for the Southeastern Michigan CHP region[9].

8/ The document is not included as an appendix due to its length (68 pages).

9/ This ruling differs from the situation in California unless the Southeastern Michigan region has qualified as an "economically depressed" area due to its recent and persistent high unemployment rate; the author was not given this impression.

Development of County Councils

A separate research paper could be written on the development, importance, and operation of county health planning councils and how they relate (or don't relate) to the regional body. A few notes will be made here about the pluses and minuses of the areawide CHP Council organizing and cultivating county counterparts.

The Southeastern Michigan CHP Council at this time does not have county health planning councils affiliated with it.

The Mid-Ohio Health Planning Federation has a county health planning council in each of its seventeen member counties. Their existence appears to be primarily due to the local orientation of the residents who distrust regional organizations and to the community organization training of the senior staff members of the Federation.

The Federation, as has been mentioned, has used the county councils as a training and proving ground for the nominees to their Board of Trustees. The Federation is attempting to establish a process of local problem identification, prioritizing, and recommending solutions. Thus, the Federation feels its credibility is largely dependent upon the success of these local councils.

On the minus side, the Federation has had difficulty in promoting acceptance of the necessity for regional cooperative action to solve problems which transcend county lines; this is because the county councils are immersed in their own problems. The counties

have traditionally fought the regionalization of their health departments despite the fact that they are underfunded and understaffed. Another major problem is that of the allocation of staff time to county councils. Most counties cannot afford to hire professional staff on a full-time basis, and yet an active comprehensive health planning council requires professional help to achieve its work program objectives and to keep abreast of what is occurring in health planning at the regional, state, and national levels.

One county in California, Marin, was wealthy and sincere enough to secure its own professional planning staff - in fact many of the San Francisco Bay Area counties each have their own full-time professional staff. The difficulty in this case was that the county staff often found itself running counter to the wishes of the regional staff. As an example of the kind of problems which may develop, the reader is referred back to the situation of Southern California CHP Areawide Council which was cited earlier. Following the dismissal of the region's executive director, the discontent among the county members of the Southern California region was so intense that the State Health Planning Council permitted the division of the region into five new regions. The Orange County CHP Council was so well organized and adamant about the "uniqueness" of its problems that it succeeded in becoming the State's first and only single-county CHP agency; thus, defeating one of the main intents of P.L. 89-749 - to create regional health planning bodies.

The Golden Empire Comprehensive Health Council inherited at the time of its incorporation three pre-existing county health planning coun-

cils. These county councils were sponsored by the board of supervisors in each county as an advisory body to which the supervisors could route controversial health and welfare problems and project proposals for their review and comment. The author found that these councils understood neither the purpose of the regional 314b council nor their relationship to it. The county councils were loyal to the supervisors who constantly reminded the council members that, "We [the supervisors] make the decisions around here; you are only an advisory body." The county councils often felt that the regional body was "meddling in their affairs" and "expecting too much work from them."

The main difficulties underlying the poor relationships between the county councils and the regional body were the lack of professional staff time available to invest in these groups and, until recently, an absence of persons on the regional staff with backgrounds in community organizing to develop county councils where none existed. One partial remedy to this situation would have been for the regional staff to frankly and honestly discuss their limitations and expectations for the county councils with them rather than issuing the following terse, uninformative statement about the proposed regional/local relationship[10]:

> "The Golden Empire Health Council has stated, as one of its underlying principles, 'that local health problems can best be identified and solved at the local level with the coordination and technical assistance available at the regional level.' The goals inherent in this statement can only be

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10/ Source: Document GECHC, April, 1970, "Relationships Between the Golden Empire Health Council and County Comprehensive Health Planning Councils - Philosophy and Roles" (2 pages).

> realized through the development of strong county organizations capable of responding to local needs and problems and the identification of local health priorities as well as providing the necessary 'input' into the areawide health planning machinery."

The Mid-Ohio Health Planning Federation has produced a document, "Health Planning Procedures" (April, 1972), which does detail the intended responsibilities of a county health planning council from "finances" to "communications." It is the author's firm belief that county health planning councils must be informed of their role(s) and given regular staff services; otherwise, their existence will prove to be a millstone around the neck of the staff of the regional agency.

Summary

The author has attempted to show that an examination of two factors, namely, the basic philosophy held by the staff and the methods which were used in the selection of board members, reveals much information about the political and economic substructure of the agency under study. Also, there was observed a firm link between the sources of agency funds and the planning agenda which was subsequently adopted.

There is a myriad of variables which can be studied in an analysis of how a CHP agency has been organized and what forces determine the planning agenda. However, the most productive place to start appears to be a review of the answers to these questions:

1) Who was/was not on the board of directors?
2) How did/didn't they get there?
3) What were the agency's sources of funds?

By studying the membership and organizational representation of the CHP council's board of directors, it was possible to define the set of actors who set planning policy for the region. This author considered three observations about board membership to be significant; they were as follows:

1) Organizations and monetary interests supporting CHP had representatives on the board of directors;
2) Professional organizations opposing CHP had representatives on the board (often in self-defense);
3) Potentially influential groups, such as labor unions, which

were represented on the board of directors of one regional CHP agency but not on the board of a CHP agency in some other region were either not formally organized and active in community affairs in the latter area or were intentionally excluded from board membership by the agency staff.

The last point became more obvious when the Board membership of the Golden Empire CHP Council was compared with that of the Southeastern Michigan and Mid-Ohio Councils. For example, labor unions and organizations formed by the disadvantaged, primarily the poor, were not initially members on the GECHC Board of Directors. However, representatives of both the UAW (United Auto Workers) and the WRO (Welfare Rights Organization) were vocal and influential members of the Southeastern Michigan CHP Council Board of Directors. At the time of this study, in Mid-Ohio labor unions were just beginning to be invited to accept representation on the Council's Board of Directors and committees; whereas the poor were being intentionally excluded from Board membership by the staff. The Mid-Ohio staff said that the interests of the poor would be better understood and acted upon if some of the professional staff members were assigned the task of being liaisons with the poor and then later reported their findings to the Board.

Thus, the particular combination of groups and organizations represented on each of the regional CHP council's board of directors studied appeared to result from the initiative by each organized health care interest group to join plus the framework for board membership devised by the staff. It is not possible, however, to

say that the CHP agency's commitment to change can be directly gauged by the degree of pluralism, or lack of it, reflected in the board membership list because output measures for the CHP agencies remain ill-defined.

The Mid-Ohio Health Planning Federation Board of Directors membership was selected from the region's leaders in the areas of business and health (the community elite model). It was felt that "to get things done" there had to be persons with leadership qualities on the Board to move resources in the right directions and to handle any blocks erected by "the establishment".

Since there were diverse, powerful health care interest groups in Southeastern Michigan each of which was at a differect point on the status-quo-to-change continuum, the Council employed a "balancing of powers" approach to membership on the Board. A mediator group was needed and was found at the University of Michigan School of Public Health. Dean Myron Wegman and Dr. Robert Grosse attended the early organizational meetings and helped forge compromises which promoted the development of the CHP agency.

In Sacramento, the Golden Empire Comprehensive Health Council staff spent most of their time reassuring the civic minded individuals who originally promoted the development of the Council that planning was being done while at the same time fending off the attacks of the area's medical society. This medical society had established a foundation for health planning whose staff at one point in time said that they, "...intended to obviate the need for comprehensive health planning."

Obviously, these three approaches are somewhat different due to the philosophy of the professional staff at each agency and due to the political situation with which they were confronted. Since this report examines only two case studies and since not enough time has elapsed to evaluate the outputs of these agencies, it is not possible at this time to conclude which of these approaches will work best. It is probable, however, that there is no universal rule for organizing CHP agencies which will work in all circumstances.

In regard to defining the mission of the agency as understood by those involved, this author believes that the most insight about what the agency is or is not doing can be obtained, not by opinion surveys, but by analyzing the CHP agency's sources of funds and the conditions which are attached to the receipt of these monies. It should be noted that rarely are there not provisos connected with contributions to voluntary agencies. Also, there are no "correct" sources of funds nor any normative rules for fund raising. The point being made here is that unless the agency is somehow financially independent, it will have to raise funds from somewhere; and this will often involve some bargaining in order to continue the supply of dollars in the future.

In Southeastern Michigan, the United Foundation was a major contributor to the CHP Council via UHO (the United Health Organization). In recognition of the generosity of the United Foundation, the CHP Council had a contract with GDAHC (Greater Detroit Area Hospital Council), which also had been supported by the United Foundation, to perform health facilities planning services. The

region's hospitals and physicians were large contributors to the Mid-Ohio HPF, and in turn the Federation devoted a large amount of its planning effort to health facilities and physicians' services planning. In California the CHP agencies received State collected hospital and nursing home "bed taxes" for health facilities planning services. However, the amount of money received by each of the CHP agencies depended not upon how much money was collected from the hospitals in the area but rather upon the amount of time the agency had budgeted for health facilities planning (as the percentage of staff time increased the State contribution increased).

Therefore, there is some evidence to suggest that the sources of agency funds, and the conditions attached to these contributions, will affect the agency's planning agenda and possibly the agency's overall direction or goals.

As a final observation, the author also concluded that more thought and research should be focused upon the adviseability of the regional agencies organizing county councils. This would help CHP agencies like the Southeastern Michigan CHP Council in deciding whether the benefits of investing staff time in local planning organizations would be greater than the costs.

The Mid-Ohio Health Planning Federation has successfully used county (local) councils as a "proving ground" for training candidates for membership on the regional board. The Golden Empire CHP Council found that recognizing pre-existing local health advisory bodies as official county counterparts often resulted in

provincialism and divided loyalties (toward the regional body and the county supervisors). The main difficulties underlying the poor relationships between the county councils and the Golden Empire CHP Council were the lack of professional staff time available to invest in these groups and, until recently, an absence of persons on the regional staff with backgrounds in community organizing to develop county councils where none existed.

One partial remedy to this situation would have been for the regional staff to discuss frankly and honestly with the county councils their agency's limitations and expectations. The Mid-Ohio Health Planning Federation has produced a document which does detail the intended responsibilities of a county health planning council from "finances" to "communications".

In sum it is the author's belief that regional CHP agencies should realistically assess the amount of resources needed to organize and maintain county CHP councils and should decide specifically what functions these councils will be asked to perform. The county health planning council(s) must then be informed of their role(s) and given regular staff services; otherwise, their existence will prove to be a millstone around the neck of the staff of the regional agency.

CONCLUSION

As was stated in the introduction to this paper, the author had two purposes in mind while writing this paper; they were the following:

1. Comparison of the political and organizational forces which affected the development and operation of each of the CHP 314b agencies studied and to gauge the impacts of possible determinants of the planning process itself, such as sources of agency funds, agency jurisdiction, board member representation, and staff recruitment (this comparison was presented in Part III);

2. Reply to some of those persons who have made normative statements concerning "solutions" to some of the problems experienced by CHP 314b agencies.

In regard to the latter objective, the author presents in this section an application of this study's findings (with related information from other sources) by evaluating the potential results of two suggestions for improving the CHP process at the regional level. In brief these suggestions are that 1) national leadership, i.e., case studies, guidelines and priorities, for comprehensive health planning should be provided by the Federal Government; 2) public leadership should be given to CHP by merging 314b councils with public regional councils, such as COG's.

In addition to a discussion of the potential impacts of the two suggestions mentioned above, some unanswered questions which arose during the course of this investigation will be mentioned in the context of possible topics for future research. Next, the significance of the sources of local matching funds in relation to agency planning priorities is discussed.

Funding - The Local Share

As was shown in Part III, the sources of funds largely determine the priorities of the 314b agency. In the case of GECHC in California, the State actually institutionalized a planning bias in the areawide agencies by making the amount of monies available to the councils from the health facility bed tax dependent upon the percentage of staff time allocated to health facilities planning. Since none of the other health problem areas, eg. environmental health, offered any cash reimbursement for staff planning, they became consequently less important.

In Southeastern Michigan the United Foundation was a large contributor to the CHP council. The U.F. also had previously supported GDAHC. As a condition of the funds made available to them, the Southeastern Michigan CHP Council agreed to contract with GDAHC for health facility planning services until 1977.

Thus, local funding of CHP councils is a double-edged sword. On one hand if the State increases its funding to the 314b agency, there will be "some strings attached" which will affect the agency's planning priorities. In the other case, if the funding sources are local, the agency's priorities will inevitably be linked with the donor's planning concerns. There appears to be no answer to this dilemma; the author wishes only to point out that is exists.

National Performance Standards for CHP 314b Agencies

Somers (1969) makes the following comment about comprehensive health planning:

> "... PL 89-749 sought to substitute one power base for another - the power of public funds channeled through state government....
> "But if this were the intent, there was a serious miscalculation ... the U.S. personal health care economy still is predominantly private.
> "To the 'nonsystem' of health care has been added a layer of 'nonplanning'."

Somers concludes by stating that there is a need for national leadership, i.e., case studies, guidelines, and priorities to be provided by the Federal Government. The previous section mentioned the high likelihood of the CHP agency's funding sources "attaching strings" or establishing qualifying requirements to the provision of monies. Somers suggests that this could be a positive thing. This author suggests, however, that operationalizing this idea is more difficult than it appears to be at first glance and may in fact defeat the purpose of regional comprehensive health planning.

The Federal Government has not in fact developed performance standards for 314b agencies. This author believes the reason for this is that neither the Government, nor anyone else, knows what these standards should be because comprehensive health planning and planning in general in the United States is still in an experimental stage.

As to the Federal Government establishing priorities, it faces the

classic problem of determining by whose values the priorities should be assigned. Brown (1969) has pointed out that, "Only the public can control the public: the trouble with the public is that it is made up of many individuals and groups of individuals, who quite naturally act as individuals, rather than as the public-at-large." Who in Washington, D.C., can say what constitutes the public good in Ann Arbor, Michigan?

The Government has made two general requirements of 314b agencies, namely, that they 1) report their progress several times a year and 2) establish planning priorities in their regions based on community input.

The requirement of basing the agency's planning priorities upon community input is important. A former hospital planning council may retain a health facilities planning point of view after being designated as a 314b areawide agency. May (1967) states the problem in this manner:

> "Hospitals and their associations tend to 'sub-optimize', i.e., reach decisions which, while perfectly sound from their own point of view, neglect the interests and needs of other components of the system and therefore are narrowly, rather than comprehensively oriented."

May (1967) also points out that while there appears to be a "non-system" for health care services there are local patterns of health care delivery:

> "What is sometimes overlooked is that the components of the system were already related to one another as the result of custom, reputation, etc., and only by recognizing existing relationships and either altering or building on them could any superordinate agency hope to accomplish its aims."

Thus, this author would argue in favor of priority setting being kept at the local level rather than having choices made by bureaucrats in Washington.

The author suspects that one of the reasons why the Federal Government has requested progress reports from CHP 314b agencies is not so much to assess their performance but to perhaps discover in what areas 314b agencies are having success and to cite these as examples for other agencies to possibly imitate.

As for the future, the 314b agencies must eventually implement their plans, either by themselves or through other agencies, to evaluate their performance. May (1967) says:

> "Only an agency which is concerned with effecting the programs it has developed need be concerned with whether or not it is doing a good job. The planner can always (subjectly) answer ... criticisms and neither the evaluators nor the planners can objectly demonstrate that the plan is good or bad, realistic or impractical."

CHP's and COG's - Merged?

Ardell (1970) argues for "merging" 314b CHP councils with public regional councils, such as COG's and RPC's as the "strongest basis for comprehensiveness." It is relevant at this time to review the two premises of his article and test their validity by them juxtaposing with the results of this investigation and with information from other sources.

In his article Ardell points out that by June, 1970, over 90% of the developing CHP 314b agencies had begun with either a hospital

planning council or a health and welfare planning council receiving the initial 314b grant. The reader will no doubt recall that in this investigation all three planning councils which were compared with each other began with the hospital planning council in the region becoming the 314b grantee organization. However, it was pointed out that soon afterward the organizational path followed in each area differed according to the political/economic climate. In Southeastern Michigan AHOC with heavy labor and disadvantaged group interest soon took over the management of the 314b grant when an executive director had been hired; the hospital planning council, GDAHC, remained operative as a separate entity. In the Sacramento region, the health and welfare council instigated the movement which culminated in writing the 314b organization grant but then did not contribute funds nor full-time staff resources to develop the CHP organization. Although the CHP 314b Council, GECHC, was housed in the same offices as the Sacramento Hospital Planning Council, the influx of "outsiders" on the CHP Council Board of Directors soon dissolved the HPC. In the Mid-Ohio region the Columbus Hospital Federation did become the Mid-Ohio Hospital Planning Federation but there were significant county membership changes, additions to the staff (eg. two community organizers whose function was to determine and present the needs of the disadvantaged to the Federation), and an expansion of the membership on the Board of Trustees. It becomes evident upon a deeper analysis of the circumstances represented by the statistics quoted by Ardell that what is true at one point in time will change depending upon the dynamics of the area. Thus, it is not true that the present CHP 314b councils are merely extensions of

the pre-existing hospital planning councils and the health and welfare planning councils which were the original 314b grantee organizations.

Ardell then makes the following statements:

> "Basically, both hospital and welfare planning councils are restricted purpose agencies without public mandate. Both are somewhat elitist in structure, lack procedures for due process and effective implementation of proposals, suffer from insecure funding bases, are dominated by special interests, and offer unexceptional track records of achievement.
> "The purpose in recognizing the above limitations is not to deny the contributions and successes of coordinating council planning but rather to emphasize that the private model is basically unsuited for leadership in areawide CHP."

This author has provided evidence above which demonstrates that the operation of CHP 314b Councils cannot necessarily be equated with that of their predecessors. The PL 89-794 legislation points out that comprehensive health planning is to be a "partnership involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations." Thus, in the philosophy and administration of the "Partnership for Health" Act, the base of community input to the planning process, theoretically, is to be enlarged beyond what it was with the hospital planning councils and the health and welfare planning councils. There is, however, a more important point which Ardell is attempting to make when he says that "the private model is basically unsuited for leadership in areawide CHP."

Ardell is suggesting two things: First, that a public entity ipso facto is better suited to perform CHP responsibilities due to its

structure: and second, that it would be possible, and not only that but better, if health planning were to be conducted in an "official" versus "private" arena.

In regard to Ardell's intuitive knowledge that the public regional council is an inherently superior structure to that of a comprehensive health planning council, Gregg (1970) summarizes the evidence collected by political scientists on the general issue of the relationship between political factors, including administrative structuce, and policy making as follows:

> "Recent research of the state and local public sector supports the remarkable conclusion that political structure does not have strong consequences for policy outcomes.
>
> "... many investigators in the field might agree with Hofferbert's carefully qualified conclusion that the most fruitful line of inquiry is into the social and economic structures of states and communities."

What then is the crucial factor which determines whether or not a particular health planning approach will be successful? Ardell comments that, "Until the laissez-faire, free-enterprise, fee for service, and crisis orientation groundrules are actually amended or discarded, the impact of planning institutions will remain modest." Are health planning activities stymied until some sort of health care revolution takes place?

Somers (1969) has a more positive suggestion concerning how health planning can be made effective:

> "By definition planning is not regulation or decision making. For planning to be effective, however, it must be closely related to some decision making process."

The question then is, "Where are the decisions made?" Marquis (1967) in his study of models for urban social systems made the following comment about the health care system:

> "Just as with education, the health and safety states and stages tend to be defined by the service organizations. Thus, the definitions of sickness and injury, as well as of recovery and disability, are established by medical and service personnel. Similarly, the policies for admission to various medical treatment stages, and the discharge from one stage to another, or back to the general population, are determined by doctors and by hospital and nursing home personnel. Just as with schools, these definitions of state can be used as controls, but controls that define the quality of system performance."

The conclusion is inescapable that a health planning agency to be successful must have the involvement and cooperation of hospital personnel and physicians. Although it is not often stated publicly, it is true that physicians are leading citizens in communities; they have wealth and status. They control not only health care institutions, but physicians own banks, real estate, invest in other businesses; and they are able to influence politicians. Ginzberg (1949) when speaking about creating changes within a hospital said:

> "The success of any system (of coordinated hospital service) depends in the first instance upon the cooperation of the local physicians, whose cooperation can be secured only if they are convinced that the plan will aid them professionally and that their economic position will not be jeopardized through loss of their more interesting and difficult cases."

At the present time it is not fashionable to defend the position of physicians within the "health care system;" it is important, however, to realize that the concentration of power which the physicians currently have in the area of health care in the

United States is largely based upon the fact that legally they assume responsibility for most of the health care given. Until the legal responsibilities of the physicians are shared by other health care professionals to a much greater extent than they are now, physicians will remain at the top of and in control of a health care hierarchy in this country.

This author has argued that a "private" health planning agency, i.e., one that has physicians and hospital administrators as active members, is more likely to be able to implement their plans for change than would a public regional council which has its membership limited to elected officials. In addition there is at the present time one other limitation of public regional councils which make them unsuitable as potential areawide planning agencies.

As was mentioned in the introduction to this paper, health care has not yet been declared a public good by the Congress; therefore, anyone attempting to regulate or modify the existing methods of health care delivery is walking on soft ground. Public regional councils were originally organized in metropolitan areas, such as the San Francisco Bay Area, Los Angeles, Detroit, Seattle, Atlanta, Philadelphia and Salem, for purpose of mutual assistance by fostering cooperative arrangements. Most of these organizations operate by a unanimity rule (as opposed to majority rule in the case of CHP 314b agencies) so as not to disaffect any local government's support of the association. Hanson (1966) states:

> "They [COG's] are frequently formed for defensive purposes to prevent more powerful or drastic regional governmental reorganization. But in most metropolitan areas a general metropolitan government is not a prominent possibility.

> The key challenge is for associations to adopt an evolutionary rather than static pattern of behavior. This is not always easy, especially where part-time marginal interest by elected officials is fused with unimaginative or timid staff leadership."

One would expect that these organizations would tend to avoid "sensitive" issues. Hansen (1968) wrote that, "The principal criticism of COG's relate to their alleged inability to act on questions embroiled in controversy along with their low level of public visibility."

This author has attended both 314b CHP agency board meetings and COG board sessions; in the former case there is often a freewheeling discussion of the issues on the agenda with occasional lapses in procedural protocol; while in the latter case the agenda moves very quickly with little discussion under the orchestration of the COG's executive director. Harris (1970) has made a similar observation about COG's:

> "The success of COG's as voluntary organizations depends to a large degree on the political leadership in the organization. COG's operate in the political world without the conventional weapons to do the job. Recognizing the fact that regional issues are often highly explosive, the political representatives in the COG are prone to move cautiously. Although the elected officials within the organization should provide the bulk of political leadership, in most cases the job falls on the shoulders of the executive director. Some executive directors seem to carry responsibilities covering the entire gamut of staff and political fundtions."

This author feels that the argument for merging CHP and COG agencies is not self-evident, and that the wisdom of such an approach remains to be demonstrated.

Unanswered Questions - Future Research

In the preceding paragraphs, the author argued that there exists substantial evidence which cautions against generally recommending that CHP 314b agencies be part of or merged with public regional councils (COG's). However, it is true that there are at least 13 public regional councils[1] which have been designated as 314b grantee agencies by the Federal Government. Many of these public regional councils, though, have subcontracted with private health groups to carry out the CHP responsibilities. In any event a study of the organization and operation of these 13 councils would provide possibly more conclusive evidence concerning the wisdom of basing CHP 314b operations within public regional councils.

Another area of potentially useful research would be the study of the benefits and costs incurred by the regional council in creating and maintaining county health planning council affiliates and a discussion of which type of relationships or under what specific conditions county councils positively contribute to the CHP effort rather than hinder it.

In conclusion, the author has observed during his collection of data on the CHP 314b agencies' local funding sources and on the active political forces at the time of each organization's devel-

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1/ HSMHA, U.S. Public Health Service data released in 1970.

opment that two apparent relationships appeared to be true:

1. The major funding sources which financed the CHP 314b agency's predecessor continued to be the main contributors after the 314b agency was formally organized;

2. The number of organized political forces who were interested in the developing CHP agency increased in direct proportion to the size (population) and organizational complexity of the region.

In GECHC's region with a population of 870,000 and two major sources of employment - government and aerospace, we find that health facility administrators and physicians were the most active persons in guiding the development of the organization while labor, government, business and disadvantaged groups were not involved in the beginning. In Mid-Ohio region with a population of 2 million, businessmen as well as health facility administrators and physicians were concerned with and were active in the organization of the CHP Federation. The Southeastern Michigan CHP Council had labor, business, government, and disadvantaged groups as well as health care providers making input to the formation of the Council.

Perhaps a future researcher in this area could conceptualize and operationalize these observations into an experimental framework and test the existence of these relationships and theorize their significance.

Health planning at the present time is as much an art as a science. George Bugbee, Professor and Director of the Center for Health Administration Studies at the University of Chicago was quoted by Joel May (1967) as saying the following about planning:

"... it is important to remember that we have little proven experience and that planning must be approached with some humility. Success in planning is not inevitable but will require wisdom and understanding for progress."

Summary

The author drew the following conclusions from this study:

1. The particular combination of groups and organizations represented on the regional CHP council boards of directors studied resulted from the initiative by each of the organized health care interest groups to join under the framework for board membership devised by the staff. Therefore, by discovering who the board members were, it was possible to obtain a general idea about what organizational philosophy was subscribed to by the staff (i.e., who was included; who was excluded, and why?). Also, the sets of actors who would both be drafting planning policies and possibly raising obstacles for the planning process were identified according to their organizational affiliation.
2. At this early stage in the development of these CHP councils, there was some evidence to suggest that the sources of agency funds, and the conditions attached to these contributions, circumscribed the agency's planning agenda. The Federal Government was a notable exception to this observation, up to the present time, even though 50% of a typical CHP regional council's funds come through HEW. At the time of this study, the politics at the board of directors level affected the structural components of the agency (eg. the acceptable consumer/provider representation ratio); whereas the economic power held by state and local funding sources impacted upon procedural items (eg. what the council would plan for and how).

No doubt the reader has observed that not all of the data collected in this study was useable. The weaknesses in the methodology were somewhat confounded with the lack of measurable output from the agencies. Thus, it was not possible to judge the significance of the backgrounds and qualifications of the staff members because there are no guidelines as to what types of persons a CHP regional staff should be composed of. Nor was there any way of judging the adequacy or bias of planning decisions since few decisions had been made.

In like manner it was not possible to evaluate how well the CHP organizations worked with other agencies in the areas of mental health, mental retardation, environmental quality, etc. because the agreements made on paper may or may not have reflected the degree of cooperation which was actually present. Since there were few examples of joint planning ventures or inter-agency conflicts, this data did not surface beyond the staffs' written statements of intent.

Also, because the sample size was limited to two agencies it was not possible to draw out examples of planning successes or failures based on each agency's planning methodology. Both agencies (and GECHC in Sacramento) relied heavily upon standing committees to process data and make planning decisions. A large number of agencies would have to be sampled in order to determine what planning methodologies positively (or negatively) correlate with their outputs as measured against the criteria of efficiency, equity, significance, permanence, etc.

Finally, the impact of state enabling legislation for comprehensive health planning could not be assessed since none existed in Michigan and Ohio. It was pointed out that such legislation does, however, exist in California, and that it has had a significant impact upon agency funding and, in turn, upon the planning priorities of the regional CHP agencies in that state.

Several hypotheses for future testing emerged from this study; they are as follows:

- When substantial state government funding contributions are made to regional CHP councils, the planning priorities of these councils will shift away from regional concerns and toward the state's planning agenda. The relative amount of displacement toward the state's agenda will depend upon the conditions attached to the receipt of the monies by the regional CHP council.

- The number of organized political forces (interest groups) who are active in developing a regional CHP agency will be in direct proportion to the size (population) and organizational complexity (degree of economic and social pluralism) of the region.

- The ability of the CHP agency to unite the region in planning for solutions to common health care problems will be negatively affected by the regional staff officially subsuming into the organization pre-existing local planning bodies (unless these groups were created in the past by the same regional staff for some other areawide planning purpose).

• The creation of new local planning groups affiliated with the regional council will also have a negative effect on the areawide planning process unless the tendency toward provincialism is anticipated and counteracted (eg. via regional staff contact at the local level, regular communications, and the assignment of specific roles and tasks).

• The placement of regional CHP responsibilities within public regional planning groups such as councils of government and regional planning commissions, will not prove to be effective because there will be a replacement of the prime decision makers in the health care service industry (i.e., physicians and hospital administrators) by government officials.

• To be effective to any significant degree, decisions made by CHP boards will have to be linked with the authority to implement the changes they have advocated.

Several dilemmas faced by the executive director of a regional CHP agency have also been highlighted in this study. They are as follows:

1. Since physicians and hospital administrators are the key decision makers in the area of health care services, they must be included as members of the board of directors; how can this be done without these professionals taking control of the board due to their expertise?

2. Should staff time be devoted to training consumer board mem-

bers; if so, how should they be taught to participate in agency affairs?

3. Is it better for the agency to be horizontally comprehensive (to plan for all health services and needs) or to be vertically comprehensive (i.e., to specialize the agency's planning efforts)? For example, what should be the relationship between the regional CHP council and pre-existing health facility planning councils? Would consolidation of both agencies be preferable to a contractual arrangement?

4. Are county (local) health planning councils a blessing or a curse; i.e., should the planning effort be directed and controlled at the areawide level or should sufficient staff resources be committed to develop functional county councils? What are the potential benefits and costs to the regional agency of both of these approaches?

5. What types of funding arrangements will maximize the probability of the continued existence of the agency in the future while minimizing the political impact upon the agency's planning agenda?

6. How should government be represented on the board of directors to avoid both extremes of "tokenism" and total governmental control? Also, can a CHP council be given the authority to implement their planning decisions without becoming a governmental regulatory agency?

7. What are the agency's responsibilities in the areas of environmental health, mental health, mental retardation; and how should the CHP council relate to existing agencies in these areas?

In conclusion it can be seen from the list of dilemmas presented that there are no obvious answers nor researchable questions to many of these issues. Health planning is still very much in the process of evolving as is planning in general in the United States. After 50 years of practice, city planning, for example, is just now being taken seriously by the public.

Within the last 15 years, health planning has moved away from a strictly private voluntary model, i.e., the health and welfare councils, through a semi-public model, namely, the hospital planning councils, and now to the partnership for health, the public-private-government model of comprehensive health planning under P.L. 89-749. However, since the health care system is still essentially private, despite massive government controls, the potential impact of comprehensive health planning has not been actualized to date due primarily to the absence of incentives, including coercion, for the private health sector to cooperate with CHP agencies.

With the eventual passage of national health care insurance, the mandate given to those involved in comprehensive health planning, to assure health care services to every citizen as their right, will become national policy. Unless planners and health care consumers can successfully influence politicians to pass legis-

lation to permit and encourage experimentation with forms of health care delivery which may eventually serve the nation's health care needs, national health insurance will only increase the demand for a limited supply of physicians and inflate health care costs.

CHP councils will need to determine how these services will be delivered once they are promised. To do this the CHP decision making process requires the authority and means to implement their plans now and in the future. Therefore, logically the next evolutionary stage in health planning is fast approaching. Thought should be given by planners as to the most desirable political and organizational forms which this next progression could take toward the goal of rationalizing the private health care system, either by inducement or compulsion, to assure the implementation of national health care policy at the local level.

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APPENDIX A - Areawide Health Operating Committee
Members and Alternates

(Source: 1970 CHPC-SEM Grant Application)

GRANT APPLICATION

APPENDIX "A"

AHOC MEMBERS & ALTERNATES

Chairman.....Myron E. Wegman, M.D.

Members	Alternates
Richard H. Austin (Consumer - Wayne County) Vice Chairman Wayne County Board of Auditors 1236 City-County Building Detroit, Michigan 48226 Business - 224-5064 Home - 834-9566	Lawrence Carter (Consumer - Wayne County) Customer Representative Lawyers Title Company 935 Griswold Detroit, Michigan 48226 Business - 963-5810 Home - 925-5094
Clayton L. Berdan (Consumer - St. Clair County) Community Relations Manager Michigan Bell Telephone Company 627 Fort Street Port Huron, Michigan 48060 Business - 1 - 987-2521 Home - 982-6636	William J. Dinnen Jr., M.D. (Provider - St. Clair County) President St. Clair County Medical Society 2425 Military Port Huron, Michigan 48060 Business - 1 - 985-8144 Home - 984-1863
Bernard D. Berman, M.D., Director (Provider - Oakland County) Oakland County Department of Health 1200 North Telegraph Road Pontiac, Michigan 48053 Business - 1 - 332-9255 Home - 549-4753	Leland C. Brown, M.D. (Provider - Macomb County) Macomb County Health Department 43525 Elizabeth Road Mt. Clemens, Michigan 48043 Business - 1 - 465-2161 Home - 293-3625
John H. Burton (Consumer - Washtenaw County) International Representative Region 1-E, UAW 9650 South Telegraph Road Taylor, Michigan 48180 Business - 291-2750 Ext. 54 Home - 482-4060	Paul Morris (Consumer - Oakland County) Community Relations Representative Region 1-E, UAW 9650 South Telegraph Road Taylor, Michigan 48180 Business - 291-2750 Ext. 54 Home - 231-9072
Ralph R. Cooper, M.D. (Provider - Wayne County) 1515 David Whitney Building Detroit, Michigan 48226 Business - 962-6361 Home - 882-8026	Sidney Adler, M.D. (Provider - Wayne County 755 Fisher Building Detroit, Michigan 48202 Business - 875-8417 Home - 444-1224

-continued-

Members	Alternates
Noah Folks (Consumer - Wayne County) 2799 Martinsville Road New Boston, Michigan 48164 Business - 1 - 697-0900 Home - 654-6014	Fred Hunter (Consumer - Wayne County) 35460 Border Road Wayne, Michigan 48184 Home - 722-4962
William H. Frank (Consumer - Oakland County) 12944 Talbot Lane Huntington Woods, Michigan 48070 Business - 547-7955 Home - 547-7955	Norman D. Katz, Partner (Consumer - Wayne County) Katz & Victor, Attorneys 3408 Guardian Building Business - 963-2306 Home - 545-4857
Ernest D. Gardner, M.D. (Consumer-Wayne County) Former Dean, School of Medicine Wayne State University 1400 Chrysler Freeway Detroit, Michigan 48207 Business - 577-1048 Home - 543-2791	
Oscar A. Lundine (Consumer - Wayne County) Executive Vice President - Finance General Motors Corporation General Motors Building Detroit, Michigan 48202 Business - 556-3581 Home - 646-0251	Robert M. Cone, Director (Consumer - Wayne County) Insurance & Pension Section General Motors Corporation 715 General Motors Building Detroit, Michigan 48202 Business - 556-4146 Home - 651-2695
John A. Gronvall, M.D. (Provider - Washtenaw County) Acting Dean Medical School University of Michigan 1335 Catherine Street Ann Arbor, Michigan 48104 Business - 1 - 763-1468 Home - 761-0340	
Mrs. Walter Jones Jr. (Consumer - Oakland County) 21397 Remanville Avenue Royal Oak Township Ferndale, Michigan 48220 Home - 546-4250	Miss Mattie R. Carter (Consumer - Oakland County) 20792 Garden Lane Ferndale, Michigan 48220 Home - 544-7825

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Members	Alternates
Edward G. McPherson (Consumer - Livingston County) Senior Vice President McPherson State Bank 207 North Michigan Avenue Howell, Michigan 48843 Business - 1 - (517) 546-3410 Home - (517) 546-4272	Irwin Glover (Consumer - Livingston County) 730 Devonshire Fowlerville, Michigan 48836 Business - (517) 223-9139 Home - (517) 223-9168
Jerry J. May, President (Consumer - Monroe County) Harry May Chevrolet-Cadillac Inc. 15180 South Monroe Street Monroe, Michigan 48161 Business - 1 - 242-4200 Home - 242-2592	Richard S. Hiltz, Administrator (Provider - Monroe County) Memorial Hospital 700 Stewart Road Monroe, Michigan 48161 Business - 1 - 241-6500
Allen W. Merrell, Vice President (Consumer - Wayne County) Civic and Governmental Affairs Ford Motor Company The American Road Dearborn, Michigan 48121 Business - 322-2678 Home - 885-9166	Ray C. Kooi (Consumer - Wayne County) Executive Director Ford Motor Company Fund Ford Motor Company The American Road Dearborn, Michigan 48121 Business - 322-8711
Kenneth Morris, Director (Consumer - Oakland County) International Union UAW - Region 1-B 8000 East Jefferson Avenue Detroit, Michigan 48214 Business - 926-5341	Paul Massaron (Consumer - Wayne County) International Union - UAW 8000 East Jefferson Avenue Detroit, Michigan 48214 Business - 926-5439 Home - 837-7104
Howard J. Pridmore (Consumer - Wayne County) Assistant Secretary Chrysler Corporation P.O. Box 1919 Detroit, Michigan 48231 Business - 956-2845	

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Members	Alternates
Januarius A. Mullen (Consumer-Wayne County) Chairman of the Board Sheller Globe Corporation 1641 Porter Street Detroit, Michigan 48216 Business - 962-7311 Home - 885-2070	H. Clay Howell (Consumer-Oakland County) Associate Director United Foundation 1528 Woodward Avenue Detroit, Michigan 48226 Business - WO 5-7100
H. Dale Palmer (Consumer-Macomb County) 8488 West St. Clair Avenue Romeo, Michigan 48065 Home - 1 - 752-2844	
Glen H. Peters (Consumer-Macomb County) 39880 Sylvia Avenue Mt. Clemens, Michigan 48043 Business - 872-6100 Ext. 4321 Home - 463-2295 4881	Patrick J. Johnson, Vice Chairman (Consumer-HEW Committee Macomb County) Macomb County Board of Commissioners 21506 Tanglewood St. Clair Shores, Michigan 48080 Business - 293-0343
Alex S. Pollock (Consumer - Wayne County) Pollock & Richard 18600 Schoolcraft Avenue Detroit, Michigan 48233 Business - 838-2420 Home - 835-0763	James M. McHugh, M.D. (Provider-Oakland 702 Northland Medical Bldg. County) Southfield, Michigan 48075 Business - 357-0410 Home - 642-4850
Mel Ravitz, Councilman (Consumer-Wayne County) City of Detroit 1340 City-County Building Detroit, Michigan 48226 Business - 965-4200 Ext. 586 Home - 835-0594	Marvin D. Meltzer, Director (Provider-Wayne Regional Medical Programs County) Wayne State University 1575 East Lafayette - Suite 103 Detroit, Michigan 48207 Business - 577-1580 Home - 224-7682
Mrs. Edward E. Stark (Mildred B)(Consumer- 16176 Chesterfield Macomb County) East Detroit, Michigan 48021 Business - 1 - 465-1211 Home - 777-0127	Oscar Stryker, M.D. (Provider-Macomb County) 38422 Hidden Lane Mt. Clemens, Michigan 48043 Home - 463-5112

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Members	Alternates
Paul W. Trimmer, D.O. (Provider-Oakland County) 1109 Pontiac State Bank Building Pontiac, Michigan 48058 Business - 1 - 335-9411 Home - 646-7124	Robert Ward, D.O. (Provider-Macomb County 22211 Schafer Mt. Clemens, Michigan 48043 Business - 1 - 791-4430
Thomas Turner, President (Consumer-Wayne County) Metropolitan Detroit AFL-CIO 2310 Cass Avenue Detroit, Michigan 48201 Business - 963-4233 Home - 862-3015	Norman G. Mackay, Editor (Consumer - Detroit Labor News Wayne County) Metropolitan Detroit AFL-CIO 2310 Cass Avenue Detroit, Michigan 48201 Business - 963-4233
Mrs. Jean Washington (Consumer-Wayne County) 3511 Oakman Blvd. Detroit, Michigan 48204 Business - 895-8033 Home - 931-4361	
Myron E. Wegman, M.D., Dean (Provider - Washtenaw County) School of Public Health University of Michigan Ann Arbor, Michigan 48104 Business - 1 - 764-5423 Home - 971-7560	Robert N. Grosse, Ph. D. (Provider - Washtenaw County) Professor of Health Planning School of Public Health University of Michigan Ann Arbor, Michigan 48104 Business - 1 - 764-9476 Home - 971-3079
Mrs. John P. Yori (Consumer-Wayne County) 29649 Chester Avenue Garden City, Michigan 48135 Home - 422-8848	Thomas R. Pollard (Consumer-Wayne County) 29024 Hennepin Garden City, Michigan 48135 Business - 482-7800 Ext. 585 Home - 422-2693

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APPENDIX B - A Brief history of AHOC and CHPC, Southeastern Michigan Region

(Source: "Comprehensive Health Planning in Southeastern Michigan, A Tenuous Partnership" (unpublished), James P. Ardnt, Program in Health Planning, School of Public Health, University of Michigan, December 11, 1972)

A Brief History of AHOC and CHPC, Southeastern Michigan Region

The formation of a comprehensive health planning organization for southeastern Michigan was an arduous task, despite initial agreement by all concerned parties that such an organization was needed. In response to the 1966 Act (PL 89-749), three existing organizations in the Detroit area began negotiations to determine which would serve as the area-wide planning authority. The Greater Detroit Area Hospital Council (GDAHC) eventually excluded itself from consideration by merging with the United Health Organization, a private association of health providers. The other organization was the Southeast Michigan Council of Governments, a public governmental organization.. SEMCOG and UHO squabbled over the issue for a while, until they were warned by the newly-formed state agency (314-A) to cooperate or lose the State Health Department's authorization, necessary for federal funding. This threat forced the opponents to negotiate. They decided to choose one hundred committee members on whom they could agree to begin the organization. Since

nowhere near 100 people were satisfactory to both parties, the Areawide Health Operating Committee (AHOC) was established in January 1969 with 27 members.

The stated objectives of AHOC were put forward at one of its initial meetings:

> To create a forum in which all interested organizations and individuals within the seven-county area of southeastern Michigan can participate in a meaningful dialogue directed toward defining goals, responsibilities, and methods for comprehensive health planning in our area.
>
> To develop a structure within which the means for providing proportionate representation in a comprehensive health planning organization are defined. 7/

As we shall see, the AHOC became embroildd in the latter task to such an extent that progress toward the former goal was seriously threatened. Many organizational difficulties were encountered. First, the chosen few were evidently poorly chosen, for the interest groups often claimed that they had never heard of their so-called "representatives," and demanded freedom to replace them. Then another hassle was touched off over the acceptability of alternates to replace absent members. More time was wasted worrying about the brevity of the first Federal grant. The government provided only a one-year organizational grant because an agency (GDAHC) already existed which could accomplish preliminary objectives and establish a basis for the new comprehensive health planning organization. Another source of difficulty was the committee structure. Were the committees to reflect various health provider interests or were they to concentrate on health problems and issues?

Another committee-related problem was that of financing; fifty

percent of the cost of instituting comprehensive health planning had to be borne locally to match the Federal grant. Of this amount, 50 percent was to be raised by the private voluntary sector (solicited by the United Fund and the United Hospital Organization), 25 percent by provider groups (solicited by AHOC), and 25 percent by local government (solicited by SEMCOG). A finance committee was established to coordinate the fund-raising effort. Thus an organizationally problem-oriented committee structure began informally, although the work program subsequently established a formal orientation toward substantive health problems; the need for such a structure became apparant after the AHOC staff, mainly transplanted from GDAHC, submitted the first work program draft.

AHOC was stymied at first by co-chairmen who represented conflicting interest groups: Mel Ravitz of SEMCOG and Januarius Mullen of UHO. Eventually Dr. Robert N. Grosse of the University of Michigan School of Public Health succeeded in convincing both the AHOC staff and the Department of Health, Education, and Welfare that the abolition of the co-chairmanship was a necessary condition of funding eligibility. Subsequently, Dr. Myron Wegman, Dean of the University of Michigan School of Public Health, was elected chairman because he held no brief for any special interest group. In the same way, the initial issue of private versus public health care providers was effectively neutralized by the insistence that both groups work together or forfeit their funding.

A new issue soon emerged, however. The granting organization required that health consumers constitute a majority of the membership of the comprehensive health planning agency. Consumer participation was

legitimized by the Federal guidelines, and consumers formed a Health Caucus to protect their interests against those of the corporate providers. AHOC became a forum for violent arguments between the two interest groups. The Health Caucus demanded a 100 percent consumer organization, with a provider advisory council. Dr. Wegman and other neutral parties managed to convince the militant consumers to "coopt" the providers, presenting a united front to the external world, rather than leaving providers out of the ranks as an antagonistic separate force. The consumers consented to a 60/40 consumer-provider division, in return for which they were guaranteed that at least some providers would be sympathetic to consumer interests. In April 1970, AHOC adopted a consumer/provider ratio of 60/40. Private and public health providers now suddenly awoke to their common interests and began to demand 49 percent representation on the health planning council, which they felt was implied by the law requiring a consumer majority. The issue of health provider representation has been the central one in Southeast Michigan's comprehensive health planning program ever since.

In May, public hearings were held at several locations in the seven-county area; sixty-percent consumer representation was substantiated at these hearings. The initial membership committee then wrote to various interest groups to request slates of nominees for membership on the Comprehensive Health Planning Council (CHPC), projected at 215 members. Many provider groups were delinquent in submitting their nominations and were reminded that with the dissolution of AHOC and the formation of CHPC in August, no AHOC commitments on questions of repre-

sentation need be honored. Dr. Wegman wrote to the dissenting providers encouraging them to ccoperate and attend the CHPC meeting at least as observers. Subsequently, and ad hoc committee of providers and AHOC executives established the principle that all organized groups having representation on CHPC be allowed to designate their representatives by name, and voted narrowly to support the 60/40 agreement. Provider societies supplied names for the designated posts on the Council. At the first council meeting, August 11, a nominating and membership committee was chosen to designate a Board of Trustees. "No provision had been made in the planning for the various official groups, consumer or provider, to designate which of their members of the Council should serve on the Board of Trustees, but there was a tacit agreement that the Nominating Committee would give consideration to these wishes." 8/

At CHPC's second general meeting, September 1, Dr. James Fryfogle, representing the provider groups, pointed out that the individuals chosen for the Board of Trustees were competent, but had not been chosen by the medical societies themselves and could not, therefore, appropriately represent their interests. He moved to substitute a slate of names which he insisted had been previously supplied to the staff (who insisted they had never received it). "Dr. Fryfogle made a very strong plea for accepting his nominations, making quite clear that the provider societies considered this a test of whether CHPC really wished to take their opinions into account. In the subsequent voting the slate proposed by the Nominating Committee was elected by a wide margin." 9/

The provider groups felt that they had been betrayed, and returned to their original 51/49 demand. Many medical, dental, podiatric and dental associations withdrew from CHPC in late September, citing lack of ap-

propriate representation, lack of due process, and violation of HEW guidelines. A typical complaint was:

> It has become increasongly apparent that the Comprehensive Health Planning Council neither meets the letter nor the spirit of the law, since CHPC has invariably disregarded the role of practicing physicians in the comprehensive health planning framework, thus defeating the concept of a "partnership for health." We are convinced that the non-producers of health services on CHPC aspire to control the distribution of services rather than to achieve the objective of assuring comprehensive health servides of high quality for every person...Our continued participation without adequate representation would publicly bind practicing physicians, who are the providers of health services, to decisions of CHPC which could well interfere with existing patterns of private practice of medicine. This is not the intent of PL 89-749, and it is not in the best interests of public health. 10/

CHPC offered the providers six new positions on the Board of Trustees, raising their proportion to 43%. This and other proposals were summarily rejected. On November 5, members of the Department of Health, Education and Welfare staff, Region Five, paid a site visit to Southeast Michigan, during which the HEW personnel expressed their concern about provider dissatisfaction. On November 20, a letter was sent to William McNary, Executive Director of AHOC, from Dr. Howard Siple of HEW Region Five, stating that CHPC's grant application had been reviewed and evaluated by the regional advisory committee: "I regret to inform you that the Committee strongly recommended that action on the application be ddferred because of the community disord which exists...Accordingly, our office will take no further action on the application until assurances have been made that community differences have been resolved and citizen and provider groups truly accept the agency." McNary notified the membership and trustees of the deferment of funding, pointing out that other programs in the region offered little in the way of guidelines, having consumer percentages ranging from 51 to 63 percent, and that some matters referred

to in Siple's letter were correctable by staff work, but community discord had to be resolved by all concerned parties.

At the December Board of Trustees meeting, Dr. Wegman indicated that meetings with representatives of the dissenting providers were continuing, but that resolution would be difficult. Dr. Grosse pointed out the importance to providers of power balance and effective control, as opposed to mere technical representation ratios. Subsequently, according to a January 11 memorandum from the trustees to the membership, the bylaws were changed to enlarge the Board of Trustees from 35 to 40, including four new providers and one consumer. 11/ At the general meeting on January 20, the members passed a motion increasing the Board's size to 41, including four new providers, one consumer, and a member of the Michigan Area Regional Medical Programs, to be considered neutral. This created a 55/45 ratio, which was felt to be acceptable to providers. Chairman Wegman expressed satisfaction at the improvement in organizational matters because pressing new programmatic issues were confronting CPHC.

On January 29, William McNary and the Council staff submitted a Grant Supplement, including a work program and staffing pattern, to Howard Siple of Region Five. The letter referred to the resolution of community differences and the anticipated receipt of provider group and county endorsements. Only a few minor providers remained intractable, the Michigan Nursing Home Association and the Michigan State Podiatry Association. In late February, 1971, the Region Five office of the Department of Health, Education, and Welfare approved the grant application of the Comprehensive Health Planning Council of the Southeastern Michigan region.

APPENDIX C - History of Planning in Southeastern Michigan

(Source: 1970 CHPC-SEM Grant Application)

IV. The CHPC of Southeastern Michigan, History and Development

A. History of Health Planning in Southeastern Michigan

Areawide health planning in southeastern Michigan began in 1956 when the Detroit Hospital Council (a trade association for hospitals) reorganized to include coordinated hospital planning. This reorganization came at the request of community and hospital leaders, after the 1955 Metropolitan Detroit Building Fund drive was able to satisfy little more that ten percent of the voluntary hospitals' capital requests.

Initially the Hospital Council oriented its efforts around the expansion and construction of acute care facilities. Gradually, however, the Hospital Council expanded its role. In addition to acute care facilities, the Council has reviewed plans for long term care units. The Council expanded its "bricks and mortar" approach to planning to emphasize program planning. It began encouraging hospital mergers and joint hospital planning committees. It began emphasizing institutional planning for disadvantaged services, ambulatory care services, extended care services. It became involved with manpower planning, and with the planning of services for alcoholism and drug abuse. In short, the Hospital Council became a planning agency for personal health services that are institutionally based.

The passage of P. L. 89-749 marked a turning point for areawide health planning in southeastern Michigan. Three organizations potentially qualified for 314(b) designation - GDAHC, SEMCOG, and UHO (United Health Organization). The Hospital Council decided not to seek the designation for several reasons. First, the role of personal health services planning was a substantial task itself. Secondly, the Hospital Council was fearful of diluting its facility-programming responsibilities and feared dilution of community support. Additionally, it was felt that a completely new type of staff would be required to carry out the function of a comprehensive areawide health planning agency. Finally, it was felt that a better and more objective comprehensive health planning agency could be developed by the creation of a new agency as opposed to a transformation of an old organization. With GDAHC no longer a potential 314(b) agency, there remained SEMCOG (a governmental unit) and UHO (a private unit) as logical candidates for 314(b) designation.

The first really productive efforts at achieving cooperation for comprehensive health planning between governmental and nongovernmental organizations concerned with health in southeastern Michigan began in April 1968. At that time state and local leaders concerned about health, met at McGregor Center on the campus of Wayne State University in Detroit to discuss the development of comprehensive health planning in southeastern Michigan. As a result of that meeting two organizations, the Southeast Michigan Council of Governments and the United Health Organization, representing large segments of the public and private health sectors respectively, began cooperative efforts toward forming an organization which would meet the requirements of Section 314(b) of P. L. 89-749.

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Section IV

During the summer and early fall of 1968, these two organizations worked hard on forming an "Areawide Health Operating Committee" that would have the task of developing a permanent Comprehensive Health Planning organization for southeastern Michigan. Originally it was intended to have 105 members represented on the committee with an Executive Committee of 20-30. In late November, 1968, however, the State Comprehensive Health Planning Commission indicated that the southeast Michigan region should submit an organizational application by the third week in January, 1969. Given this time limitation it became impossible to form a committee of 105 members.

As a result a 27 member Areawide Health Operating Committee (AHOC) was evolved on the basis of (1) geography, (2) population, (3) professional representation, and (4) consumer representation. In forming this 27 member group the goal was to have 27 people who could work together on an interim basis to develop an operating organization that would meet the legal requirements of P. L. 89-749 and could do comprehensive health planning for southeastern Michigan. The Areawide Health Operating Committee was comprised of people who over a number of years have shown their objectives interests in health and welfare in southeastern Michigan community. The goal of the Areawide Health Operating Committee was to emerge with a recommendation for a comprehensive health planning mechanism that is acceptable to the various groups concerned about health in the southeastern Michigan community. These would include government agencies, consumer organizations, labor groups, racial and ethnic groups, medical societies, osteopathic associations, dental associations, hospital associations and private health agencies. (See appendix for list of AHOC members and their affiliations).

The Greater Detroit Area Hospital Council (the regional hospital and health facilities planning organization) was asked to apply for an organizational grant under Section 314(b) of P. L. 89-749. This was done in order to make use of the Hospital Council's planning resources and because the Hospital Council is a legally established non-profit organization eligible to apply. AHOC acts as the policy-making body in all matters pertaining to the development of comprehensive health planning in southeastern Michigan. A one year organizational grant from the United States Department of Health, Education, and Welfare was given in July 1969 to the Greater Detroit Area Hospital Council effective June 1, 1969.

The purpose of the developmental project was essentially twofold: the development of an effective mechanism for comprehensive areawide health planning in southeastern Michigan; and, the continuation of health services and facility planning activities.

Concerning the efforts toward the development of a comprehensive areawide health planning agency, AHOC activities included the following:

1. Establishing appropriate rapport and dialogue with the consumers and providers of health services, and the public and private health and health related organizations to assure meaningful input and participation

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Section IV

in the organizational phases;

(2) Organizing an areawide structure and program for ongoing comprehensive health planning, which included obtaining community consensus on the proposed structure and program for areawide comprehensive health planning;

(3) Stimulating development of subarea organizations for comprehensive health planning that are directly related to the regional comprehensive health planning organization;

(4) Phasing the organizational efforts into a viable regional comprehensive health planning mechanism that allows for appropriate subarea health planning mechanisms.

To accomplish these tasks, AHOC established several subcommittees. The Subcommittee on Relationships was formed to develop appropriate relationships between all those interested in and directly concerned with community health and to develop appropriate mechansims for their participation in areawide health planning. Over 700 organizations were contacted for comments and suggestions regarding role and composition of a CHP agency. The Subcommittee on Organization was formed to develop bylaws, articles of incorporation and an organizational structure for areawide comprehensive health planning. The Ad Hoc Committee on Key Issues was formed to develop guidelines for establishing the composition for an organization that would be both politically viable and operationally feasible. CHPC represents the culmination of the successful efforts of AHOC. (See appendix for specific list of accomplishments).

Concerning the facility planning function of the developmental project, the major activities of the Hospital Council were as follows:

1. Continuation of areawide program planning in relation to general acute care and long term care services and facilities.

2. Continuation of activities desgined to meet the health needs of disadvantaged groups (e.g. current negotiations between the Detroit Maternal and Infant Care Project and nine voluntary hospitals in the City of Detroit toward the development of an operating program to provide proper pre- and postnatal care for pregnant women, mothers, and their infants).

3. Continuation of activities in the area of ambulatory and emergency services planning. (e.g. a current study involving five hospitals in one section of the city to determine the extent of their increasing emergency department case load problems. The goal is to establish a cooperative method of meeting the emergency department visits in facilities that are capable of rendering quality services, with adequate staff, on a 24 hour

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APPENDIX D - CHP Council of Southeastern Michigan,
Articles of Incorporation and By-Laws

(Source: CHPC-SEM Document, October, 1972)

Articles

OF

Incorporation

AND

By-Laws

OF THE

COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN

REVISED OCTOBER 18, 1972

1300 BOOK BUILDING
DETROIT, MICHIGAN 48226
Telephone (313) 964-6950

(Non-Profit)
ARTICLES OF INCORPORATION
OF
THE COMPREHENSIVE HEALTH PLANNING
COUNCIL OF SOUTHEASTERN MICHIGAN

STATE TREASURER

These Articles of Incorporation are signed and acknowledged by the incorporators for the purpose of forming a non-profit corporation under the provisions of Act No. 327 of the Public Acts of 1931, as amended, as follows:

ARTICLE I

(a)

NAME

The name of the corporation is The Comprehensive Health Planning Council of Southeastern Michigan.

(b)

GEOGRAPHIC AREA

The geographic area in which the corporation shall operate shall be the area of the seven Michigan counties of Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne.

ARTICLE II

The purposes for which the corporation is formed are:

1. To serve the public in the southeastern Michigan area in the identification of health needs and health resources, the determination of health goals and priorities, in planning and stimulating the improvement of health services and programs in the area, and in encouraging whatever actions may be necessary to improve the health status of residents in the area.

PURPOSE

2. To provide professional guidance in the coordination and development of health services and programs of all kinds, including but not limited to services and programs relating to hospital care, physicians' care, dental care, nursing and long-term care, health manpower, preventive health, occupational health, rehabilitation, mental health, communicable diseases, alcoholism, drugs and drug addiction, nutrition and malnutrition, air and water pollution and other aspects of environmental health, and health needs of low-income groups.

3. To develop and conduct a comprehensive areawide health planning program in the area of southeastern Michigan, with the objective of coordinating existing and planned health services, including the facilities and persons required for provision of such services.

4. To engage and participate in projects for training, studies or demonstrations looking toward the development of improved and more effective comprehensive health planning throughout the Nation.

5. To engage and participate in the development and support, for initial or trial periods, of new programs of health services, including training relating to the furnishing of such services.

6. To engage in educational, scientific and statistical research, projects and studies, and to inform and instruct the general public, in the fields of health.

7. To engage and participate in activities, consistent with the purposes elsewhere expressed in this Article II, which qualify the corporation to receive or share in grants, loans, subsidies, donations, services or other aid

   (a) under the Federal Public Health Service Act, 40 USC §201 et seq., as amended, including but not limited to activities under Public Law 89-749, the "Comprehensive Health Planning and Public Health Service Amendments of 1966," and under Public Law 90-174, the "Partnership for Health Amendments of 1967," and

(b) under any other health planning programs or projects (i) sponsored or aided by Federal, state or local governmental bodies or agencies, or (ii) sponsored by non-governmental institutions, agencies, or individuals.

8. To request, apply for, solicit, and receive grants, loans, subsidies, donations, services or other aid from governmental and non-governmental sources for the purposes and activities of the corporation.

9. To cooperate with the State of Michigan in its program of statewide health planning, to the end that regional health planning in the southeastern Michigan area shall be carried on in consonance with the statewide planning activities of the State; to cooperate also with the various agencies of the Federal Government in health planning programs of national scope.

10. To cooperate with and guide the activities of agencies within the southeastern Michigan area which may engage in health and health-related planning of a more specialized nature, and to cooperate with and guide the activities of other general health and health-related planning agencies including those which may hereafter be organized on a more localized basis within the area.

11. To cooperate with regional comprehensive health planning agencies which shall operate in areas adjacent to the counties of Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne.

12. To contract with other qualified organizations for performance of portions of the planning and related activities of this corporation, when it may be in the public interest that such portions of the work of this corporation be carried on by such organizations.

13. The corporation is organized and shall be operated exclusively for purposes stated in §501(c) (3) of the Federal Internal Revenue Code of 1954, as heretofore or hereafter amended. In the event of dissolution, all assets real and personal shall be distributed to such organizations as are qualified as tax exempt under §501(c) (3) of the Internal Revnue Code or the corresponding provisions of a future United States Internal Revenue Law.

In general, to carry on any activities in connection with and incidental to the foregoing purposes not forbidden by the laws of the State of Michigan, and with all the powers conferred on non-profit corporations by the laws of the State of Michigan.

ARTICLE III

LOCATION OF FIRST OFFICE

The location of the first registered office was:
921 Penobscot Building
Detroit, Michigan 48226

The post office address of the first registered office was:
921 Penobscot Building
Detroit, Michigan 48226

ARTICLE IV

FIRST RESIDENT AGENT

The name of the first resident agent was: William McNary.

ARTICLE V

Said corporation is organized upon a non-stock basis.

The amount of assets which said corporation possesses at the date hereof is:

ASSETS

Real property: none
Personal property: $29,201.65 (October 3, 1972)

Said corporation is to be financed by funds received from government agencies and from private philanthropic sources.

ARTICLE VI

INCORPORATORS

The names and places of residence, or business addresses, of each of the incorporators are as follows:

Names	Residence or Business Addresses
Jerry J. May	15180 South Monroe Street Monroe, Michigan 48161
Januarius A. Mullen	1641 Porter Street Detroit, Michigan 48216
Mel Ravitz	City-County Building Detroit, Michigan 48226
Myron E. Wegman, M.D.	University of Michigan Ann Arbor, Michigan 48104
Mrs. John P. Yori	29649 Chester Avenue Garden City, Michigan 48135

ARTICLE VII

FIRST BOARD OF TRUSTEES

The names and addresses of the first board of trustees are as follows:

Names	Residence or Business Addresses
Jerry J. May	15180 South Monroe Street Monroe, Michigan 48161
Januarius A. Mullen	1641 Porter Street Detroit, Michigan 48216
Mel Ravitz	City-County Building Detroit, Michigan 48226
Myron E. Wegman, M.D.	University of Michigan Ann Arbor, Michigan 48104
Mrs. John P. Yori	29649 Chester Avenue Garden City, Michigan 48135

ARTICLE VIII

TERM

The term of the corporate existence is perpetual.

ARTICLE IX

RESPONSIBILITIES OF MEMBERSHIP

The number, qualifications, rights, responsibilities, and procedures of the membership of the corporation shall be fixed by the by-laws of the corporation.

We, the incorporators, sign our names this 15th day of June, 1970.

JERRY J. MAY

MYRON E. WEGMAN, M.D.

JANUARIUS A. MULLEN

MRS. JOHN P. YORI

MEL RAVITZ

BY-LAWS
OF
THE COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN

PREAMBLE

PREAMBLE

1. These By-Laws are made for the regulation and government of the affairs of The Comprehensive Health Planning Council of Southeastern Michigan, a Michigan non-profit corporation, the purposes of the corporation having been stated in its Articles of Incorporation, which have been heretofore accepted for filing in accordance with law by the State of Michigan, Department of Treasury. A copy of said Articles and these By-Laws shall be made available to every member of the corporation.

MEMBERSHIP

MEMBERS OF THE CORPORATION

Number

2. The membership of the corporation shall consist of not less than 100 nor more than 250 persons, the exact number to be fixed, initially, by the incorporators, and thereafter to be fixed from time to time by the Board of Trustees. The members shall consist of Governmental Representatives and Private Members and shall be qualified and selected in the manner hereafter set forth in these By-Laws.

Election of Members

3. The members shall elect members and trustees of the corporation, and certain committee members as hereinafter provided, and shall have and exercise all such other rights, powers, duties and privileges as and in the manner prescribed in these By-Laws, or as provided for members of a non-profit corporation by the Michigan General Corporation Act.

Consumer Representation

4. A majority of the membership as a whole shall consist of persons who are consumers, as hereinafter defined by By-Law 5.

5. Within the meaning of these By-Laws, an individual is a consumer if his major occupation is neither the provision nor administration of any type of health services, and neither teaching nor research in the health field.

Governmental Representation

6. The membership shall include representation of county and local governments and other appropriate governmental or quasi-governmental units, agencies, institutions, authorities or corporations. Such members shall be known as Governmental Representatives.

Statutory Membership

7. The persons from time to time holding or occupying the following public offices shall automatically be given the opportunity to be and remain members of the corporation, as Governmental Representatives:
   (a) The chairman of the Board of Commissioners, or in his place a member of the Board of Commissioners to be named by said chairman, in each of the Michigan counties of Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw and Wayne. (Said seven-county area being hereinafter called the Planning Area.)
   (b) The president of the common council or similar legislative body of any city within the Planning Area having population in excess of 300,000, or in his place a member of said common council or legislative body to be named by said president.
   (c) The director or chief executive officer of the County Health Department in each county in the Planning Area.
   (d) The director or chief executive officer of the Mental Health Board of each county in the Planning Area.
   (e) The director or chief executive officer of the environmental pollution control agency or division, if any, of the health or other appropriate department in each county of the Planning Area.
   (f) An officially designated representative of the Michigan Association for Regional Medical Programs.

(g) The director or chief executive officer of the city health department of any city in the Planning Area having a population in excess of 300,000.

(h) The director or chief executive officer of the public health nursing division, if any, of the health or other appropriate department in each county in the Planning Area.

(i) The director or chief executive officer of the public health nursing division, if any, of the health or other appropriate department, if any, in each city in excess of 300,000 population in the Planning Area.

(j) The director or chief executive officer of the environmental pollution control agency or division, if any, of the health or other appropriate department of any city in the Planning Area having a population in excess of 300,000.

OTHER GOVERNMENTAL REPRESENTATION

8. The Governmental Representatives, other than those described in By-Law 7, shall be chosen from among officials of counties, cities, and other governmental or quasi-governmental units, agencies, institutions, authorities or corporations within the Planning Area.

Selection

9. Governmental Representatives shall be chosen on a basis which will provide fair representation for units of government throughout the Planning Area, having due regard for geographic factors, population densities, and the various sizes and functions of the units of government involved.

10. Governmental Representatives shall be named by the incorporators prior to the first meeting of the members of the corporation. Each member so selected by the incorporators shall be admitted to membership upon the receipt by the incorporators of his written acceptance. Governmental Representatives, other than those designated in By-Law 7, shall serve, except as hereinafter limited during the first years of the corporation's existence, for terms of three years. The incorporators shall assign to one-third of such Governmental Representatives selected by them a term which shall expire at the conclusion of the first annual meeting of members to be held in accordance with By-Law 18; to one-third of such Governmental Representatives a term which shall expire at the conclusion of the second annual meeting; and to the remaining one-third a term to expire at the conclusion of the third annual meeting. After the initial meeting of the members, the provisions of By-Law 14 shall govern as to the filling of vacancies resulting from the death or resignation of Governmental Representatives, and the provisions of By-Law 13 shall govern as to the selection of additional Governmental Representatives.

PRIVATE MEMBERSHIP

11. Members other than Governmental Representatives shall be known as Private Members. The Private Members shall consist of persons, resident in the Planning Area, who shall be interested and concerned in areawide health planning. A number of the Private Members shall be representatives of the poor or disadvantaged and of minority groups within the Planning Area, and in selecting such representatives care shall be taken that the representatives are acceptable to such groups. A number of the Private Members shall be health professionals or affiliated with providers of health services; such as physicians, nurses or administrators of voluntary hospitals or health centers. Private Members shall be chosen on a basis which will be appropriate to the purposes of this corporation and will provide representation of the public within the Planning Area, having due regard for varying ethnic and socio-economic segments of the population.

Selection

12. Private Members shall be named by the incorporators prior to the first meeting of the members of the corporation. Each member so selected by the incorporators shall be admitted to membership upon the receipt by the incorporators of his written acceptance. Private Members shall serve, except as hereinafter limited during the first

Term of Office

years of the corporation's existence, for terms of three years. The incorporators shall assign to one-third of the Private Members selected by them a term which shall expire at the conclusion of the first annual meeting of members to be held in accordance with By-Law 18; to one-third of the Private Members a term which shall expire at the conclusion of the second annual meeting; and to the remaining one-third a term to expire at the conclusion of the third annual meeting. After the initial meeting of members, the provisions of By-Law 14 shall govern as to the filling of vacancies resulting from the death or resignation of Private Members, and the provisions of By-Law 13 shall govern as to the selection of additional Private Members.

Selection Procedures

13. Beginning with the first annual meeting of the members (see By-Law 18), Private Members and Governmental Representatives other than By-Law 7 Governmental Representatives shall be elected as members for three-year terms by the members, in accordance with the following procedure:

(a) At least sixty days prior to each annual meeting, the Board of Trustees shall advise the Nominating and Membership Committee (see By-Law 43 et seq.) of the number of members to be elected at said meeting. The Board's advice to the Nominating and Membership Committee shall include a statement as to the number of members currently fixed pursuant to By-Law 2, the number of members to be elected and for what terms, and, of those to be elected, the requisite number of consumers in accordance with By-Laws 4 and 5.

(b) The Nominating and Membership Committee shall consider suitable nominees for membership and in so doing shall take into account the interests or interest groups represented by those members whose terms are expiring. When the Nominating and Membership Committee determines that a nomination or nominations shall be made in representation of a given interest group, organization or body, such group, organization or body shall be accorded the privilege of submitting to the Committee its own names to be placed in nomination. The Nominating and Membership Committee shall afford a fair opportunity for the existing members of the corporation to submit names for its consideration. After due consideration of all proposed nominees, the Nominating and Membership Committee shall prepare a slate of nominees for election. There shall be one nominee for each member to be elected at the ensuing annual meeting. The Committee's slate of nominees shall be submitted to the membership with the notice of meeting required by By-Law 21.

(c) At the annual meeting, any member may place in nomination from the floor any name which has previously been duly submitted to the Nominating and Membership Committee for nomination at such annual meeting but has been omitted from the Committee's slate. In addition, any group of members present at the meeting whose number shall be at least ten per cent of the number of all members in office may place names in nomination which may not have been previously submitted to the Nominating and Membership Committee.

(d) In all elections of members, each member voting may cast one vote for each position to be filled. Each vote shall be for a separate candidate, cumulative voting not being permitted.

Vacancies

14. The Board of Trustees may appoint persons to fill any vacancies in the membership occurring from time to time through death or resignation, or, in the case of a By-Law 7 Governmental Representative, through cessation or loss of governmental office; provided, however, that any such appointment shall be approved by the membership before the appointee shall become a member.

Limitation on Term of Office

15. Members, except those designated in By-Law 7, may not be nominated, elected or appointed so as to serve more than two successive three-year terms. A person ineligible for membership by reason of the foregoing

shall again become eligible after a one-year absence from the membership.

16. Any member who without just excuse repeatedly and continually fails to attend meetings of the corporation, or of the Board or any committees of the corporation of which he may be a member, may be removed from office by the Board of Trustees. Loss of Membership

MEETINGS OF MEMBERS OF THE CORPORATION

17. The first meeting of the members of the corporation shall be held at such time and place as shall be determined by the incorporators of the corporation. First

18. An annual meeting of the members of the corporation shall be held on the third Wednesday of October of each year at such hour and place as shall be determined by the president; provided, that the Board of Trustees may by action taken not later than sixty days prior to the date as fixed above change the annual meeting to any other business day in said month of October; and provided further that if the annual meeting date is so changed, written notice thereof shall be given to all the members of the corporation at least thirty days in advance of the meeting. (Thus the first annual meeting, unless changed in accordance with this By-Law, shall be held on October 20, 1971.) At the annual meeting a report shall be received from the officers of the corporation with respect to the operations of the corporation during the preceding year, and its financial condition; members of the corporation, trustees and committee members shall be elected; and such other business shall be transacted as shall come before the meeting. Annual

19. In addition to the annual meeting, regular quarterly meetings of the membership shall be held on the third Wednesday of January, April, and July of each year, at such hour and place as shall be determined by the president; provided, that by majority vote of the members present at any meeting, one or more regular quarterly meetings scheduled to be held subsequent thereto and prior to the next annual meeting may be cancelled or the date thereof changed to another business day within the indicated month. Quarterly

20. Special meetings of the members of the corporation may be called by the president, and shall be called by him on the request of ten or more members of the Board of Trustees. Special meetings shall be held at such time and place as shall be determined by the president. Business transacted at any special meeting shall be limited to matters stated in the notice of the meeting. Special

21. At least ten days written notice shall be given to all members of the corporation of each meeting of the members of the corporation (except when a thirty-day notice may be required under the provision of By-Law 18 permitting a change to be made in the annual meeting date). Notification

22. One-third of the members of the corporation shall constitute a quorum for the transaction of business, and the acts of a majority of the members present in person or by designated alternate at any meeting at which there is a quorum shall be the acts of the members of the corporation, except as otherwise provided by these By-Laws, the Articles of Incorporation or the laws of the State of Michigan. Quorum

23. Each member may, by written notice to the secretary of the corporation, designate an alternate who, in the absence of the member at any meeting, may attend, act and vote in the member's place and stead except that he may not act as chairman in the event he is an alternate for the chairman. In the event of the chairman's absence from a meeting the assistant chairman, or in his absence, another committee member, shall serve as chairman. Voting by means of written proxies shall not be permitted. Designation of Alternates

Reimbursement

24. The members of the corporation shall receive no compensation for their services as members of the corporation, but may be reimbursed for expenses of attendance at meetings of the corporation, including meetings of the Board of Trustees, committees established by these By-Laws, and committees of the corporation which may hereafter be created. The Board of Trustees shall determine an equitable policy as to expenses to be reimbursed, giving special consideration to any financial burdens upon low-income members.

Open Meetings

25. All meetings of the members shall be open to the public, unless the membership shall by resolution declare that all or a portion of a given meeting is not to be open to the public.

Parliamentary Procedure

26. Any question concerning procedure arising at a meeting of the members shall be resolved by the presiding officer in accordance with these By-Laws, and in case of a question not clearly resolved by reference hereto, the presiding officer shall resolve the question by reference to the latest edition of Robert's Rules of Order Revised, and the meeting shall proceed in accordance with his decision based upon said Rules.

BOARD OF TRUSTEES

BOARD OF TRUSTEES

Number

27. The corporation shall have a Board of Trustees to consist of 41 members of the corporation, provided that one of those members is an official representative of the Michigan Association for Regional Medical Programs.

Election

28. Members of the Board of Trustees shall be elected at each annual meeting of the members of the corporation. As near as may be, one-third of the number of trustees shall be elected at each annual meeting, and the persons elected shall serve for three-year terms. Trustees may by re-election succeed themselves and in case of re-election may continue to serve as Trustees as long as they continue to be members of the corporation.

Consumer Representation

29. At all times a majority of the Board of Trustees must consist of consumers, as defined in By-Law 5.

Election Procedures

30. There shall accompany the notice of each meeting of the members at which Trustees are to be elected a slate of nominees, prepared by the Nominating and Membership Committee, for Trustees to be elected at such meeting. Such nominations shall be designed, so far as practicable, to maintain a balanced representation on the Board of the various interests and groups, public and private, which compose the membership of the corporation, and at the same time to maintain a consumer majority. Additional nominations may be made by members from the floor at the meeting upon the same conditions as are stated in By-Law 13 (c), providing for floor nominations in the election of members.

31. In all elections of Trustees, each member may cast one vote for each position to be filled, e.g., if twelve Trustees are to be elected for a three-year term, and there are twelve or more candidates for such Trusteeships, each member shall vote for not more than twelve candidates, and each vote shall be for a separate candidate, cumulative voting not being permitted.

Responsibilities

32. The Board of Trustees shall manage the affairs and property of the corporation, elect officers of the corporation, and have such other powers, authorities, duties and responsibilities as may be provided or limited by these By-Laws, or are otherwise provided for the Board of Trustees of a non-profit corporation by the Michigan General Corporation Act.

Vacancies

33. In the event that the number of members of the Board of Trustees shall at any time be less than 41, by reason of death, resignation or retirement, or for any other reason whatsoever, the Board of Trustees may appoint a person or persons to fill such vacancy or vacancies; provided, however, that any such appointment shall be approved by the membership before the appointee shall take office as Trustee.

MEETINGS OF THE BOARD OF TRUSTEES

MEETINGS

34. The first meeting of the Board of Trustees shall be held at such time and place as shall be determined by the members of the corporation. — First

35. Regular meetings of the Board of Trustees shall be held monthly at such time and place as shall be fixed by the Board or by the president of the corporation. — Monthly

36. Special meetings of the Board of Trustees may be called by the president and shall be called by him upon the written request of five members of the Board of Trustees. Business transacted at a special meeting of the Board of Trustees shall be limited to the matters stated in the notice of the meeting. — Special

37. At least seven days written notice shall be given for each meeting of the Board of Trustees, whether regular or special. — Notification

38. A majority of the members of the Board of Trustees shall constitute a quorum for the transaction of business, and the acts of a majority of the members of the board present at any meeting at which there is a quorum shall be the acts of the Board, except as otherwise provided by these By-Laws, the Articles of Incorporation, or the laws of the State of Michigan. — Quorum

39. All meetings of the Board of Trustees shall be open to the public, unless the Board shall by resolution declare that all or a portion of a given meeting is not to be open to the public. — Open

EXECUTIVE COMMITTEE

EXECUTIVE COMMITTEE

40. There shall be an Executive Committee of the Board of Trustees, to consist of eleven trustees appointed by the Board, which may meet between meetings of the Board, and shall perform such duties as may from time to time be delegated to it by the Board of Trustees; provided, however, that all actions taken by the Executive Committee between meetings of the Board shall be fully reported to the Board at the ensuing meeting of the Board. — Number

41. The eleven members of the Executive Committee shall include the president, the secretary and the treasurer of the corporation, who shall be members of the Executive Committee by virtue of the offices held by them. A majority of the Executive Committee shall consist of persons who are consumers, as defined in By-Law 5. — Composition

42. Meetings of the Executive Committee shall be held at such time and place as shall be determined by the president of the corporation. At least two days' written notice of each meeting of the Executive Committee shall be given to all members of the Executive Committee, at their latest addresses appearing on the records of the corporation. A majority of the members of the Executive Committee shall constitute a quorum at all meetings; and a vote of a majority of the members present at any meeting shall be the action of the Committee. — Meetings

NOMINATING AND MEMBERSHIP COMMITTEE

NOMINATING AND MEMBERSHIP COMMITTEE

43. There shall be a Nominating and Membership Committee consisting of 16 members of the corporation which shall carry out the responsibilities conferred upon it in these By-Laws and perform such other duties with respect to questions of membership, nominations and elections as may be delegated to it by the membership of the corporation. — Number

44. A majority of the membership of the Nominating and Membership Committee shall consist of consumers as defined by By-Law 5. — Consumer Representation

45. The members of the Nominating and Membership Committee shall be elected by the members of the corporation. At the first meeting of the members of the corporation, all sixteen members of this Committee shall be elected. Each Committee member's term shall be coextensive with his term as a member of the corporation. Successors — Election; Term of Office

Vacancies

to Committee members whose terms shall expire, shall be terminated, or who shall die or resign, shall be elected by the members of the corporation at any annual meeting. In the interim period vacancies on the Nominating and Membership Committee may be filled by the Board of Trustees with full power, provided, however, that these new members' continuance after the next regular meeting of the membership is confirmed by members of the corporation or they are replaced.

46. As soon as possible after the election of the Nominating and Membership Committee at the first meeting of members of the corporation, the Committee shall meet, appoint a chairman and a secretary, proceed to select a slate of nominees for election to the Board of Trustees and also to select nominees for election as members of any Planning Committees established by the members of the corporation.

PLANNING COMMITTEES

PLANNING COMMITTEES

47. The members may, at the first meeting or any annual or regular meeting, or at any special meeting called for such purpose, establish any number of committees, each consisting of 15 to 25 members of the corporation, to deal especially with health planning problems within enumerated categories — e.g., a committee on Development of Community Health Services, a committee on Health Facilities, a committee on Environmental Health, a committee on Mental Health, a committee on Health Personnel, and a committee on Occupational Safety and Health (hereinafter called Planning Committees).

Membership

48. All of the members of a Planning Committee, except members to be appointed by the Board of Trustees as hereinafter provided, shall be elected directly by the membership. Members of a Planning Committee shall serve for terms which are coextensive with their respective trms as members of the corporation. Successors to elected Planning Committee members whose terms expire (and who shall not be re-elected to membership), or who shall die or resign, shall be elected by the members of the corporation at any annual or regular meeting or at any special meeting called for that purpose. Nominations for such Planning Committee members shall be made by and received from the Nominating and Membership Committee and elections shall be conducted following as nearly as possible the procedure elsewhere established in these By-Laws for the election of members of the corporation. In addition to the Planning Committee members elected directly by the general membership, two members of the Board of Trustees, to be appointed from time to time by the Board, shall be members of each Planning Committee.

Procedures

49. Each Planning Committee shall make its own rules of procedure, provided, however, that it must elect at least annually from the Committee membership a chairman and assistant chairman at its first meeting following the annual meeting of the corporation. The committees may elect such other committee officers as they deem necessary or expedient. A majority of the members of a Planning Committee shall constitute a quorum. A Planning Committee may also establish one or more Ad Hoc Advisory Committees — whose membership need not consist of members of the corporation or of a majority of consumers and need not reflect the composition of the general membership — to study and make recommendations and reports to the Planning Committee on particular planning problems; provided, always, that the hiring and direction of staff employees of the corporation, and the payment of compensation for services of consultants or professional advisors shall at all times be and remain under the exclusive control of the Board of Trustees, except as may be specifically delegated by the Board.

Officers

50. After reviewing any report and recommendation of an Ad Hoc Advisory Committee concerning a particular planning problem, a Planning Committee shall report and make its recommendations to the Board of Trustees with respect thereto, and the Board of Trustees shall review said report and recommendations and make its determina-

tion in the matter. In the event that Board action is inconsistent with recommendations of the Planning Committee, the Planning Committee may instruct the Board to place the question before the membership of the corporation at the next regular or special meeting of the members of the corporation, and the Board shall in case of such request see that such question is placed on the agenda for such meeting. The members of the corporation shall at such meeting attempt to resolve any differences between the Board and the Planning Committee by appropriate action.

OTHER COMMITTEES

OTHER COMMITTEES

51. The members and the Board of Trustees may from time to time create other committees, determine their powers and duties, elect or appoint their members, prescribe procedures for meetings and action at meetings, and confer other appropriate authorizations and prescribe limitations with respect thereto. Members of such committees may, but need not, be members of the corporation or of the Board of Trustees.

REFLECTION OF MEMBERSHIP COMPOSITION IN BOARD OF TRUSTEES AND COMMITTEES

COMPOSITION OF BOARD AND COMMITTEES

52. The Nominating and Membership Committee and the Board of Trustees, in all matters of nomination and appointment with which they are concerned, shall follow the objective that the composition of the general membership is to be reflected so far as possible in the Board of Trustees and other committees of the corporation (other than Planning and Ad Hoc Advisory Committees); and to that end successors to members or Board or committee members who terms expire, or who shall die or resign, etc., shall be chosen who will represent as nearly as possible the interest or interest group represented by the members being replaced.

RELATIONSHIPS WITH OTHER PLANNING AGENCIES IN SOUTHEASTERN MICHIGAN

EXTERNAL RELATIONSHIPS

53. The members of the Board of Trustees shall take appropriate actions to ensure cooperation with other general health and health-related planning agencies including those which may hereafter be organized on a more localized basis within the Planning Area.

OFFICERS

OFFICERS

54. The officers of the corporation shall be a president, an executive director, a secretary and a treasurer, and if the Board of Trustees shall so determine, a vice president or vice presidents, an assistant secretary or assistant secretaries, and an assistant treasurer or assistant treasurers. The president of the corporation shall be a member of the Board of Trustees.

Number

55. Officers of the corporation shall be elected by the Board of Trustees. Officers shall hold their offices for such terms as may be fixed by the Board.

Election

56. The president shall be the chief executive officer of the corporation, shall preside at meetings of the members and the Board of Trustees, and shall have such powers and duties as are vested in the president of a corporation by law or custom, or by these By-Laws, and as may be determined from time to time by the Board of Trustees.

PRESIDENTIAL POWERS

57. The executive director shall be the chief planning officer of the corporation, subject to the authority of the president of the corporation. He shall be employed solely by the corporation. He shall supervise and direct all the planning activities and projects of the corporation. He shall meet with the Board of Trustees regularly and with the various Planning Committes. He shall provide continuing information as to the activities of the staff to the Board of Trustees and the various committees of the corporation, the membership and the public. He shall have such other powers and duties as may be determined from time to time.

RESPONSIBILITIES OF THE EXECUTIVE DIRECTOR

RESPONSIBILITIES OF THE SECRETARY

58. The secretary shall attend all meetings of the members of the corporation and all meetings of the Board of Trustees, and record the minutes of the meetings in a book to be kept for that purpose. He shall give or cause to be given notice of all meetings of the members of the corporation and the Board of Trustees, and shall perform such other duties as may be prescribed by the president, under whose supervision he shall be. The secretary may delegate any of his duties, powers and authorities to one or more assistant secretaries, unless such delegation be disapproved by the Board of Trustees.

RESPONSIBILITIES OF THE TREASURER

59. The treasurer shall have custody of corporate funds and securities, and shall keep full and accurate accounts of receipts and disbursements in books belonging to the corporation, and shall deposit all moneys and valuable effects in the name and to the credit of the corporation in such depositories as may be designated by the Board of Trustees. He shall have the responsibility for making recommendations to the Board of Trustees with respect to investment of the funds of the corporation. He shall render to the president and the Board of Trustees, whenever they may require it, an account of the financial transactions and conditions of the corporation. The treasurer shall also be responsible for obtaining a certified audit of the books and financial records of the corporation annually. The report of the audit shall be submitted to the Board of Trustees no later than three calendar months following the end of the fiscal year. The treasurer may delegate any of his duties, powers and authorities to one or more assistant treasurers, unless such delegation be disapproved by the Board of Trustees.

RESPONSIBILITIES OF THE ASSISTANT SECRETARY AND ASSISTANT TREASURER

60. The assistant secretaries shall perform the duties and exercise the powers and authorities of the secretary in case of his absence or disability. The assistant treasurers shall perform the duties and exercise the powers and authorities of the treasurer in case of his absence or disability. The assistant secretaries and assistant treasurers shall also perform such duties as may be delegated to them by the secretary and treasurer, respectively, and also such duties as the Board of Trustees may prescribe.

BONDS

BONDS

61. The Board of Trustees of the corporation may require any officer, agent or employee to give bond for the protection of the corporation, in such sum and with such surety or sureties as the Board may deem advisable. Premiums on such bonds shall in all cases be paid by the corporation.

CHECK SIGNATORS

CHECKS AND OTHER INSTRUMENTS

62. All checks, drafts, or demands for money, and notes of the corporation, shall be signed by such officer or officers or such other person or persons as the Board of Trustees may from time to time designate.

CONTRACTS

63. The Board of Trustees may in any instance designate the officers and agents who shall have authority to execute any contract, conveyance, or other instrument on behalf of the corporation, or may ratify or confirm any execution. When the execution of any instrument has been authorized without specification of the executing officers or agents, the president or any corporate officer specifically authorized by him may execute the same in the name and on behalf of the corporation.

NOTIFICATION OF MEETING

NOTICES AND WAIVERS OF NOTICE

64. All notices of meetings required to be given to any member of the corporation or any member of the Board of Trustees, or of the Executive Committee, may be given by mail, telegram, radiogram or cablegram to such member at his last address as it appears on the books of the corporation, and in default of such address, to such member at the general post office in the City of Detroit, Michigan. Such notice shall be deemed to be given at the time when the same shall be mailed or otherwise dispatched.

65. Notice of the time, place and purpose of any meeting of the members of the corporation or any meeting of the Board of Trustees, or of committees of the corporation, may be waived by telegram, radiogram, cablegram, or other writing, either before or after the meeting, or in such other manner as may be permitted by the laws of the State of Michigan. Presence at a meeting without objection to the manner in which notice has been given shall constitute waiver of notice of the meeting.

WAIVER O
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INDEMNIFICATIOI

66. The corporation shall indemnify each member of the Board of Trustees and each officer of the corporation, at any time in office, against expenses actually and necessarily incurred, in connection with the defense of any action, suit or proceeding to which he is made a party by reason of being or having been a member of the Board of Trustees, or officer of the corporation, except in relation to matters as to which any such person shall be adjudged in such action, suit or proceeding to be liable for negligence or misconduct in the performance of duty and as to such matters as shall be settled by agreement predicated on the existence of such liability. The foregoing requirement of indemnification shall not exclude any member of the Board of Trustees or officer from any other rights of indemnification or otherwise to which such a person may be entitled as a matter of law.

AMENDMENTS

AMENDMENT

67. The By-Laws of the corporation may be amended, altered, added to or repealed, in whole or in part, by majority vote of the members of the corporation present at any meeting wherein changes in the By-Laws may properly be voted upon; provided, however, that in order for any such change in the By-Laws to pass, the votes in favor of the change must be greater than one-third of the whole number of members then in office.

68. Changes in the By-Laws may be initiated and proposed for consideration at a meeting of the members only in accordance with the following procedures:

Procedures

(a) The Board of Trustees may initiate such changes by means of written notification to the members of the full text of the proposed change or changes, which notification shall accompany the written notice of meeting required by By-Law 21.

(b) Any group composed of ten percent or more of the members may intiate such changes by submitting to the Board of Trustees, at least thirty days prior to the date fixed for the next meeting of members, the full text of the proposed change or changes. The Board of Trustees shall be obligated to submit such proposed changes to the members in writing in the same manner as specified in subparagraph (a) for changes initiated by the Board. The Board shall state in its notification to members whether it recommends adoption or defeat of such proposed changes.

(c) Any By-Law proposals submitted in accordance with subparagraphs (a) or (b) hereof must be considered and voted upon at the ensuing meeting of the members.

69. The fiscal year of the corporation shall be January 1 - December 31.

FISCAL YEA

70. There shall be a Finance Committee consisting of seven members of the corporation which shall perform such duties with respect to questions of financing the corporation as may be delegated to it by the Board of Trustees. The members of the Finance Committee shall be designated by the president. Each Committee member's term shall be coextensive with his or her term as a member of the corporation. Successors to Committee members whose term shall expire or shall be terminated, or who shall die, or resign, shall be appointed by the Board of Trustees.

FINANC
COMMITTE

APPENDIX E - CHP Council of Southeastern Michigan,
Board of Trustees (November, 1970)

(Source: 1970 CHPC-SEM Grant Application)

GRANT APPLICATION

APPENDIX "F"

CHPC BOARD OF TRUSTEES

Name	Address	County of residence of involvement	Occupation or Affiliation
Mrs. Margaret Lee Anderson (Consumer)	3679 Hunt Street Detroit, Michigan	Wayne	Member-Detroit Model Neighborhood Citizens Governing Board
Richard H. Austin (Consumer)	1236 City-County Bldg. Detroit, Michigan	Wayne	UF of Greater Detroit
Edward E. Barker, Jr. (Consumer)	P.O. Box 599 Pontiac, Michigan	Oakland	Trustee, St. Joseph Hospital, Pontiac, Michigan
Bernard D. Berman, M.D. (Provider)	1200 N. Telegraph Pontiac, Michigan	Oakland	Health Officer
John H. Burton (Consumer)	9650 S. Telegraph Taylor, Michigan	Washtenaw	Member-NAACP Ypsilanti Branch

Mrs. Leora Cleggett (Consumer)	532 1/2 Franklin Rd. Pontiac, Michigan	Oakland	Member-National Welfare Rights Organization
Herschel Clover (Consumer)	8222 Joy Road Detroit, Michigan	Wayne	International Representative, Region 1-A, UAW
Merlin E. Damon (Provider)	43525 Elizabeth Road Mt. Clemens, Michigan	Macomb	Sanitary Engineer
Robert A. DeVries (Provider)	512 S. Thompkins Howell, Michigan	Livingston	Hospital Administrator
Mrs. Kate Emerson (Consumer)	519-B Longshore Ann Arbor, Michigan	Washtenaw	Housewife & National Welfare Rights Organization employee
James D. Fryfogle, M.D. (Provider)	15901 W. 9 Mile Rd. Southfield, Michigan	Wayne	Practicing Physician

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APPENDIX "F" - CHPC
Board of Trustees

Name	Address	County of residence or involvement	Occupation or Affiliation
Walter H. Garcia (Consumer)	1298 Wheelock Detroit, Michigan	Wayne	Teacher - Volunteer at LASED
Della Goodwin, R.N. (Provider)	19214 Appoline Detroit, Michigan	Wayne	Registered Nurse
Gordon Hanna (Consumer)	900 Cadillac Square Detroit, Michigan	Wayne	Michigan Civil Rights Comm.
Garnet T. Ice, M.D. (Provider)	8401 Woodward Detroit, Michigan	Wayne	Practicing Physician
Mrs. Pepper Jacques (Consumer)	330 E. Adams Detroit, Michigan	Wayne	Member-Detroit Model Neighborhood Citizens Governing Board
Ray Lewis, M.D. (Provider)	3000 David Broderick Tower, Detroit, Michigan	Wayne	Director, Wayne County Mental Health Board

Mark T. McKee, Jr. (Consumer)	P.O. Box 707 Mt. Clemens, Michigan	Macomb	Newspaper Publisher
Norman Mackay (Consumer)	2310 Cass Avenue Detroit, Michigan	Wayne	Staff Representative, Metropolitan Detroit - AFL-CIO
Allen W. Merrell (Consumer)	The American Road Dearborn, Michigan	Wayne	Vice President of Civic & Governmental Affairs, Ford Motor Company
Ken Morris (Consumer)	8000 E. Jefferson Ave. Detroit, Michigan	Oakland	Director - Region 1-B, UAW
Ann L. McCoy (Consumer)	21149 McGovern Mt. Clemens, Michigan	Macomb	Secretary
Neil McGinniss (Provider)	18101 Oakwood Blvd. Dearborn, Michigan	Wayne	Hospital Director
Sylvia R. Peabody, R.N. (Provider)	4421 Woodward Ave. Detroit, Michigan	Wayne	VNA of Detroit
Glen H. Peters (Consumer)	39880 Sylvia Mt. Clemens, Michigan	Macomb	Vice Chairman, County Planning Committee

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APPENDIX "F" - CHPC
Board of Trustees

Name	Address	County of residence or involvement	Occupation or Affiliation
Mel Ravitz (Consumer)	#2 Woodward Ave. Detroit, Michigan	Wayne	President - Detroit Common Council
Roy J. Robertson, D.D.S. (Provider)	17170 Livernois Detroit, Michigan	Wayne	Dentist
Harry Riggs, M.D. (Provider)	149 Franklin Road Pontiac, Michigan	Oakland	Practicing Physician
Frederick O. Rouse, Jr. (Consumer)	729 N. Riverside Ave. St. Clair, Michigan	St. Clair	Chairman - County Board of Commissioners
Ronald Scott (Consumer)	3520 Gibson-Apt. 1053 Detroit, Michigan	Wayne	Coalition of Health Consumers
Herbert Silverman, M.D. (Provider)	Veterans Administration Hospital, Allen Pk.	Oakland	Clinical Psychologist
Mrs. Patricia Varco (Consumer)	90 W. Madge Street Hazel Park, Michigan	Oakland	Hazel Park Advisory Council OEO
Robert Ward, D.O. (Provider)	22211 Schafer Mt. Clemens, Michigan	Macomb	Practicing Physician
Myron E. Wegman, M.D. (Provider)	University of Michigan Ann Arbor, Michigan	Regional	Dean - U.M. School of Public Health
Arden T. Westover (Consumer)	106 E. First Street Monroe, Michigan	Monroe	Chairman - County Board of Commissioners

APPENDIX F - Summary Budget for CHP Council of Southeastern Michigan, 1970

(Source: 1970 CHPC-SEM Grant Application)

COMPREHENSIVE HEALTH PLANNING COUNCIL
of SOUTHEASTERN MICHIGAN
921 Penobscot Building, Detroit, Michigan 48226

SUMMARY BUDGET FOR CHPC

A.	Personnel		
	Professional Salaries	$145,000	
	Clerical Salaries	37,000	
	Fringe Benefits	21,840	
			$203,840
B.	Consulting Services		14,500
C.	Furniture & Equipment		17,206
D.	Supplies		8,000
E.	Travel and Parking		7,140
F.	Other (Staff Expense, Rent, Phone, etc.)		33,940
G.	Contracts		300,374
H.	Consumer Participation		15,000
			$600,000

APPENDIX G - Contract for Performance of Health Facilities Planning in Southeastern Michigan

(Source: 1970 CHPC-SEM Grant Application)

GRANT APPLICATION

APPENDIX "G"

CONTRACT FOR PERFORMANCE OF HEALTH FACILITIES PLANNING IN SOUTHEASTERN MICHIGAN

THIS AGREEMENT, entered into this 1st day of August, 1970, between GREATER DETROIT AREA HOSPITAL COUNCIL, INC., a Michigan non-profit corporation (hereinafter called "Hospital Council") and the COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN, INC., a Michigan non-profit corporation (hereinafter called "CHPC"), WITNESSETH:

WHEREAS, it is desired by the parties hereto, and by the United States Department of Health, Education andWelfare that there be improved and intensified health facilities planning in Southeastern Michigan, and

WHEREAS, CHPC is in the process of making application to the Department of Health, Education and Welfare for an operating comprehensive areawide health planning Federal grant for the purpose of implementing such planning, and

WHEREAS, Hospital Council has experience and community support for health facilities planning in Southeastern Michigan and is actively doing such planning; and said Hospital Council is desirous of undertaking further such planning, and

WHEREAS, the parties desire to set forth their agreement concerning the use of part of a grant which may be obtained by CHPC for the above purposes from the Department of Health, Education and Welfare and the mutual rights and responsibilities of the parties with respect to the carrying out of health planning services contemplated by such planning grant.

NOW THEREFORE, the parties hereto do mutually agree as follows:

1. This agreement shall become operative at such time as a planning grant to CHPC sahll be received by CHPC from the Department of Health, Education and Welfare.

2. CHPC shall distribute the Hospital Council's portion of the monies ($240,374 - See Addendum for detail) as indicated in the planning grant application, to Hospital Council to enable the latter to carry out the health planning services described in part III B, 1, 2 and 3 (pp. 7-10) and part IV C, 1 (pp 26-27) of the Work Program (Section V) of said planning grant application. In general, such services to be performed by the Hospital Council include:

a) updated identification of all available hospital and related health care facilities and services including extended care and nursing home facilities and services, and

b) detailed data describing facility utilization by service and by patient origin

c) assist health facilities in developing major capital expenditure program proposals to assure their conformity to demonstrated community need and their financial feasibility and their consistency with community priorities

d) development of planning guidelines in the following area:

1. Specialized hospital services - will inventory, assess, and develop guidelines for such specialized hospital services as cobalt therapy, coronary care, neonatal intensive care, open heart surgery, renal dialysis, etc.

2. Bed need determination - by utilizing patient origin information, past utilization trends, and population characteristics a regression model will be developed to project acute care bed needs by service.

3. Ambulatory care - after evaluating ambulatory care data, will develop guidelines for the development of a regional system of emergency departments and outpatient departments.

4. Long term care - after evaluating levels of care provided in nursing homes, will develop long term care guidelines on a regional basis.

e) evaluation of hospital proposals for modernization, expansion, mergers, replacement, and new construction, and

f) assistance in developing comprehensive maternal and infant care programs, and

g) continue to promote and staff joint hospital planning committees, and

h) continued support to smaller hospitals as they consolidate their services and work toward merger.

3. Hospital Council will use and expend the subject grant in accordance with the appropriated portion of the indicated budget which forms a part of the planning grant application.

4. Services to be performed by Hospital Council hereunder shall commence on or about December 1, 1970, and shall be completed on or about November 30, 1971. Distributions of monies hereunder from CHPC to Hospital Council shall commence on or about December 1, 1970, and thereafter be made at intervals as shall be mutually agreed upon by the parties and as shall be sufficient to enable Hospital Council to carry out its functions hereunder.

5. Between December 1, 1970 and November 30, 1971, Hospital Council shall periodically, and at any time upon request, report to CHPC concerning its progress, accomplishments and any proposals or recommendations which have been developed as a result of the activities of the Council carried out by virtue of the planning grant monies. CHPC shall evaluate said reports and in the event of any deficiencies therein shall confer with Hospital Council concerning said report and means of improving the performance of Hospital Council hereunder. As soon as reasonably possible after November 30, 1971, Hospital Council shall submit to CHPC an updated report as to the progress, accomplishments, and any proposals or recommendations of Hospital Council. CHPC may call for any underlying data developed by Hospital Council in connection therewith.

6. In order that the respective activities of CHPC and Hospital Council in the health planning field shall be coordinated and not wastefully duplicative, and for purposes of general guidance and information exchange, there shall be regularly scheduled joint staff meetings between CHPC and Hospital Council during the period of this contract.

7. The personnel and staff of Hospital Council shall be and remain under the direct supervision and control of Hospital Council and not CHPC.

8. This contract shall not be assigned by either party.

IN WITNESS WHEREOF, the parties have executed this contract in duplicate original as of the day and year first above written.

* * * * * *

APPENDIX H - Contract for Professional Services with
Southeast Michigan Council of Governments

(Source: 1970 CHPC-SEM Grant Application)

GRANT APPLICATION

APPENDIX "H"

CONTRACT FOR PROFESSIONAL SERVICES
With
Southeast Michigan Council of Governments

THIS AGREEMENT, made and entered into this 15th day of September, 1970, between SOUTHEAST MICHIGAN COUNCIL OF GOVERNMENTS, a Regional Planning Commission (hereinafter called "SEMCOG"), and the COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN, INC., a Michigan non-profit corporation (hereinafter called "CHPC"), WITNESSETH:

WHEREAS, it is desired by the parties hereto, and by the United States Department of Health, Education and Welfare that there be continued development of an effective partnership between the public and private sectors of health care and protection in Southeastern Michigan; that CHPC be responsible for the stimulation of community discussion regarding the identification of health goals and needs, and the coordination and maximum utilization of all existing and planned facilities, services, and manpower in the fields of physical, mental, and environmental health, and

WHEREAS, it is desired by the parties hereto, and by the United States Department of Health, Education and Welfare that there be improved and intensified planning to create a regional mechanism to monitor environmental quality and develop appropriate relationships for defining environmental quality and bringing environmental conditions to standard in Southeastern Michigan, and

WHEREAS, it is desired by the parties hereto, and by the United States Department of Health, Education and Welfare that there be established a demographic data bank for each area of CHPC concern, that the development of this data bank be an ongoing project and be coordinated with existing data collection bodies, and that there be planning to establish a central clearinghouse for all health and health related data, and

WHEREAS, CHPC is in the process of making application to the United States Department of Health, Education and Welfare for an operating comprehensive areawide health planning Federal grant for the purpose of implementing such planning, and

WHEREAS, SEMCOG has experience and community support for environmental health planning in Southeastern Michigan and is actively doing such planning and is desirous of continuing and exploring its activities in this area, and

-continued-

WHEREAS, SEMCOG is recognized by the United States Bureau of the Census as a Census Summary Tape Processing Center and, as a joint project of SEMCOG's Office of Planning Services and office of Data Systems, is desrious of continuing and expanding the benefits and capabilities of its data service function to CHPC, and

WHEREAS, the parties desire to set forth an agreement concerning the use of part of a grant which may be obtained by CHPC for the above purposes from the United States Department of Health, Education and Welfare and concerning the mutual rights and responsibilities of the parties with respect to the carrying out of health planning services contemplated by such planning grant,

NOW THEREFORE, the parties do hereto mutually agree as follows:

1. This agreement shall become operative at such time as a planning grant to CHPC shall be received from the United States Department of Health, Education and Welfare.

2. CHPC shall distribute to SEMCOG that portion of the monies ($60,000), as indicated in the planning grant application, to enable SEMCOG to carry out the environmental health planning services and provide demographic data and related information system assistance as described in the Work Program of said planning grant application.

3. SEMCOG shall do, perform and carry out in a satisfactory and proper manner, as determined by CHPC, the following services:

   A. Environmental Health Planning

      1) In conjunction with the appropriate categorical planning committee of CHPC, identify the necessary participants to establish a high level task force with broad representation from both consumers and providers and both public and private interests.

      2) Prepare brief papers on the following topics:

         a. Elements of the environment to be dealt with;

         b. Goals and objectives for an environmental program;

-continued-

c. Mechanisms for establishing environmental standards;

d. Mechanisms for monitoring the environmental and relationships necessary to do so;

e. Mechanisms and mandates for enforcement and control of environmental standards.

3) Assist the task force in seeking solutions for resolving environmental health problems and in implementing solutions on a demonstration basis.

4) Assist the task force to develop mechansims to measure the quality of the environment on an ongoing basis.

5) Assist the task force to outline specific short and long range goals to be used by CHPC to assist in the amelioration of environmental health problems.

6) Assist the task force to outline recommendations and action strategies pertaining to "b" above.

B. Information Services Program

1) SEMCOG will provide CHPC with its own copies of computer files in anticipation of CHPC's future need for its own individual information system or health data clearinghouse.

2) The "products" of this information service program will provide CHPC with graphic materials which may be utilized in a variety of media, such as in seminars as well as reports.

3) Although SEMCOG is responsible for delivering specific end products, it is understood that, unless other provisions are made, CHPC will be intimately involved in the development of the data files and end products for CHPC. In this way, because of greater understanding of the data, the CHPC staff will be able to make more effective use of the information products and be better able to develop the overall CHPC Information System.

-continued-

4) CHPC may develop its own unique schedule of priorities and assignments. Since SEMCOG has an array of data at its disposal, CHPC can be provided unique project information as the need arises.

5) While the health data needs will be determined by CHPC, SEMCOG will provide the following information and services:

a. Demographic Information (Population characteristics, distribution and migration as related to employment, income, housing, socio-economic conditions, etc.)

The purpose of this service is to establish a primary data base utilizing 1970 Census Data. This includes:

i. Membership in SEMCOG Summary Tape Processing Center.

ii. Receipt of standardized Census Reports including population, housing and other information.

iii. Special reports

On request by CHPC for Special and unique tabulation of Census data, separate tabulations will be run and reports prepared as specified. These reports may include:

(a). Mutilvariate analysis, file searches and analysis.

(b). Relating different type of information to small geographic areas, political jurisdictions, or census blocks.

(c). Displaying information through computer mapping and graphs.

(d). Compilations on designated health and social indications from small or large areas of the metropolitan area.

-continued-

6) Computer Systems -- Technical Assistance

a. Assistance will be rendered, on request, to assist CHPC in defining a strategy and program requirements, costs and approaches necessary to develop a central clearinghouse for all health and health related data.

b. Assistance will be rendered, on request, to CHPC in coordinating state and regional health information systems plans and planning data needs.

4. SEMCOG shall commence the work required by this Agreement on the date specified in a written notice to proceed and will complete the work specified within 12 consecutive months after the data of the aforesaid written notice to proceed, unless the time therefore is extended by mutual agreement of the parties hereto as evidenced by letters from each to the other.

5. For the services performed and expenses incurred by the Consultant under this Agreement, it is agreed that the total cost shall not exceed the amount of $60,000 without the written approval in the form of a Supplemental Agreement hereto.

CHPC agrees to pay SEMCOG on a monthly basis, upon proper invoices and certification for services actually performed hereunder, within thirty (30) days.

Checks in payment for services rendered hereunder shall be drawn to the order of the SEMGOC and mailed to its address.

SEMCOG shall maintain accounting records and other evidence pertaining to the costs incurred and make the records available at its office at all reasonable times during the contract period and for three (3) years from the date of final payment of Federal funds to CHPC with respect to the Planning Grant. Such accounting records and other evidence pertaining to the costs incurred will be made available for inspection by CHPC, or any authorized representative of the Federal Government, and copies thereof shall be furnished if requested.

6. CHPC may at any time, by written order, make changes in the work and services to be performed under this Agreement and within the general scope thereof. If such changes cause an increase or decrease in the cost of performing the work, and services under this Agreement, or in the time required for its performance, and equitable adjustment shall be made and the Agreement shall be modified in writing accordingly.

-continued-

7. Personnel

SEMCOG represents that it has, or will secure at its own expense, all personnel required in performing the services under this Contract.

All of the services required hereunder will be performed by SEMCOG or under his supervision, and all personnel engaged in the work shall be fully qualified and shall be authorized under State and local law to perform such services.

8. General

All Studies, procedures and estimates made in connection with these services are subject to review and approval of CHPC for completeness and fulfillment of the requirements of this agreement.

The interests of CHPC require close cooperation, and SEMCOG shall confer as necessary and cooperate with CHPC in order that the work may proceed in a mutually satisfactory manner.

SEMCOG shall appear before the CHPC or other agencies as may be requested by CHPC for presentation of its findings, recommendations, conclusions, and pertinent material.

During the performance of work under this Agreement, SEMCOG shall submit to CHPC, five (5) copies of progress reports, completely and clearly stating the current status of SEMCOG's work under this Agreement.

All reports, estimates, memoranda and other papers and documents submitted by SEMCOG shall be dated and bear SEMCOG's name.

9. SEMCOG agrees it will not discriminate against any employee or applicant for employment, to be employed in the performance of this Contract, with respect to his hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment because of his race, color, religion, national origin, ancestry, sex, or age except when based on a bona fide occupational qualification. Breach of this covenant may be regarded as a material breach of this Contract.

10. SEMCOG shall make abailable to CHPC all of the data, reports, analysis, drawings, maps, talbes and other pertinent background information related to the work under this agreement.

-continued-

11. This contract shall not be assigned by either party.

IN WITNESS WHEREOF, the parties have executed this contract in duplicate original as of the day and year first above written.

COMPREHENSIVE HEALTH PLANNING
COUNCIL OF SOUTHEASTERN MICHIGAN

ATTEST:

_____
(Title)

_____
(Title)

SOUTHEAST MICHIGAN COUNCIL
OF GOVERNMENTS

ATTEST:

BY _____
Executive Director

BY _____

** ** ** ** **

APPENDIX I - Statement of Revenues and Expenditures and Statement of Program Expenditures, Five Months Ended April 30, 1973, for CHP Council of Southeastern Michigan

(Source: CHPC-SEM Document, May, 1973)

COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN
1300 Book Building, Detroit, Michigan 48226, Telephone 964-6950

STATEMENT OF REVENUES AND EXPENDITURES
Five Months Ended April 30, 1973

		FUNDS		8 Month
	Total	General	HEW Grant	Budget
Revenues:				
City of Detroit	$ 5,000.00	$ 5,000.00	$	$ 5,000.00
Grant from HEW	171,055.00		171,055.00	273,691.00
Health Insurers	400.00	400.00		400.00
Hospitals	19,733.59	19,733.59		19,733.59
Macomb County	7,700.00	7,700.00		7,700.00
St. Clair County	1,166.70	1,166.70		1,166.70
Washtenaw County	3,033.31	3,033.31		3,033.31
Michigan Hospital Service	58,333.00	58,333.00		58,333.00
United Health Organization	77,000.00	77,000.00		77,000.00
Unpledged Matching Required	---	---		101,324.40
Total Revenues	$343,421.60	$172,366.60	$171,055.00	$547,382.00
Expenditures:				
Personnel	$138,613.39	$ 69,306.69	$ 69,306.70	$243,424.00
Consultant Services	500.00	150.00	350.00	3,400.00
Equipment	5,808.26	1,011.00	4,797.26	15,720.00
Supplies	2,946.89	1,473.45	1,473.44	8,000.00
Travel	7,248.61	1,963.57	5,285.04	14,800.00
Staff Expense	4,626.95	4,626.95	---	9,080.00
CHPC & Committee Meetings	1,342.95	---	1,342.95	3,200.00
Contracts	112,430.00	59,215.00	53,215.00	193,624.00
Other	21,261.26	10,630.63	10,630.63	56,134.00
Total Expenditures	$294,778.31	$148,377.29	$146,401.02	$547,382.00
Excess of revenues over expenses	$ 48,643.29	$ 23,989.31	$ 24,653.98	

COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN
1300 Book Building, Detroit, Michigan 48226, Telephone 964-6950

STATEMENT OF PROGRAM EXPENDITURES
Five Months Ended April 30, 1973

Expenditure	Total	PROGRAM ALLOCATIONS 401	405	410	420	435
Salaries	$124,025.44	$ 33,602.82	$10,677.54	$ 7,798.45	$ 8,385.33	$ 8,167.05
Payroll Taxes	6,016.91	1,657.44	501.35	332.62	464.85	445.06
Fringe Benefits	8,570.99	3,348.73	713.68	277.69	419.29	460.00
Sub-Total Personnel	$138,613.39	$ 38,608.99	$11,892.57	$ 8,408.76	$ 9,269.47	$ 9,072.11
Consultant Services	500.00	400.00	---	---	---	---
Equipment	5,808.26	5,808.26	---	---	---	---
Supplies	2,946.89	2,946.89	---	---	---	---
Travel	7,248.61	2,926.00	278.60	667.28	806.99	454.16
Staff Expense	4,626.95	2,900.59	156.86	800.67	159.10	29.50
CHPC & Committee Meetings	1,342.95	448.40	---	---	71.60	---
Contract Services	112,430.00	---	---	---	---	---
Other:						
Legal	66.66	66.66				
Subs. & Ref. Publications	979.20	979.20				
Membership Dues	1,282.50	1,022.50	---	32.50	10.00	---
Telephone & Telegraph	4,066.70	1,285.49	363.23	363.23	271.60	291.83
Postage & Shipping	2,610.95	1,220.95	174.00	174.00	130.00	130.00
Newsletter	2,775.85	2,200.45	575.40	---	---	---
Rent	9,090.40	2,778.67	792.20	792.20	591.87	594.66
Insurance	389.00	118.68	33.84	33.84	25.28	25.28
Sub-Total Other	$ 21,261.26	$ 9,672.60	$ 1,938.67	$ 1,395.77	$ 1,028.75	$ 1,041.77
Total Expenditures	$294,778.31	$ 63,711.73	$14,266.70	$11,272.48	$11,335.91	$10,597.54

401 - Administration
405 - Information Services
410 - Community Development, Organization, and Participation
420 - Community Development of Health Services Planning
435 - Sub-Area Planning

COMPREHENSIVE HEALTH PLANNING COUNCIL OF SOUTHEASTERN MICHIGAN
1300 Book Building, Detroit, Michigan 48226, Telephone 964-6950

STATEMENT OF PROGRAM EXPENDITURES
Five Months Ended April 30, 1973

Expenditure	Total	PROGRAM ALLOCATIONS 445	460	475	485	495
Salaries	$124,025.44	$10,250.43	$ 19,565.11	$ 8,357.54	$ 9,595.54	$ 7,625.63
Payroll Taxes	6,016.91	458.35	906.66	343.11	475.60	431.92
Fringe Benefits	8,570.99	866.01	1,132.45	514.24	621.80	217.10
Sub-Total Personnel	$138,613.39	$11,574.79	$ 21,604.22	$ 9,214.89	$10,692.94	$ 8,274.65
Consultant Services	500.00	---	---	---	---	100.00
Equipment	5,808.26	---	---	---	---	---
Supplies	2,946.89	---	---	---	---	---
Travel	7,248.61	506.73	659.41	125.58	414.35	409.51
Staff Expense	4,626.95	51.99	306.54	70.40	100.80	50.50
CHPC & Committee Meetings	1,342.95	199.60	51.00	30.00	542.35	---
Contract Services	112,430.00	---	112,430.00	---	---	---
Other:						
Legal	66.66	---	---	---	---	---
Subs. & Ref. Publications	979.20	---	---	---	---	---
Membership Dues	1,282.50	22.50	125.00	---	70.00	---
Telephone & Telegraph	4,066.70	271.60	363.23	282.33	363.23	210.93
Postage & Shipping	2,610.95	130.00	174.00	174.00	174.00	130.00
Newsletter	2,775.85	---	---	---	---	---
Rent	9,090.40	591.87	792.19	781.04	792.19	583.51
Insurance	389.00	25.28	33.84	33.84	33.84	25.28
Sub-Total Other	$ 21,261.26	$ 1,041.25	$ 1,488.26	$ 1,271.21	$ 1,433.26	$ 949.72
Total Expenditures	$294,778.31	$13,374.36	$136,539.43	$10,712.08	$13,183.70	$ 9,784.38

445 - Environmental Health Planning
460 - Health Facilities Planning
475 - Health Personnel Planning
485 - Mental Health Planning

APPENDIX J - State of Michigan Health Facilities Certification of Need Legislation, Act No. 256, Public Acts of 1972

(Source: State of Michigan 76th Legislature, Regular Session of 1972)

Act No. 256
Public Acts of 1972
Approved by Governor
August 8, 1972

STATE OF MICHIGAN

76TH LEGISLATURE

REGULAR SESSION OF 1972

Introduced by Rep. Huffman
Rep. Mahalak named as co-sponsor

Enrolled House Bill No. 4949

AN ACT to require certificates of need for new construction or conversion of, addition to or modernization of health facilities; to provide for the issuing of certificates of need; to establish a state health facilities commission; to provide fees and penalties; and to make appropriations.

The People of the State of Michigan enact:

Sec. 1. As used in this act:

(a) "Addition" means adding patient rooms to a health facility or the adding of ancillary service areas or other accommodations resulting in a single project cost including construction, engineering and fixed equipment in excess of an amount which shall be determined by the director with the approval of the state health facilities commission.

(b) "Certificate of need" means a certificate attesting to need for new construction, or conversion of, addition to or modernization of a health facility.

(c) "Commission" means the state health facilities commission established by this act.

(d) "Consumer" means any individual not connected, directly, with any person, organization, corporation or institution associated with the provision of health care and services. A doctor; nurse; administrator or operator of a hospital,

nursing home or home for the aged; agent or employee of a health insurance provider; a pharmacist; or one who contracts to perform services for the foregoing is not a consumer.

(e) "Conversion" means converting an existing building not previously licensed as a health facility to such use or converting of an area of any other institution to health facility use.

(f) "Department" means the department of public health.

(g) "Director" means the director of the department of public health.

(h) ~~"Health facility" means a hospital or any part thereof licensed by the department of public health in accordance with Act No. 17 of the Public Acts of 1968, being sections 331.411 to 331.430 of the Compiled Laws of 1948 or Act No. 263 of the Public Acts of 1913, as amended, being sections 331.401 to 331.406 of the Compiled Laws of 1948.~~

(i) ~~"Modernization of the physical plant" means a major upgrading, alteration or change in function of any part or area of a health facility resulting in a single project cost including construction, engineering and fixed equipment in excess of an amount which shall be determined by the director with the approval of the state health facilities commission. Modernization shall not include normal maintenance and operational expenses.~~

(j) "New construction" means construction of a health facility where a health facility did not exist or construction as a replacement for an existing health facility.

(k) "Person" means an individual, copartnership, corporation, association, agency, organization or unit of government including any receiver, trustee or assignee thereof.

Sec. 2. A state health facilities commission is created in the department of public health. The governor shall appoint the members with the advice and consent of the senate. The commission shall consist of 11 members, 6 of whom shall be designated in conformance with the requirements of Public Law 88-443. A majority of the members shall be consumers. Consumer members shall include 2 representatives from labor, 2 representatives from business and 3 representatives of the public. In appointing the first members of the commission, the governor shall designate 4 members for a term of 1 year, 4 members for a term of 2 years and 3 members for a term of 3 years. Thereafter, members shall be appointed for 3-year terms. A vacancy other than by expiration of term shall be filled by appointment by the governor with the advice and consent of the senate for the unexpired term. The members of the commission shall receive $40.00 per day for each full day while on commission business and $20.00 for each half day while on commission business and shall be reimbursed for actual expenses incurred in the performance of their official duties. Seven members constitute a quorum for the transaction of business. The chairman shall be elected annually by the members of the commission and shall be a consumer. The commission shall meet at the call of the chairman or the director and in any case at least twice a year.

Sec. 3. (1) The commission shall advise and consult with the director to implement the provisions of Act No. 17 of the Public Acts of 1968 and Act No. 299 of the Public Acts of 1947, as amended, being sections 331.501 to 331.516 of the Compiled Laws of 1948, and the requirements of Public Law 88-443.

(2) The commission shall review all applications for certificate of need

denied by the director and shall conduct hearings when requested pursuant to this act. Decisions made by the commission are binding on the director.

Sec. 4. A health facility shall not be constructed, converted, added to or modernized subject to section 1 (i) without first obtaining a certificate of need which documents a demonstrated need and grants permission for the proposed project. The director shall promulgate rules, after prior consultation with local and regional health planning agencies and the concurrence of the state comprehensive health planning advisory council, subject to the approval of the commission, in accordance with and subject to Act No. 306 of the Public Acts of 1969, as amended, being sections 24.201 to 24.315 of the Compiled Laws of 1948, to provide for the issuance of certificates of need. The director shall submit periodic reports to the commission concerning certificates of need issued and the reasons for granting the certificate. A certificate of need shall be consistent with but need not necessarily follow exactly the state plan for hospital and medical facilities construction and the policies and procedures governing the issuance of certificates of need required for projects under federal grant-in-aid programs or federal loan guarantee programs. In instances where a state or federal agency contracts with a health maintenance organization to render comprehensive health care services, a certificate of need may be waived for those inpatient and outpatient facilities that are necessary for the health maintenance organizations to achieve maximum effectiveness in rendering comprehensive health care services.

Sec. 5. Application for a certificate of need for new construction, conversion, addition to or modernization of a health facility, shall be made to the director on forms provided by him.

Sec. 5a. In evaluating an application for a certificate of need, the commission shall take into account the following factors and criteria:

(a) The patterns and level of utilization, availability and adequacy of existing facilities, institutions, programs and services, in the immediate community and region concerned.

(b) The degree to which the residents and physicians of the immediate community and region concerned, are provided access to the services and programs of the health facility applying for the certificate of need.

(c) The availability, and adequacy and promotion of services such as pre admission, ambulatory or home care services which may serve as alternatives or substitutes for inpatient or resident care.

(d) The possible economies and improvement in service to be derived from consolidation of highly specialized health facility services and from the operation of cooperative or shared central services including but not limited to laboratory, radiology, pharmacy and laundry service.

(e) The possible economies and improvement in patient or resident care to be anticipated from affiliation or other contractual arrangements between facilities, institutions and service agencies and organization.

(f) The availability of manpower.

(g) That the health facility does not discriminate because of race, religion, color or national origin in any area of its operations including but not limited to employment, patient admission and care, room assignment, and professional and nonprofessional selection and training programs.

(h) In the case of a nonprofit hospital, that such health facility is in fact governed by a body which is composed of a majority consumer membership.

(i) The applicant's ability to finance the project for which the certificate of need is requested and ability to finance the operation of the health facility following completion of the project.

(j) Local and regional rules, regulations and standards adopted by the appropriate local and regional areawide comprehensive health planning agencies which reflect the conditions, problems and resources of the various areas represented by such agencies and which are not inconsistent with the foregoing criteria.

(k) Such other factors and criteria which contribute toward the orderly development of quality health care for all citizens.

Sec. 6. Before issuing a certificate of need, the director shall take actions necessary to obtain all of the following:

(a) From the person applying for the certificate, evidence of his ability to finance the construction, conversion, addition or modernization project for which the certificate is requested and ability to finance the operation of the new, converted or modernized facilities following completion of the construction, conversion, addition or modernization.

(b) Recommendations from those local or regional area wide comprehensive health planning agencies designated by the office of comprehensive state health planning. Necessity for receiving the recommendations may be disregarded by the director when the recommendations are not provided within 30 days of written request for same. After receiving recommendations of the regional areawide comprehensive health planning agency or after expiration of the 30 days, the state department of public health shall act within 60 days. The applicant and the areawide planning agency shall be allowed to appeal a negative decision, based on causes shown by the department.

(c) Advice and counsel from the commission in those instances when local or regional areawide comprehensive health planning agency recommendations are not in agreement with the state plan for hospital and medical facilities construction prepared in accordance with Act No. 299 of the Public Acts of 1947, as amended.

Sec. 7. The director shall require from the person applying for a certificate of need a fee in the amount of ½ of 1% of the estimated cost of the new construction, conversion, addition or modernization of the health facility including cost of construction, engineering and equipment, subject to section 1 (i). The fee shall not exceed $500.00 for 1 certificate.

Sec. 8. If when the person who applies for a certificate of need is aggrieved by the decision of the director or if the recommendation of the local planning council is not accepted then he or the local planning council may request a hearing to be conducted by the commission in accordance with and subject to Act No. 306 of the Public Acts of 1969, as amended. If the certificate of need is not granted by the commission or the person who applies for the certificate of need is aggrieved by the decision of the commission, then he or the local planning council may appeal to the circuit court of the county in which the appealing health facility is located requesting an order reversing the decision of the commission in the same manner as is provided for a civil suit.

Sec. 9. Notwithstanding the existence and pursuit of any other remedy, in addition the commission or the director of public health may maintain an action in the name of the state for injunction or other process against any person to restrain or prevent the construction, conversion, addition or modernization

project, as described in this act, without a certificate therefor or in a manner contrary to law.

Sec. 10. The state health facilities council as established under Act No. 17 of the Public Acts of 1968 is abolished and its functions, powers and duties are transferred to the state health facilities commission.

Sec. 11. There is appropriated to the state department of public health from the general fund of the state for the fiscal year ending June 30, 1973, the sum of $60,000.00 or as much thereof as may be necessary to carry out the purposes of this act.

Sec. 12. This act shall not become effective unless and until House Bill No. 5574 of the 1971 regular session is enacted and becomes effective.

Clerk of the House of Representatives.

Secretary of the Senate.

Approved _____

_____

Governor.

APPENDIX K - State of Michigan Legislation Limiting the Ability of Blue Cross Insurance Co. to Refuse Payment to "Unapproved" Health Facilities, Act No. 233, Public Acts of 1972.

(Source: State of Michigan 76th Legislature, Regular Session of 1972)

HOSPITAL SERVICE CORPORATIONS—SUPERVISION AND REGULATION

PUBLIC ACT NO. 233

HOUSE BILL No. 5574

AN ACT to amend section 3 of Act No. 109 of the Public Acts of 1939, entitled "An act to provide for and to regulate the incorporation of non-profit hospital service corporations; to provide for the supervision and regulation of such corporations by the state commissioner of insurance; and to prescribe penalties for the violation of the provisions of this act," being section 550.503 of the Compiled Laws of 1948.

The People of the State of Michigan enact:

Section 1. Section 3 of Act No. 109 of the Public Acts of 1939, being section 550.503 of the Compiled Laws of 1948, is amended to read as follows:

M.C.L.A. § 550.503

Sec. 3. Any such corporation may enter into contracts for the rendering of hospital service to any of its subscribers only with hospitals maintained by the state, or any of its political subdivisions, or the board of regents of the university of Michigan, or maintained by a nonprofit corporation organized for hospital purposes. Any such corporation shall not deny on the basis of a lack of community need a participating hospital contract with any nonprofit or governmental hospital licensed by the department of public health in accord with Act No. 17 of the Public Acts of 1968, being sections 331.411 to 331.430 of the Compiled Laws of 1948, or any municipality owned hospital exempt from such licensing, providing that the participating hospital contract is applicable only to the number of acute general hospital beds certified on July 1, 1971 by the state department of public health to the state department of social services, or the number of acute general beds for which at least schematic plans for new construction or additions have been filed as of November 5, 1971 with the department of public health by hospitals that were licensed on July 1, 1971, or to the number of acute general hospital beds for which a certificate of need has been issued by the state department of public health; and further provided that the hospital has been accredited by either the joint commission on the accreditation of hospitals or the American osteopathic association. All contracts issued by such corporation to the subscribers shall constitute direct obligations of the hospital or hospitals with which such corporation has contracted for hospital service. The rates charged to the subscribers for hospital service, and the rates of payment of such corporation to the contracting hospitals, shall at all times be subject to the approval of the commissioner of insurance.

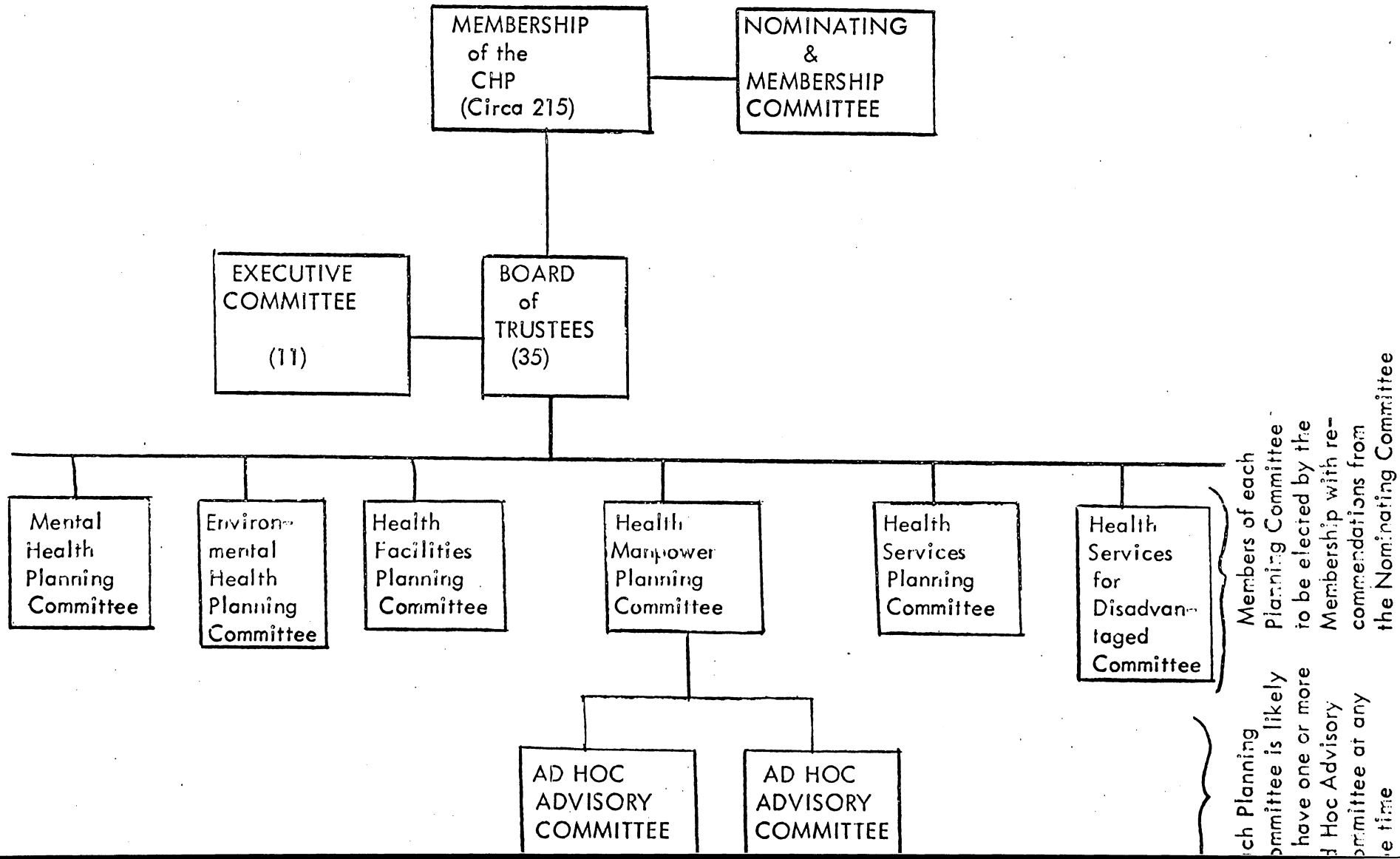
Section 2. This act shall not become effective unless and until House Bill No. 4949 of the 1971 Regular Session is enacted and becomes effective.

Approved July 27, 1972.

APPENDIX L - Committee Structure, CHP Council of Southeastern Michigan

(Source: 1970 CHPC-SEM Grant Application)

APPENDIX A
POSSIBLE ORGANIZATION CHART
FOR THE CHP OF SOUTHEASTERN MICHIGAN



APPENDIX M - Status Report on Grant Proposals Submitted to CHP Council of Southeastern Michigan, 1972

(Source: CHPC-SEM Document, January, 1973)

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

January-December 1972

No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-001	St. Joseph Mercy Hosp. of Detroit	Construction of New Wing	No Government Funds Requested	12-3-71	1-21-72	GDAHC Facilities Planning	Recommended in Principle	
72-002	Oakland Cty. Health Dept.	Construction of an addition and Remodeling of County Health Center	Hill Burton $140,000	2-28-72	3-7-72	GDAHC	Recommended	Approved by 1972 Board of Sup. 1973 Board will be reconsid-ering approval
72-003	Southeastern Michigan Family Planning Project	Expanded Budget	HSMHA $402,019	5-15-72	5-17-72	Community Development of Health Services Planning	Not Reviewed	Not Funded
72-004	Garden City	Garden City Ford Road-Middlebelt Renewal Project	HUD $1,557,434	1-7-72	1-10-72	Not Assigned to a Committee	Not Reviewed	Funded
72-005	City of Pontiac	Pontiac Reloca-tion Plan and Budget 1971-1972	HUD $4,300,000	12-22-71	1-18-72	Not Assigned to a Committee	Not Reviewed	Funded
72-006	Mich. Dept. of Public Health	Center for Health Statistics	HSMHA $2,193,062	12-6-71	1-24-72		No Comment	Funded
72-007	Mich. Cancer Foundation	Human Virus Containment Lab	Hill Burton $200,000	12-15-71	1-24-72	Health Facilities	Reviewed NO	Funded

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

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No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-008	Mt. Elliot Medical Center	HMO	HSMHA $51,300	2-3-72	2-3-72	Too Late to assign committee	No Comment	Not Funded
72-009	Wayne State University	Coordinated Patient Care Improvement Program for Small Inner-City Hospitals	RMP $82,530	1/72	1/72	No Committee Referral	No Action	Not Funded
72-010	Wayne State University	Proposal for Continuation of Planning Grant	RMP $236,610	1/72	1/72	No Committee Referral	No Action	Not Funded
72-011	Michigan State University	Lakeside Comprehensive Health Services Delivery System	RMP $119,649	1/72	1/72	No Committee Referral	No Action	Not Funded
72-012	Wayne State University	Stroke Base Center	RMP $63,140	1/72	1/72	No Committee Referral	No Action	Not Funded
72-013	Wayne State University	Southeastern Michigan Regional Cancer Program	RMP $267,739	1/72	1/72	No Committee Referral	No Action	Not Funded
72-014	Wayne State University	Development of an Evaluation & Treatment Center for Cerebrovascular Diseases	RMP $383,486	- '72	1/72	No Committee Referral	No Action	Not Funded
72-015	Zieger Botsford Hospitals	Michigan Osteopathic Planning & Project Development Program for	RMP $227,072	/72	1/72	No Committee Referral	No Action	Not Funded

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

January-December 1972

No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-016	Martin Place Hospital East/ Zieger/ Botsford Hosp	Stroke Day Care Center	RMP $56,177	1/72	1/72	No Committee Referral	No Action	Not Funded
72-017	Wayne County General Hosp	Demonstration of Comprehensive Health Care for the Urban Poor	RMP $484,919	1/72	1/72	No Committee Referral	No Action	Not Funded
72-018	Detroit Osteopathic Hospital	Stroke Demonstration Unit	RMP $140,786	1/72	1/72	No Committee Referral	No Action	Not Funded
72-019	Model Neighborhood Comprehensive Health Program	Program for Community Health Services Coordinators	RMP $146,537	1/72	1/72	No Committee Referral	No Action	Not Funded
72-020	Model Neighborhood Comprehensive Health Program	Community Based Comprehensive Hypertension Follow-Up Services & Prevention Prog.	RMP $127,987	1/72	1/72	No Committee Referral	No Action	Not Funded
72-022	Metropolitan Hospital	Parkvue Acquisition	Hill Burton $127,380	11/71	1/72	GDAHC Facilities	Recommended	Addition Acquired
72-023	Metropolitan Hospital	Addtion to Ambulatory Facilities	Hill Burton $270,000	1/72	2-16-72	GDAHC	Recommended	Construction begun
72-024	Det-Wayne County Comm. Mental Health	Improving Program Administration & Evaluation	Mich. Dept. of Mental Health $111,894	4-72	4-28-72	Mental Health	Recommended	Funded $95,040

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

January-December 72

No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-025	Southwest Comm. Mental Health Service	Southwest Crisis Center	Mich. Dept. of Mental Health $125,063	4-25-72	4-28-72	Mental Health	Recommended	Funded $100,000
72-026	Det-Wayne County Comm. Mental Health Board	Area B After Care Services	Mich. Dept. of Mental Health $122,720	4-25-72	4-28-72	Mental Health	Recommended	Not Funded
72-027	Pontiac State Hospital	Vinton Cottage Program	Mich. Dept. of Mental Health $9,790	4-14-72	4-15-72	Mental Health	Recommended	Funded $7,500
72-028	Mayor's Comm. for Human Resources	Drug Abuse Program	CEO $1,178,842	4-10-72	4-12-72	Mental Health	Recommended	Funded
72-029	Oakland Cnty Comm. Mental Health Board	Day Treatment for Emotionally Disturbed Children	Mich. Dept. of Mental Health $72,034	4-21-72	4-22-72	Mental Health	Recommended	Not Funded
72-030	U of M Inst. for Study of Mental Retardation & Related Disabilities	Occupational Therapy Consultation to Comm. Placement Parents	Mich. Dept. of Mental Health $31,415	4-26-72	5-5-72	Mental Health	Reviewed No Comment	Not Funded
72-031	Detroit Dept. of Health	Disease Control Immunization Prog.	Public Health Services $168,369	2-23-72	3-3-72	Environmental Health	Recommended	Grant Awarded
72-032	Detroit Dept. of Health	Lead Based Paint Poison Control Program	Public Health Services $357,346	2-28-72	2-29-72	Environmental Health	Recommended	Grant Awarded
72-033	U of M School of Public	Health Service Training Grant	OEO $222,491	2-16-72	3-7-72	Health Personnel	Recommended	Funded

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

January-December . 72

No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-034	Detroit Health Department	Family Health Center	HSMHA $317,027	2-29-72	3-2-72	Community Development of Health Services	Not Recommended	
72-036	Oakland Cnty Dept. of Health	HMO	HSMHA $65,579	12-10-71	2-10-72	Community Development of Health Services	Recommended	Not Funded
72-037	Health Council Inc.	Consumer Training Program	HSMHA $175,000	1-10-72	1-24-72	Community Development of Health Services	Recommended	Grant Awarded
72-038	Washtenaw County Mental Health	Development of Caretaking Functions in Clergy	Mich. Dept. of Mental Health $50,000	5-1-72	5-4-72	Mental Health	Not Recommended	Funded $26,000
72-039	Washtenaw County Comm. Mental Health	Behavioral Science for Children	Mich. Dept. of Mental Health $72,350	5-1-72	5-4-72	Mental Health	Recommended	Not Funded
72-041	Model Neighborhood	Environmental Improvement & Education	No New Funds	3-17-72	3-18-72	Environmental Health	Recommended	Grant Awarded
72-043	TimRoNanGo Center for Disturbed Children	Tim Ro Nan Go	Mich. Dept. of Mental Health $10,520	4-30-72	5-12-72	Mental Health	Recommended	Not Funded
72-044	U of M School of Public	Evaluation of Continuity of	Mich. Dept. of Mental Health	4-18-72	4-26-72	Mental Health	Reviewed No Comment	Funded $52,960

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

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No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-046	St. Joseph Hosp., Mt. Clemens	Construction of New Facility	No Funds	5-15-72	5-17-72	Health Facilities	Recommended	Construction Begun
72-047	Detroit Osteopathic Hospital	Construction of 7,900 Sq. Ft. Addition	No Funding	5-15-72	5-17-72	Health Facilities	Recommended	
72-048	South Macomb Hospital	Construction of New Wing	No Funding	5-15-72	5-17-72	Health Facilities	Recommended	Construction Begun
72-049	Wyandotte General Hospital	Construction of 8 Bed Psychiatric Addition	No Funding	5-15-72	5-17-72	Health Facilities	Recommended	
72-050	Wm. Beaumont Hospital	Construction of a New Wing	No Funding	5-15-72	5-17-72	Health Facilities	Recommended	
72-052	Wayne State Regional Medical Programs	Continuation of Planning Grant	RMP $182,463	1/72	3-16-72	Community Development of Health Services	Not Reviewed	Approved by State RMP
72-053	Detroit Medical Surgical Center	Family Health Center	HSMHA $79,650	4-14-72	4-19-72	Community Development of Health Services	Funding was recommended for one or the other of these proposals	Not Funded
72-054	Detroit Medical Surgical Center	HMO Continuation	HSMHA $61,150	4-14-72	4-19-72	Community Development of Health Services		
72-055	Det. Medical Foundation	HMO Continuation	HSMHA $70,000	4-10-72	5-2-72	" "	Not Reviewed	Grant Awarded

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

January-December 1972

No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-056	Southwest Det. Hosp. Comm. Health Prog.	Family Health Center	HSMHA $315,260	4-10-72	4-12-72	Community Development of Health Services	Recommended	
72-057	Kirwood Mental Hlth Center	Psychiatric Day Care Center	Mich. Dept. of Mental Health $87,647	5-1-72	5-3-72	Mental Health	Recommended	Not Funded
72-058	Comprehensive Neighborhood Health Serv.	Refunding	HSMHA $875,205	5-5-72	5-19-72	Community Development of Health Services	Not Recommended	Returned for Rewrite
72-059	Martha T Berry Medical Care Facility	Establishment of a Psychiatric Care Unit	No Funding	5-17-72	5-19-72	Mental Health	Recommended	Approved by Macomb County Board of Supervisors
72-060	Mich. Dept. of Mental Health	Oakland Medical Surgical Center	No Funding	2/72	5/72	GDAHC Facilities		
72-061	Macomb Cnty Comm. Mental Health Serv.	Delivery of Service	Mich. Dept. of Mental Health $43,750	3-10-72	4-4-72	Mental Health	Recommended	Not Funded
72-062	Macomb Cnty Comm. Mental Health Serv.	Psychiatric Day Care Center	Mich. Dept. of Mental Health $96,469	3-10-72	4-4-72	Mental Health	Recommended	Not Funded
72-063	Macomb Cnty Comm. Mental Health Serv.	Improving Preventive Service & Delivery of Service in North Macomb County	Mich. Dept. of Mental Health $42,420	3-10-72	4-4-72	Mental Health	Recommended	Not Funded

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

January-December 72

No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-064	Comprehensive Neighborhood Health Serv.	Refunding Request	HSMHA $1,400,000	6-28-72	7-3-72	Community Development of Health Services	Negative Comments	Funded
72-065	Sumby Memorial Hospital	Modernization Program	Hill Burton $576,000	6-29-72	6-30-72	Health Facilities	Recommended	
72-067	Wayne State University School of Medicine	Medical Information Services MIST	RMP $171,572	6-20-72	7-12-72	Health Personnel	Recommended	Funded
72-068	NUCARE and Wayne State University	NUCARE Inc.	RMP $155,100	6-28-72	7-20-72	Health Personnel	Returned for Rewrite	Funded
72-069	Wayne State University School of Medicine	TROIKA on Innovative Health Care Group	RMP $76,844	7-1-72	7-20-72	Community Development of Health Services	Not Recommended	Not Funded
72-070	University of Michigan Medical Center	A Model to Provide Consultation by a Center of Medical Expertise	RMP $18,122	6/72	7-20-72	Health Facilities	Recommended	Funded
72-071	University of Michigan Medical Center	Subregional Newborn Care in Community Hospitals	RMP $72,649	7-21-72	7-20-72	Community Development of Health Services	Recommended	Funded
72-072	University of Michigan Medical Center	Model Burn Care Training Program	RMP $109,049	5-17-72	7-20-72	Health Personnel	Recommended	Funded

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

January-December 72

No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-073	Pinckney Community Clinic	Establishment of a Pilot Satellite Clinic in Pinckney	RMP $27,003	5-15-72	7-28-72	Community Development of Health Services	Not Recommended	Not Funded
72-074	National League for Nursing	Course in Continuing Education	CHPC 314C $64,284	1-14-72	7-28-72	Health Personnel	Recommended	
72-075	Community Health & Social Service Center	Southwest Community Child & Family Center	HSMHA $484,700	5-31-72	8-1-72	Community Development of Health Services	Recommended	Not Funded
72-076	Communities United for Action	Study & Analysis of Health Service Needs	RMP $165,460	7-31-72	8-22-72	Community Development of Health Services	Not Reviewed	Not Funded
72-078	St. Joseph Mercy Hospital, Ann Arbor	Comprehensive Community Health Center	No Federal Funding requested, Estimated Construction Cost $46,459,000	9-20-72	9-27-72	GDAHC & Health Facilities	Recommended	Site Purchased
72-079	Wayne State University College of Nursing & Det-Wayne County Health Dept.	A Proposal for Training of a Core of Public Health Nurses for Implementation of Medicaid Screening	RMP $12,129	10-6-72	10-10-72	Community Development of Health Services	Not Reviewed	Funded
72-081	Consumer Training	Continuation Grant	CHP 314 $428,820	11-8-72	11-13-72	Community Development of		

STATUS REPORT ON GRANT PROPOSALS SUBMITTED TO CHPC FOR REVIEW & COMMENT

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No.	ORGANIZATION	TITLE OF PROPOSAL	AMOUNT REQUEST & FUNDING AGENCY	DATE OF PROPOSAL	DATE REC'D BY CHPC	COMMITTEE REFERRAL	COMMITTEE ACTION	FINAL ACTION
72-082	United Community Service of Metropolitan Detroit	Area Health Subsystems	RMP $24,170	11/72	11-20-72	Health Personnel	Favorable Comment	Funded
72-083	Northeast Guidance Center	Community Mental Health Center New Staffing Grant	NIMH $514,710	11-27-72	12-4-72	Mental Health		
72-084	Michigan United Conservation Clubs	Inter-County Environmental Center	Environmental Quality Education Act $42,995	9-14-72	11-1-72	Environmental Health	Negative Comments	
72-085	Detroit Health Department	Detroit Health Statistics System	National Center for Health Services 3 yr. $1,118,123 1 yr. $358,528	12-15-72	12-18-72	Facilities, Community Development of Health Services		
72-086	Brighton Hospital	Construction of Addition	No Federal Funds	10-2-72	12-11-72	Facilities, Mental Health		

APPENDIX N - A Brief History of the Columbus Hospital Federation

(Source: "A Case Study of An Operating Planning Agency: A Presentation, Institute for Staffs of Hospital Planning Agencies, Chicago, "The Columbus Hospital Federation, 1666 E. Broad Street, Columbus, Ohio, December 12, 1966)

INTRODUCTORY REMARKS

Evening Session, Wednesday, December 14, 1966

By Grant A. Drennen
Associate Executive Director, The Columbus Hospital Federation

We have been asked to present a case history of The Columbus Hospital Federation, and to do this three of our staff members will present three important functions performed by the Federation.

Our Executive Director, Delbert L. Pugh, was to set the stage for these presentations by giving an overview of Federation operations. He is convalescing at home, and I can make some personal observations that he might not have made.

It is most important to point out that the Federation was incorporated in 1945 and has been under the direction of the same professional leadership since that time with several of the original organizers still active in the organization. These factors have provided a continuity of purpose and stability that is perhaps unique in the field of community organization. The leadership and vision of Del Pugh and the community leaders he recruited cannot be praised highly enough in outlining these activities.

The Federation's prime purpose at the time of organization was the coordination of planning and financing of hospital development, but other purposes were included in the Code of Regulations which had to do with standards of patient care, public relations, negotiations and such other activities as the Board might decide to be in the interests of the community.

In the beginning, there was representation of many community organizations, and the Code of Regulations spelled out that hospital representatives were to be in the majority of Board Members. As the organization developed, membership on the Board shifted to individuals selected because of community leadership rather than individuals selected by other organizations. Since that time the Board has had representation of medicine, hospital administration, hospital trustees, and laymen from all segments of the community.

This structure existed for about 17 years in Franklin County, with a metropolitan population of about 700,000. Some $70,000,000 of hospital projects were coordinated during this period.

Then in 1962, a grant of funds from the Public Health Service made possible the expansion of council territory to include 35 other counties or about 44% of the land area of Ohio. I hesitate to add that this was not the desire of the Federation staff, but was instigated by the request of Blue Cross to include several counties beyond the original twenty-odd considered by the Staff

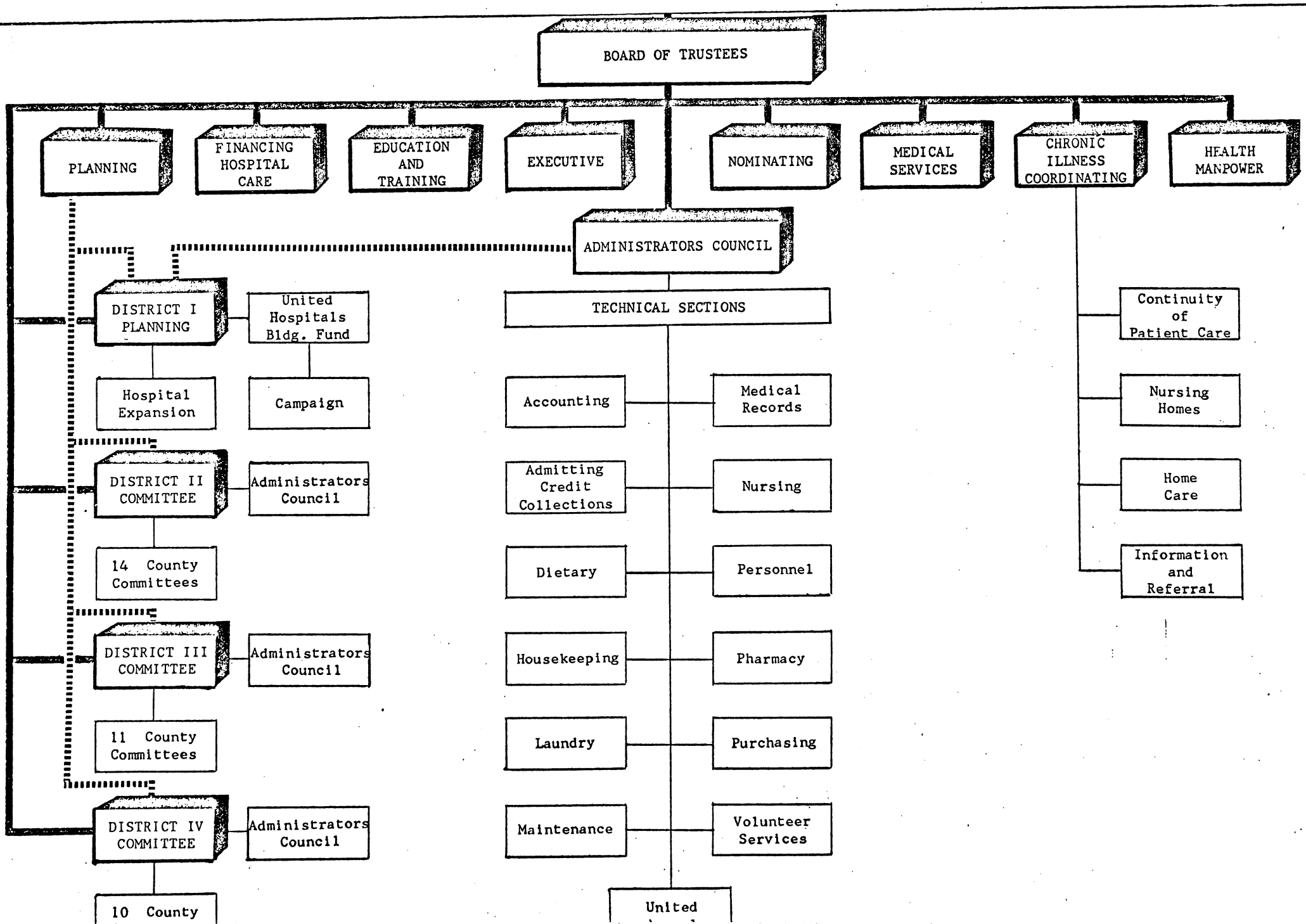
to be our patient watershed, and further instigated by the Ohio Hospital Association to include all counties of the Central District of O.H.A. It was agreed by our Board to include these counties in a study area with the provision that the area could be reduced by mutual consent of the Federation and the county involved. At the present time, no county has requested termination of the arrangement and all but one county is participating in financial sponsorship of the budget. Population of the area is 2.3 million people.

Our first plan was to use counties as building blocks or planning units and to group them in zones of three to five counties. This provided thirty-six county committees and nine zone committees. It was our thought that the zone committees would provide opportunities for meetings without extensive travel on the part of local representatives. However, experience proved that the zone meetings were too small to generate enthusiasm and difficult for the staff to administer. During this time we found out that most Counties were capable of generating enthusiasm within their own territory and could make planning decisions when provided with guidelines, data and professional staff assistance.

Upon recommendation of the staff, the Regional Planning Committee, representing the Zones and Counties, voted to realign the outside counties into 3 Districts of 10 - 14 counties with about the same number of general hospitals in each. Franklin County, with ten general hospitals and a population in excess of the other districts, was designated as District I. The District Organization provides a committee of about 35 representatives of counties, hospitals, medical societies, health departments, commerce and industry. These committees have an educational and administrative function rather than a review function which is now performed at the county level. Each District now has a functioning Administrators Council where the professionals in hospital management meet to discuss the technical matters of hospital administration. Each Chairman of the District Committees was nominated and elected to membership on the Federation Board of Trustees. It is anticipated that other outstanding citizens of the Districts will be nominated as Members-at-Large of the Board in future years.

Committees of the Board are being reorganized to include members from various parts of the region. It is expected that these committees will develop policies and programs for approval of the Board. These committees include Medical Services, Financing Hospital Care, Education and Training, Chronic Disease, Health Manpower and Planning. These changes are taking place slowly and careful attention is being given to the selection of outstanding individuals for these positions. Service on county and district committees will be a prerequisite in the future.

One of the considerations in the determination of District size was financial. We felt that the Districts should be able to support a full-time District Executive and the administrative overhead necessary to back him up with office staff. A rule of thumb used in these estimates is double the District Executive's salary which means that a district or service area should provide between $20,000 and $30,000 per year, or approximately $2,000 to $3,000 per year per county. On 50% matching grants, these amounts are reasonable and feasible. Al Hartmann can give you the details of formulae used to determine county allocations. As expected, the larger areas had to carry more of the financial burden until the service is developed and fully appreciated.


BOARD OF TRUSTEES
PLANNING
FINANCING HOSPITAL CARE
EDUCATION AND TRAINING
EXECUTIVE
NOMINATING
MEDICAL SERVICES
CHRONIC ILLNESS COORDINATING
HEALTH MANPOWER
ADMINISTRATORS COUNCIL
DISTRICT I PLANNING
United Hospitals Bldg. Fund
Hospital Expansion
Campaign
DISTRICT II COMMITTEE
Administrators Council
14 County Committees
DISTRICT III COMMITTEE
Administrators Council
11 County Committees
DISTRICT IV COMMITTEE
Administrators Council
10 County
TECHNICAL SECTIONS
Accounting
Medical Records
Admitting Credit Collections
Nursing
Dietary
Personnel
Housekeeping
Pharmacy
Laundry
Purchasing
Maintenance
Volunteer Services
United
Continuity of Patient Care
Nursing Homes
Home Care
Information and Referral

APPENDIX O - The Mid-Ohio Health Planning Federation Board of Trustees (1972)

(Source: 1972-1973 Mid-Ohio HPF Continuation Application)

THE MID-OHIO HEALTH PLANNING FEDERATION

BOARD OF TRUSTEES

The duties of the Board of Trustees are set forth in the Code of Regulations, a copy of which is included in the Appendix. The Board of Trustees includes:

	Provider	Consumer
(1) Robert Adams, D.V.M.* (Franklin) 181 Washington Blvd. Columbus, Ohio 43215	X	

Dr. Adams, the Deputy Health Commissioner of the Columbus Health Department, as long been recognized as a leader in Environmental Health. He was a member of the original staff group which prepared the Columbus Model Cities Application for the Mayor of Columbus. He has served for two years as Chairman of the Areawide Environmental Health Planning Committee and was elected to the Board as a Member-at-Large.

(2) Harvey H. Alston** (Franklin) 1893 Greenway South Columbus, Ohio 43219		X

Mr. Alston is a retired Police Inspector. He formerly served on the Governor's staff as Assistant Director of Urban Affairs. He is an expert in emergency ambulance services, having supervised the Police Department Emergency Squad operation in Columbus for many years.

(3) C. Edgar Ames (Delaware) 61 W. William St. Delaware, Ohio 43015		X

Mr. Ames, Manager of the Delaware office of the Columbus and Southern Ohio Electric Company, has served for the past two years as Chairman of the Delaware County Health Planning Council. He is a community leader and has a daughter who was a student nurse when he became a Federation member.

(4) John Barnhill, D.D.S. (Marion) 716 Richmond Ave. Marion, Ohio 43302	X	

Dr. Barnhill, a practicing dentist, has been a member of the Marion County Health Planning Council for several years.

	Provider	Consumer
(5) William E. Brown, M.D. (Franklin) 181 Washington Blvd. Columbus, Ohio 43215	X	

Dr. Brown, Health Commissioner of the City of Columbus, was formerly a member of the Clark County Health Planning Committee.

(6) George W. Byers, Sr. (Franklin) 46 E. Town St. Columbus, Ohio 43215		X

Mr. Byers, an automobile dealer and philanthropist, has been a leader in United Appeal and other community activities. For the past few years he served as Finance Chairman of the Franklin County Health Planning Council, and last year was elected a Vice President of the Federation.

(7) John E. Fisher (Franklin) 246 N. High St. Columbus, Ohio 43215		X

Mr. Fisher, President and General Manager of Nationwide Insurance Companies, has been a community leader in numerous activities. He served as Chairman of the Franklin County Health Manpower Committee and later as Chairman of the Areawide Health Manpower Committee.

(8) Howard Franz (Franklin) 174 E. Long St. Columbus, Ohio 43215	X	

Mr. Franz, President of Blue Cross of Central Ohio, has long been identified with financing of health care activities. He has also served as Campaign Chairman of the United Appeal, President of the Franklin County Red Cross, President of Rotary and President of the Navy League.

(9) Paul R. Gingher (Franklin) 311 E. Broad St. Columbus, Ohio 43215		X

Mr. Gingher, an attorney, has held most of the community leadership positions in Columbus and has served as International President of the American Automobile Association. For more than 25 years, he has been Chairman of the Metropolitan Committee which endorses and promotes

Mr. Gingher (Cont.)

county and municipal bond issues in Franklin County. He is President of the Grant Hospital Board, and a member of the County Hospital Commission. He was president of the Federation from 1960-1964.

(10) Ollie M. Goodloe, M.D.
(Franklin)
2532 Brookwood
Columbus, Ohio 43209 X

Dr. Goodloe, is the retired Health Commissioner of the City of Columbus. He has served on numerous committees and is currently Chairman of the Franklin County Health Manpower Committee.

(11) Robert W. Greer
(Franklin)
1694 King Ave.
Columbus, Ohio 43212 X

Mr. Greer has just retired as Secretary-Treasurer of the AFL-CIO Council (Central Labor Body). He has been active with the United Appeal and United Community Council, Red Cross, Blue Cross, Boy Scouts, and many other community organizations. As Labor's representative on the powerful Metropolitan Committee he has had great influence on capital improvements programs.

(12) William Habeeb, M.D.
(Clark)
1601 Woodedge
Springfield, Ohio 45501 X

Dr. Habeeb, as Health Commissioner for Springfield and Clark County, has served as Chairman of the Community Health Services Committee of the Clark County Health Planning Council.

(13) J. Arthur Hamilton, P.E.
(Marion)
121 W. Center St.
Marion, Ohio 43302 X

Mr. Hamilton, General Manager of Floyd G. Brown and Associates, Ltd., has an intensive interest in environmental health.

(14) Robert Hamilton, Esq.
(Union)
116½ S. Court St.
Marysville, Ohio 43040 X

Attorney Hamilton has been a leader in many community

		Provider	Consumer
	Robert Hamilton, Esq. (Cont.)		
	activities in Union County. He is especially interested in Mental Health and Retardation activities and is Chairman of the 648 Board for his area.		
(15)	T. Kline Hamilton (Franklin) 2250 E. Broad St. Bexley, Ohio 43209		X
	Mr. Hamilton, a retired President of the Diamond Milk Company, was formerly Campaign Chairman and President of United Appeal; a member of the Blue Cross Board; a member of two hospital Boards and a Trustee of Capital University. Mr. Hamilton served as President of the Federation during the transition from a Facilities to a Comprehensive Health Planning Agency.		
(16)	George T. Harding, Sr., M.D. (Franklin) 445 E. Granville Rd. Worthington, Ohio 43085	X	
	Dr. Harding has been described as "The Doctor Menninger of Ohio." As Medical Director of Harding (Psychiatric) Hospital, he is nationally known in the field of Psychiatry. He has served as State Chairman of most of the Governor's committees or commissions on mental health during the last 25 years, and is identified with numerous voluntary health agencies. He is currently Chairman of the Franklin County Committee on Mental Health and Mental Retardation Planning.		
(17)	Warren G. Harding, M.D., Ph.D. (Franklin) 309 E. State St. Columbus, Ohio 43215	X	
	Retiring from the practice of surgery, Dr. Harding earned a Ph.D. in Education and became Director of Medical Education for Grant Hospital of Columbus. From this position, he was selected to become Administrator of the Hospital, the position he now holds. An authority on medical practice throughout the Pacific Area, Dr. Harding has a special interest in Dietary Service.		
(18)	Richard Harley (Madison) 210 N. Main St. London, Ohio 43140	X	
	Administrator of Madison County Hospital, Mr. Harley has had experience and concern in the problems of health care		

Richard Harley (Cont.)

delivery in both urban and rural settings. He served on the Scioto County Health Planning Council prior to moving to London.

(19) Merle Hartle
(Pike)
530 Seal Ave.
Piketon, Ohio 45691 X

An engineering official of the Goodyear Atomic Corporation, Mr. Hartle is Chairman of the Pike County Health Planning Council. Mr. Hartle has a special interest in environmental health problems in the lower Scioto Valley. He is widely known as a leader in Lions Club activities in Ohio.

(20) Mrs. Evelyn Hausmann
(Licking)
1551 N. 21st St.
Newark, Ohio 43055 X

Mrs. Hausmann, a housewife, is a member of the Licking County Health Planning Council. She has been active in the Licking County Tuberculosis Association and served as Co-Chairman of the County Bond Issue Campaign Committee. She is a former member of the Board of Trustees of Licking County Memorial Hospital.

(21) Donald R. Haverick
(Franklin)
1111 E. Broad St.
Columbus, Ohio 43205 X

Mr. Haverick, President of Buckeye Union Insurance Company Division of Continental Insurance Company, has been a prominent Catholic layman in many Columbus activities. A former President of St. Ann's Hospital Board, he is a member of the County Hospital Commission.

(22) Clark A. Hess, D.D.S.
(Ross)
33 W. Main St.
Chillicothe, Ohio 45601 X

A practicing dentist, Dr. Hess has played a prominent role in the operations of the Ross County Health Planning Council. Dr. Hess has been especially interested in health manpower programs.

	Provider	Consumer
(23) Frederick B. Hill (Franklin) 980 Parsons Ave. Columbus, Ohio 43206		X

Mr. Hill, Chairman of the Board of the Miraplas Tile Company, has long been an outstanding Methodist layman. A former President of Riverside Methodist Hospital, he is currently Chairman of The Columbus Foundation, which is a large non-profit foundation receiving and dispensing philanthropy. Mr. Hill has also been prominently identified with the YMCA. A former Vice President of the Federation, he is currently Chairman of the Franklin County Health Planning Council.

(24) William H. Jackson
(Fairfield)
P. O. Box 415
Lancaster, Ohio 43130 X

Mr. Jackson, President of Diamond Power Specialty Company, a Division of Babcock & Wilcox, is Chairman of the Fairfield County Health Planning Council. He formerly served as Chairman of the County Environmental Health Committee in which he has great interest.

(25) Rev. Msgr. W. E. Kappes
(Licking)
66 Granville Rd.
Newark, Ohio 43055 X

The Pastor of St. Francis DeSales Church, Msgr. Kappes is Chairman of the Licking County Health Planning Council. As a member of the Bishop of Columbus' staff, he was prominently identified with health and welfare activities in Ohio for many years.

(26) Albert H. Kessler
(Franklin)
303 E. Broad St.
Columbus, Ohio 43215 X

An official of Columbus Mutual Life Insurance Company, Mr. Kessler has represented the health insurance industry in many activities. As an elected official of the Health Insurance Council and HICHAP, he participated in many conferences and seminars on health care. For the past two years he chaired the Federation's committee to develop the Columbus Health Insurance Program (CHIP), a program to provide a pre-paid health insurance program for the residents of the Columbus Model Cities area. His knowledge and plans are being utilized in the development of Health

	Provider	Consumer
Albert H. Kessler (Cont.)		
Maintenance Organization plans under the aegis of the Areawide Committee on Financing Health Care Committee which he now chairs.		
(27) William S. Konold (Franklin) 1087 Dennison Ave. Columbus, Ohio 43201		X
Mr. Konold is a business consultant who also serves as Executive Director of Doctors Hospital (North and West). As Executive Director of the Ohio Osteopathic Association for many years he exercised great influence in raising both the medical standards and the public acceptance of Osteopathic Medicine and hospital administration. A former Department Commander of the American Legion, he was instrumental in starting both the Buckeye Boys State and the Highway Patrol Auxiliary programs.		
(28) Russell Kross (Ross) 14 Coventry Court Chillicothe, Ohio 45601		X
Mr. Kross, a former employee of the Ohio Department of Health, is a member of the research staff of the Mead Paper Corporation and is keenly interested in environmental health. As Chairman of the Ross County Health Planning Council, he has broadened his leadership to include all aspects of health planning.		
(29) Bernard J. Lachner (Franklin) The Ohio State University 190 N. Oval Dr. Columbus, Ohio 43210		X
Mr. Lachner now serves as Vice President for Administrative Operations of the University. He is a former President of the Ohio Hospital Association and former Vice Chairman of the Federation Administrators Council.		
(30) Howard LeFevre* (Licking) 134 Everett Ave. Newark, Ohio 43055		X
Mr. LeFevre, owner of a motor freight company, has been a community leader in Newark for many years. A former President of Licking County Memorial Hospital, he served as Vice Chairman of the Areawide Facilities Committee and is now its Chairman.		

	Provider	Consumer
(31) Robert Lehman, Esq. (Clark) 327 Ardmore Springfield, Ohio 45501		X

An attorney, Mr. Lehman represents the Clark County Health Planning Council.

(32) Edgar O. Mansfield, Dr. P.H. (Franklin) 3535 Olentangy River Rd. Columbus, Ohio 43214	X	X

Dr. Mansfield, Administrator of Riverside Methodist Hospital, is Chairman of the Areawide Administrators Council. He is past national President of the American Protestant Hospital Association and past President of the Ohio Hospital Association.

(33) John N. Meagher, M.D. (Franklin) 1275 Olentangy River Rd. Columbus, Ohio 43212	X	

Dr. Meagher, a practicing neurosurgeon, is the immediate past President of the Academy of Medicine of Columbus and Franklin County. For a number of years he has served on various Federation committees.

(34) Richard L. Meiling, M.D. (Franklin) 410 W. 10th Ave. Columbus, Ohio 43210	X	

Dr. Meiling, former Dean of the College of Medicine, is the Vice President for Medical Affairs of The Ohio State University. He served on numerous national health and medical commissions.

(35) Walter C. Mercer (Franklin) 51 N. High St. Columbus, Ohio 43215		X

Mr. Mercer, President of the Ohio National Bank, is a community leader in many activities. He continues to serve as Treasurer of the Federation and Chairman of the Areawide Finance Committee. He is a trustee of the Columbus Foundation, a director of the Columbus and Ohio Chambers of Commerce and a member of the Advisory Committee of the Franklin County Multiple Sclerosis Society.

	Provider	Consumer
(36) Rev. M. J. Mitchell** (Franklin) 1628 Granville St. Columbus, Ohio 43203		X

The Rev. Mitchell is the elected President of the Model Neighborhood General Assembly. He is quite knowledgeable in the health needs of inner city residents.

(37) Rev. Robert H. New
(Knox)
100 E. High St.
Mt. Vernon, Ohio 43050 — X

The Rev. New, Rector of St. Paul's Episcopal Church in Mt. Vernon, is Chairman of the Knox County Health Planning Council.

(38) Thomas Nichols
(Scioto)
Municipal Bldg.
Portsmouth, Ohio 45662 — X

Mr. Nichols, the Health Commissioner for the City of Portsmouth, has served as Chairman of the Scioto County Health Planning Council and currently is Vice Chairman. He has had leadership positions in many health organizations and is the immediate past District Chairman of the Southeast District of the Ohio Public Health Association.

(39) Mrs. Sterling Poling
(Pickaway)
R.F.D. #4
Circleville, Ohio 43113 — X

Mrs. Poling, a farmer and housewife, has taken an active part in the Community Fund and other organizations of Pickaway County. She continues to serve as Chairman of the Pickaway County Health Planning Council.

(40) H. William Porterfield, M.D.
(Franklin)
1100 Morse Rd.
Columbus, Ohio 43224 — X

Dr. Porterfield, a plastic surgeon, is a past President of the Academy of Medicine of Columbus and Franklin County and is active in many health organizations.

	Provider	Consumer
(41) John Rhoads (Fayette) Box 535 Washington Court House, Ohio 43160		X

Mr. Rhoads, a building contractor, is a member of City Council and the County Board of Health.

(42) Reed Robertson (Clark) 14 Lowry Ave. Springfield, Ohio 45501		X

Mr. Robertson, President of the Robertson Can Company, is the Chairman of the Clark County Health Planning Council and a member of the Tri-County RMP Council.

(43) Richard W. Rowles (Fairfield) Anchor Hocking Corporation Lancaster, Ohio 43130		X

As Assistant Treasurer of the Corporation, Mr. Rowles represents his company in many community activities and is quite knowledgeable on the financing problems of health organizations.

(44) Harrison M. Sayre (Franklin) 485 S. Parkview Bexley, Ohio 43209		X

A retired publisher, Mr. Sayre has served as a member of Bexley City Council, and was instrumental in founding the City Planning Commission of Columbus, the Regional Planning Commission and the Federation. He has been a leader in the Columbus Foundation, United Appeal, United Community Council, Community Services Council, Development Committee of Greater Columbus and many others. He is a past President of the Federation and now Chairman of the Health Facilities Planning Committee of Franklin County.

(45) Robert Short** (Franklin) 1841 Bryden Rd. Columbus, Ohio 43205		X

Mr. Short now directs the Alcoholism Program for the Franklin County 648 Board. Previously he served on the Federation staff as Director of the Columbus Health Insurance Program. He is a former President of the Model Cities General Assembly.

	Provider	Consumer
(46) Norman R. Sleight (Licking) 1440 Granville Rd. Newark, Ohio 43055		X

Mr. Sleight, District Manager for State Farm Insurance Company, has been a leader in health and hospital matters in Newark for many years.

(47) Adelbert D. Theobald (Morrow) Morrow County Hospital Marion Rd., Route 95 Mt. Gilead, Ohio 43338	X	

Mr. Theobald, Hospital Administrator, has been an outstanding leader in civic as well as health affairs in Morrow County. He serves as Chairman of the Morrow County Health Planning Council.

(48) Lowell Thompson (Scioto) 1805 27th St. Portsmouth, Ohio 45662	X	

Mr. Thompson, Administrator of Scioto Memorial Hospital, serves as Executive Secretary of the Scioto County Medical Society; has been a member of the School Board, Red Cross, Community Fund and many other boards. He has been active in Federation affairs for ten years and has twice served as Chairman of the Scioto County Health Planning Council.

(49) Raymond Troyer (Logan) Hi-Point Day School Route #4 Bellefontaine, Ohio 43311	X	

Mr. Troyer, an educator, has been active in Federation affairs for several years.

(50) Charles A. Turner (Franklin) 1450 Hawthorne Ave. Columbus, Ohio 43203	X	

Mr. Turner, a Registered Nurse, served in the Hospital Corps of the Navy in World War II; completed his Graduate Degree in Hospital Administration, and is especially interested in Model Cities health problems. As Administrator of St. Anthony Hospital in the Model Cities area, he has given great cooperation in this area. As a member

		Provider	Consumer
	Charles A. Turner (Cont.)		
	of the Board of Trustees of the Franciscan Sisters of the Poor which operates several hospitals in the midwest, Mr. Turner has been a staunch advocate of community planning.		
(51)	Robert Vaughn, Esq. (Clark) First National Bank Bldg. Springfield, Ohio 45501		X
	Mr. Vaughn, an attorney, has been a civic leader in Clark County and serves on the Clark County Health Planning Council.		
(52)	Roger Williams, D.D.S. (Champaign) 409 Scioto St. Urbana, Ohio 43028	X	
	Dr. Williams, a practicing dentist, has been the advocate for health planning in Champaign County for many years.		
(53)	Richard M. Wolfe (Franklin) 62 E. Broad St. Columbus, Ohio 43215		X
	Mr. Wolfe, President of a radio-television broadcasting corporation and philanthropist, has given freely of his time and money for health, welfare and cultural activities. He serves as Chairman of the United Hospitals Campaign which raised $5 million for hospitals in 1965. He has served as Chairman of Mental Health Associations, Columbus Symphony, Art Gallery, etc. He is a trustee for Capital University and Columbus School for Girls. He has served as Chairman of the Areawide Facilities Committee and currently serves as Vice President of the Federation and Chairman of the Areawide Mental Health and Mental Retardation Planning Committee.		
(54)	Hon. Eugene Yazel* (Marion) City Hall Marion, Ohio 43302		X
	Mayor Yazel, as President of the Board of Health and Marion General Hospital, has a comprehensive view of health problems. He is a member of the State Advisory Council on Comprehensive Health Planning, and a Vice President of the Federation.		

	Provider	Consumer
(55) Harold L. Yochum, D.D. (Franklin) 814 Pleasant Ridge Ave. Bexley, Ohio 43209		X

Dr. Yochum, President Emeritus of Capital University, has long been associated with health, welfare, educational and recreational activities in mid-Ohio. His University has a Baccalaureate Nursing program and he has served as a trustee of Grant Hospital for several years. A long-time trustee of the Federation, he is currently President.

TOTAL	21	34

TRUSTEES EMERITI

(1) John D. Connor, Esq. (Franklin) 8 E. Broad St. Columbus, Ohio 43215		X

Mr. Connor is an attorney, and has served as legal counsel of the Federation for many years. He was Chairman of the first hospital planning committee in the "middle forties;" served as President of the Columbus Hospital Federation from 1947 to 1950, and Trustee Emeritus since 1965. He has served as legal counsel of the Ohio Hospital Association, and has served on numerous top level Diocesan Committees of Columbus. He has arranged numerous trusts and endowments for the benefit of Franklin County citizens. He has been a member of the County Hospital Commission of Franklin County since 1955.

(2) Clair E. Fultz (Franklin) 17 S. High St. Columbus, Ohio 43215		X

Chairman of the Board of the Huntington National Bank, Mr. Fultz is a past President, 1964 to 1967, past Vice President and past Treasurer of the Federation. He has been a Trustee Emeritus since 1965. He is Chairman of the Board of Directors of Battelle Memorial Institute and has been an officer or director of nearly every major philanthropic organization in Columbus.

APPENDIX P - Code of Regulations for the Mid-Ohio Health Planning Federation

(Source: 1972-1973 Mid-Ohio HPF Continuation Application)

CODE OF REGULATIONS FOR THE MID-OHIO HEALTH PLANNING FEDERATION

(Formerly THE COLUMBUS HOSPITAL FEDERATION, Incorporated January 12, 1945)

ARTICLE I NAME

The name of this corporation shall be The Mid-Ohio Health Planning Federation.

ARTICLE II PURPOSES

Section 1. Promote the health of all the people within the planning area through the development of a comprehensive, coordinated system of health services, utilizing existing patterns of private professional practice of medicine, dentistry and related healing arts while preserving the rights of individual institutions and agencies.

Section 2. Study, project, plan and make recommendations on an areawide basis in order to make available to the people of the planning area the highest quality hospital and related health facilities and health care at the lowest practicable cost.

Section 3. Develop policies, planning procedures and objectives leading to a comprehensive areawide health plan, to improve the system for providing physical, mental and environmental health programs, health services, health facilities and health manpower.

Section 4. Provide planning assistance to individuals, institutions, organizations, agencies or groups, public and private, in developing and implementing their plans.

Section 5. Establish a system for gathering and analyzing data on the pertinent characteristics and health problems and the availability, development and utilization of health services, facilities and manpower programs within the area.

Section 6. Provide liaison and information services to the general public, appropriate agencies and organizations at the Federal, state and local levels, which have a role in health planning, to keep them informed about planning progress and decisions, research findings, legislative or other significant developments.

Section 7. Provide advice and recommendations to individuals, institutions, agencies and organizations, including the need for adequate financial support for construction and operating funds; and where appropriate, to establish priorities of health needs in review of local applications for grants and proposals for initiating or expanding health and health related programs.

Section 8. Interpret programs of the corporation and its affiliated organizations to the general public.

Section 9. As authorized by the Board of Trustees, to perform such other activities on behalf of the membership as may contribute to the improvement of health services including, but not limited to, educational programs and services.

Section 10. To receive and acquire by gift, donation, bequest devise, purchase or otherwise hold, sell or dispose of any money, real estate, stocks, bonds, evidences of indebtedness and other property of whatsoever nature.

Section 11. NOT-FOR-PROFIT PURPOSE

This corporation is organized exclusively for charitable, research and educational purposes as a not-for-profit corporation, and its activities shall be conducted for the aforesaid purposes in such a manner that no part of its net earnings shall inure to the benefit of any member, director, officer, or individual. Upon dissolution of the corporation and after payment of just debts and liabilities, all remaining assets shall be distributed to organizations enjoying an exempt status under Section 501 (c) (3) of the Internal Revenue Code of 1954, as amended, or successor provisions. The corporation shall not substantially engage in carrying on propaganda or otherwise attempting to influence legislation.

ARTICLE III MEMBERSHIP

Section 1. Individual - Any individual, appointed or elected to a standing committee, council or Board of Trustees, shall be considered a member of the corporation, and shall be eligible to vote at the annual meeting or at any special meeting of the general membership.

Section 2. Affiliate Corporation Members - Any non-profit corporation may apply for membership and, if accepted, shall be entitled to one official member eligible to vote at the annual meeting or at any special meeting of the general membership.

Section 3. Sustaining or Associate Membership - Corporations for profit who wish to provide sustaining funds may apply for sustaining or associate membership and, if accepted shall be entitled to one non-voting member who may attend the annual meeting or any meeting of the general membership.

Section 4. General Consideration - Every effort shall be made to secure members from every county representing all individuals who are especially interested in the health field. Occupation, race, color, creed or sex shall not bar any individual from membership.

ARTICLE IV BOARD OF TRUSTEES

Section 1. Governing Authority - The general governing authority of the organization shall be vested in a Board of Trustees.

Section 2. Selection -

a) Each county participating in the program of the corporation shall have a minimum of one member on the Board of Trustees.

b) Consumers of health services shall constitute a majority of the membership of the Board of Trustees. No person, whose major occupation is the administration of health activities or performance of health services, shall be considered a Consumer representative.

c) The Board of Trustees shall be composed of 55 members, 50 of whom shall represent the several participating counties in the area in proportion each respective county bears to the total population of the area, and five members elected at-large to maintain a majority Consumer representation or to make available to the Board the services of persons of particular value or skills.

d) Each participating county health planning council shall nominate one or more representatives (see paragraph (c) preceding) for the consideration of the Nominating Committee, whose responsibility it will be to prepare a slate of Board of Trustee nominees for election at the annual meeting of the corporation.

Section 3. Term of Office -

a) All members of the Board of Trustees shall serve for one year, but may be reelected.

b) Officers shall serve for one year, but may be reelected; however, the President shall be limited to three years in office and shall not be eligible for further election as President until one year has elapsed.

c) All members of the Board and officers shall serve until their successors are elected.

Section 4. Vacancies -

a) Should a vacancy occur on the Board of Trustees in the category of county representation the respective county health planning council shall nominate a new representative.

b) Should the vacancy be created by a Member-at-Large, the President shall request the Nominating Committee to nominate a new member.

c) Ratification by the Board at the next meeting shall constitute election to fill the vacancy.

Section 5. General Duties - The Board of Trustees shall decide all questions of major policy, determine the general duties and functions of the corporation and secure financial support. It shall employ an Executive Director and is hereby empowered to do all things necessary to accomplish the purposes as set forth in Article II.

Section 6. Officers and Duties - The Board of Trustees shall be elected at each annual meeting at which time the following officers shall also be elected:

a) President
b) Two or more Vice Presidents
c) Treasurer
d) Secretary
e) Assistant Secretary

The duties of the officers shall be those usually pertaining to such offices in addition to those expressly provided for herein. The Executive Director shall serve as Secretary of the Board.

Section 7. Meetings - The Board of Trustees shall meet at least quarterly. In addition to regular meetings, the Board shall hold such special meetings as may be called by the President or by written request of six or more members. The President or Executive Director shall notify all members of the Board of special meetings not less than ten days prior to the meeting. Only that business for which the special meeting has been called shall be considered at any special meeting.

Section 8. Quorum - One-third of the members of the Board of Trustees shall constitute a quorum at any meeting but at no time shall action be taken by the concurring vote of less than a majority of those present.

Section 9. Proxy Voting - Each County Council shall determine the manner in which alternate representation is provided if the elected representative or representatives of the county are unable to attend a meeting of the Federation Board of Trustees. Written notification shall be provided to the Secretary of the Federation Board of Trustees prior to the convening of the meeting. Such notification should state who is to represent whom and should be signed by the County Chairman, or in his absence, by one of the Vice Chairmen.

Section 10. Annual Meeting - The annual meeting shall be held each year on a date designated by the Board of Trustees. Written notice shall be given to all members of the corporation at least fifteen days prior to the meeting. At the annual meeting the members of the Board of Trustees and officers of the corporation shall be elected.

ARTICLE V EXECUTIVE COMMITTEE

Section 1. Executive Committee - The Board of Trustees may designate the officers and a minimum of four other members of the Board of Trustees to act as an Executive Committee.

Section 2. Authority - The Executive Committee shall have the authority to act for the Board between meetings of the Board of Trustees, except that in no case shall the Executive Committee take any action contrary to the known general policies of the Board, nor shall the Board be obligated for any unbudgeted amounts aggregating more than $1,000.00 without its consent.

Section 3. Meetings - The Executive Committee shall meet at the call of the Chairman.

Section 4. Quorum - One-third of the members of the Committee shall constitute a quorum.

Section 5. Reports - The Executive Committee shall make a report of all actions taken by it to the Board of Trustees at the next meeting of the Board.

ARTICLE VI NOMINATING COMMITTEE

Section 1. Each year the President shall appoint a Nominating Committee of not less than five members of the Board of Trustees who shall serve through the next annual meeting.

Section 2. Board Nominations - The Nominating Committee shall be provided with the names of those nominated to represent participating counties and shall nominate Members-at-Large to comply with Article IV, Section 2 of this code and to bring the Board to the number which may be specified by the Board of Trustees and ratified by action at the annual meeting as provided in Article IV, Section 2 of this code.

Section 3. Officer Nominations - The nominating Committee shall also prepare a list of nominees for the offices set forth in Article IV, Section 6 of this code.

Section 4. Vacancies - Between annual meetings, the Nominating Committee may be convened by the President, as set forth in Article IV, Section 4.

ARTICLE VII EXECUTIVE DIRECTOR

Section 1. The Executive Director shall be the chief staff executive of the corporation and shall exercise day to day supervision over the business of the corporation and its staff. He shall have the authority to employ or discharge any worker on the staff after consultation with the President; shall cause records to be kept of the meetings of the Board of Trustees, of the membership and of all committees, shall give or cause to be given notices of all meetings when notices are required by these regulations and shall perform such other duties that may be assigned by the Board of Trustees.

ARTICLE VIII STANDING COMMITTEES

Section 1. Standing committees may be appointed or dissolved by the President with approval of the Board of Trustees or may be designated by resolution adopted by a majority of the Trustees at a meeting at which a quorum is present. Persons may be designated as such committee members who are not members of the Board of Trustees. Special emphasis shall be given to the establishment of committees to deal with the problems of health services, facilities, manpower and environmental health.

ARTICLE IX COUNTY HEALTH PLANNING COUNCILS

Section 1. Every county participating in the program of the corporation shall organize a county health planning council, whose responsibility it shall be to carry out planning for local problems affecting the sub-regions involved. Such activities shall be conducted in accordance with the general policies and recommendations of the Board of Trustees on which the county shall be represented.

County health planning councils shall fulfill the same conditions as required of the Board of Trustees in that they shall have representation of local government, civic, socio-economic and ethnic groups, and professional and institutional representation. (The suggested sample By-laws for County Health Planning Councils appended hereto were adopted on December 17, 1969.)

ARTICLE X CONTRACTS

Section 1. The Board of Trustees may authorize any officer or officers, agent or agents, of the corporation to enter into any contract or execute and deliver any instrument in the name of and on behalf of the corporation and such authorization may be general or confined to specific instances.

ARTICLE XI AMENDMENTS

Section 1. This Code of Regulations may be amended by the concurring vote of two-thirds of the Board of Trustees present, provided that copies of the proposed amendment have been sent to all members of the Board not less than ten days before the meeting at which the vote of such proposed amendment is to be taken.

(With Appendix - "Sample By-laws for County Health Planning Councils" adopted in final form on December 17, 1969.)

APPENDIX Q - Sample By-Laws for Mid-Ohio Health Planning Federation County Health Planning Councils

(Source: 1972-1973 Mid-Ohio HPF Continuation Application)

APPENDIX TO CODE OF REGULATIONS

SAMPLE BY-LAWS FOR COUNTY HEALTH PLANNING COUNCILS

ARTICLE I NAME: The name of this organization shall be "The _____ County Health Planning Council."

ARTICLE II PURPOSE: The purposes for which this organization is formed are to provide comprehensive health planning within the boundaries of this county, and to participate with other counties in an area-wide voluntary comprehensive health planning effort through the Mid-Ohio Health Planning Federation (formerly The Columbus Hospital Federation), from whose charter the county council shall draw its authority. No action shall be taken contrary to the Code of Regulations or known policies of the Federation.

Specific interest shall include, but not be limited to:

(a) Community Health Services
(b) Health Facilities
(c) Health Manpower
(d) Environmental Health
(e) Mental Health & Mental Retardation
(f) Financing Health Care

ARTICLE III MEMBERSHIP: Membership shall be open to any resident of this county who demonstrates an interest in health matters. Race, color, creed, national origin, age, sex, occupation, or economic status shall not bar any individual from membership. Any individual appointed to a committee, council or board shall be a member of the county council.

ARTICLE IV BOARD OF DIRECTORS:

Section 1. Governing Authority - The general governing authority of the county organization shall be vested in a county Board of Directors.

Section 2. Selection

(a) The Board of Directors shall consist of individuals nominated by the Nominating Committee and elected at the Annual Meeting.

(b) Consumers of health services shall constitute a majority of the membership of the Board. (A consumer, as intended here, is a person who is not gainfully employed as a planner, administrator or provider of health services.)

(c) The minimum size of the Board shall be fifteen members, but may be increased if the Board so recommends and the Annual Meeting elects the additional members.

Section 3. Term of Office

All members of the Board of Directors shall serve for one year, but may be re-elected. The term of office shall coincide with those of the parent corporation - The Mid-Ohio Health Planning Federation.

Section 2. Authority - The Executive Committee shall have the authority to act for the Board in the interim between meetings, except that in no case shall the Executive Committee take any action contrary to the known general policies of the Board.

Section 3. Meetings - The Executive Committee shall meet at the call of the chairman.

Section 4. Quorum - One-half of the members of the Executive Committee shall constitute a quorum.

Section 5. Reports - The Executive Committee shall make a report of all actions taken by it to the Board of Directors at the next meeting of the Board.

ARTICLE VI NOMINATING COMMITTEE

Section 1. Appointment - The Chairman of the Board of Directors shall appoint a Nominating Committee of not less than three members of the Board of Directors, who shall serve through the next Annual Meeting.

Section 2. Board Nominations - The Nominating Committee shall present a slate of members for nomination as members of the county Board of Directors for consideration of the Annual Meeting.

Section 3. Officer Nomination - The Nominating Committee shall also prepare a list of nominees for the offices set forth in Article IV, Section 6 of this document.

Section 4. Vacancies - During the interim between Annual Meetings, the Nominating Committee may be convened by the Chairman of the Board, as set forth in ARTICLE IV, Section 4, to fill vacancies in the Board of Directors.

ARTICLE VII COUNTY COMMITTEES

Section 1. Standing Committees - In addition to the committees enumerated above, the Chairman of the Board of Directors shall appoint the following committees:

(a) Community Health Services Committee

(b) Health Facilities Committee

(c) Health Manpower Committee

(d) Environmental Health Committee

(e) Finance Committee

Section 2. Areawide representation - The chairman of each standing committee shall serve on the Federation (Areawide) Committee of the same name to represent the county in the development of policies and procedures.

ARTICLE VIII ADDITIONAL COMMITTEES - The Chairman of the Board of Directors may appoint additional committees as may be deemed advisable by the Chairman, or by the Board of Directors.

ARTICLE IX AMENDMENTS.

This document may be amended by the concurring vote of two-thirds of The Board of Directors present, provided that copies of the proposed amendment have been sent to all members of the Board not less than ten days before the meeting at which the vote of such proposed amendment is to be taken.

GAD:jgm

Adopted by BOARD OF TRUSTEES on December 17, 1969

APPENDIX R - Sources of Mid-Ohio Health Planning Federation Support During the 1971-1972 Year

(Source: June 1972 Mid-Ohio HPF Annual Report of Progress)

SOURCES OF FEDERATION FINANCIAL SUPPORT DURING THE 1971-1972 YEAR

LICKING COUNTY:	Licking County Memorial Hospital, Newark Licking County Commissioners, Newark Licking County Medical Society, Newark
LOGAN COUNTY:	Logan County Health Planning Council, Bellefontaine Mary Rutan Hospital, Bellefontaine United Fund of Logan County, Bellefontaine
MADISON COUNTY:	Madison County Hospital, London Madison County Commissioners, London City of London
MARION COUNTY:	Community Memorial Hospital, Marion Marion General Hospital, Marion Marion County Commissioners, Marion City of Marion
MORROW COUNTY:	Morrow County Hospital, Mount Gilead
PICKAWAY COUNTY:	Berger Hospital, Circleville Pickaway County Commissioners, Circleville
PIKE COUNTY:	Pike County Hospital, Waverly
ROSS COUNTY:	Chillicothe Hospital, Chillicothe Ross County Commissioners, Chillicothe
SCIOTO COUNTY:	Mercy Hospital, Portsmouth Scioto Memorial Hospital, Portsmouth Southern Hills Hospital, Portsmouth
UNION COUNTY:	Memorial Hospital of Union County, Marysville Union County Health Planning Council, Marysville
AREAWIDE:	Blue Cross of Central Ohio Blue Cross of Southwestern Ohio Aetna Life & Casualty Insurance Company American Cancer Society

NOTE: Many agencies contributed through their County Health Planning Councils.

SOURCES OF FEDERATION FINANCIAL SUPPORT DURING THE 1971-1972 YEAR

CHAMPAIGN COUNTY: Mercy Memorial Hospital, Urbana

CLARK COUNTY: Community Hospital of Springfield & Clark County, Springfield

FAIRFIELD COUNTY: Fairfield County Health Planning, Council, Lancaster
Lancaster-Fairfield Hospital

FAYETTE COUNTY: Fayette County Health Planning Council, Washington C.H.
Fayette County Memorial Hospital, Washington C.H.

FRANKLIN COUNTY: Benjamin Franklin Hospital, Columbus
Children's Hospital, Columbus
Doctors Hospital, Columbus
Grant Hospital, Columbus
Harding Hospital, Worthington
Mercy Hospital, Columbus
Mount Carmel Hospital, Columbus
Riverside Methodist Hospital, Columbus
Saint Ann's Hospital for Women, Columbus
Saint Anthony Hospital, Columbus
The Ohio State University Hospitals, Columbus
Academy of Medicine of Columbus & Franklin County, Columbus
Columbus Board of Health, Columbus
Battelle Memorial Institute, Columbus
Big Bear Stores, Columbus
George W. Byers, Sr., Columbus
City National Bank, Columbus
Columbia Gas of Ohio, Inc., Columbus
Columbus Foundation, Columbus
Columbus Mutual Life Insurance Company, Columbus
Ernst & Ernst, Columbus
Federal Glass Company, Columbus
Huntington National Bank, Columbus
Kauffman-Lattimer Company, Columbus
F & R Lazarus Company, Columbus
Midland Mutual Life Insurance Company, Columbus
Nationwide Insurance Company, Columbus
Ohio National Bank, Columbus
James R. Riley, Columbus
Ross Laboratories, Columbus
State Auto Insurance Company, Columbus
Westinghouse Appliance Division, Columbus
Wolfe Associates, Columbus

KNOX COUNTY: Bert W. Martin Memorial Hospital, Mount Vernon

APPENDIX S - Projects Reviewed by the Mid-Ohio Health Planning Federation and List of Publications for the 1971-1972 Year

(Source: June 1972 Mid-Ohio HPF Annual Report of Progress)

PROJECTS REVIEWED

1971 - 1972

	County	Applicant	Title of Project	Total Cost & Amount Requested
7/6/71	Fairfield	Lancaster City Health Dept.	Field Evaluation Program to determine causes of High Leucocyte Counts in Milk	$ 4,156. 1,900
8/20/71	Fairfield	District Board of Health	Fairfield County Home Health Services	12,260 5,300
7/9/71	Pickaway	Village of Ashville	Construction of Sanitary Interceptor Sewer-Ashville	334,800 94,900
7/19/71	Ross	City of Chillicothe	South Central Ohio Speech & Hearing Center	25,900 12,691
7/27/71	Franklin	The OSU Hospitals	Training Program Rehabilitation Nursing	37,777 13,327
7/8/71	Ross	Village of Bainbridge	Sewage Treatment Plant & Collection System	--- ---
7/8/71	Clark	Belle Manor Nursing Home	26 bed addition	--- ---
7/29/71	Fayette	Fayette Memorial Hospital	(Letter of intent to develop master plan)	---
7/26/71	Licking	Licking County Memorial Hospital	(Letter of intent to change usage of 16 EC beds)	---
8/4/71	Pike	Village of Beaver	(Letter of intent to develop complete sanitary sewage system)	---
7/12/71	Knox	Village of Gambier	Purchase & Expansion of Water System	780,244 390,122

(Cont'd.)

	County	Applicant	Title of Project	Total Cost & Amount Requested
7/30/71	Delaware	Ohio Wesleyan University	Solid Waste Technology Assessment	$ 96,000
8/18/71	Areawide		Columbus Health Care Plan, Inc.	129,320
9/1/71	Ross	City of Chillicothe	Interceptor Sewer Extension to Hospital & Sewage Treatment Plant	2,552,000 625,400
9/3/71	Franklin	Franklin Co. Program for the Mentally Retarded	Construction of MR Classrooms (5)	---
9/15/71	Pickaway/ Fayette	Village of New Holland	Sewage Development Facilities in New Holland	710,000 665,000
9/16/71	Franklin	Children's Hospital	Rubella, Lab., Education & Research Program	35,000 17,000
9/23/71	Fairfield	Village of Sugar Grove	Secondary Waste Water Treatment Plant	216,250 108,125
9/24/71	Scioto	City of Portsmouth	Emergency Employment Funds	18,000 ---
9/24/71	Ross	City of Chillicothe	Personnel-Air Pollution Control Program	27,300 ---
9/24/71	Ross	City of Chillicothe	Personnel-Speech & Hearing Clinic	16,800 ---
10/7/71	Fairfield	Bloom Township	Emergency Medical Service	---
10/10/71	Fayette	Fayette County Health Dept.	Emergency Employment Funds	---

(Cont'd)

	County	Applicant	Title of Project	Total Cost & Amount Requested
10/10/71	Fayette	Village of Jeffersonville	Emergency Ambulance Service	$ ---
10/7/71	Franklin	Clinton Township	Emergency Medical Service	---
10/12/71	Fairfield	Fairfield County 648 Board	Fairfield County Mental Health Facility	840,000 750,000
10/14/71	Licking	City of Pataskala	Emergency Medical Service	---
10/18/71	Ross	Ross County General Health District	Supplemental Project to Family Planning	19,510. 8,760.
10/21/71	Franklin	City of Whitehall	Emergency Ambulance Service	---
10/25/71	Champaign	Champaign Soil & Water Conservation District	Resource Conservation & Development	---
10/27/71	Fayette	City of Washington Court House	Emergency Ambulance Service	---
11/1/71	Licking	Kirkersville	Emergency Ambulance Service	---
11/8/71	Franklin	Columbus Health Dept.	Detoxication Center	489,000 ---
11/9/71	Madison	Madison County Hospital	Emergency Ambulance Service	---
11/10/71	Licking	Mary Ann Township	Emergency Ambulance Service	---
11/10/71	Ross	Ross County	Emergency Ambulance Service	---

(Cont'd.)

	County	Applicant	Title of Project	Total Cost & Amount Requested
11/18/71	Franklin	Mount Carmel East (Letter of Intent)	Emergency Service	$3,200,000
11/18/71	Franklin	Family Medical Group - Lincoln Village	HMO	---
11/15/71	Ross	City of Chillicothe	Extension of Sewer & Water Lines to Industrial Park	123,000
11/25/71	Fairfield	Fairfield County Commissioners	Lancaster-Fairfield Hospital	11,154,590
11/25/71	Licking	Northview Nursing Home	4 bed addition	---
12/23/71	Fairfield	Crestview Manor Nursing Home	Extension - Certificate of Need - Expansion & Modernization 100 beds	---
1/10/72	Fayette	Fayette County Commissioners	Emergency Medical Service Improvement	---
1/28/72	Clark	Health Dept. City of Springfield	Environmental Health Nuisances 123	5,190. 2,400.
1/26/72	Clark	Clark County Health Department	Environmental Health Nuisance Project No. G1-A	8,297. 2,900.
1/28/72	Fairfield	City of Baltimore	Emergency Medical Service	---
2/1/72	Franklin	City of Upper Arlington	Emergency Medical Service	---

(Cont'd.)

	County	Applicant	Title of Project	Total Cost & Amount Requested
2/13/72	Ross	Deiber Convalescence Center	New 50 bed Convalescent Center	$ ---
2/16/72	Pickaway	Hoover's Nursing Home	25 beds	---
3/7/72	Ross	Sheriffs of Ross County	Improvement of emergency medical service	---
3/10/72	Fairfield	City Health Dept.	Lancaster Health Dept. Program to determine causes of milk contamination	3,948 1,900
3/15/72	Champaign	Village of Mechanicsburg	New Water Treatment Plant	--- 160,000
3/20/72	Franklin	Truro Township	Emergency Medical Services	---
3/22/72	Franklin	ECCO	ECCO Family Health Center	---
3/28/72	Marion	City of Marion Board of Health	Multiphasic Medical Screening Clinic	24,820 12,100
3/29/72	Licking	City of Newark Board of Health	Water Treatment Plant Improvements	158,000
3/31/72	Licking	National Volunteer Fire Department	Improvement of Emergency Medical Services	---
4/4/72	Areawide	RMP - AHEC	AHEC	60,000
4/6/72	Franklin	Columbus City Health Dept.	Improvement of Environmental Health Services	53,586 19,400
4/10/72	Areawide	ORMP	Improvement of Ohio Nursing Home Project	---

(Cont'd.)

	County	Applicant	Title of Project	Total Cost & Amount Requested
4/11/72	Franklin	Columbus City Health Dept.	Speech Service - Priority to the Aphasic Patient	$ 22,343 10,000
4/11/72	Franklin	Columbus City Health Dept.	Quality of Life of the Older Residents in Metropolitan Housing Projects	37,506 15,000
4/12/72	Franklin	Benjamin Franklin Hospital	TB Control Project	46,177 19,712
4/12/72	Franklin	OSU	Field Service in Speech & Language for Aphasics	61,683 30,405
4/17/72	Marion	Marion Health Foundation	HMO	109,900 95,000
4/18/72	Marion	Smith Foundation, Inc.	HMO	197,091 79,925
4/24/72	Franklin	Columbus Health Care Plan, Inc.	HMO	129,320
4/28/72	Marion	City of Marion	Construction of Wastewater Treatment Facility & New Intercepting Sewer	8,473,000 2,346,900
5/15/72	Pickaway	Audrey Kearns	100 bed Nursing Home	---
5/11/72	Union	Union County Health Dept.	TB Registry & Control Program	2,457 1,200
5/17/72	Champaign	City of Urbana	Water Treatment Plant Expansion	1,638,000 (Estimated
5/18/72	Champaign	Champaign County Health Dept.	Public Health Nursing Program	4,608
5/19/72	Logan	Logan County Health Dept.	Improvement of Child Home Services	9,722 4,744

(Cont'd.)

	County	Applicant	Title of Project	Total Cos & Amount Requested
5/25/72	Franklin	Sharon Township	Emergency Medical Services Assistant	---
5/15/72	Marion	City of Marion	Emergency Medical Services Assistant	---

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PUBLICATIONS

1971 - 1972

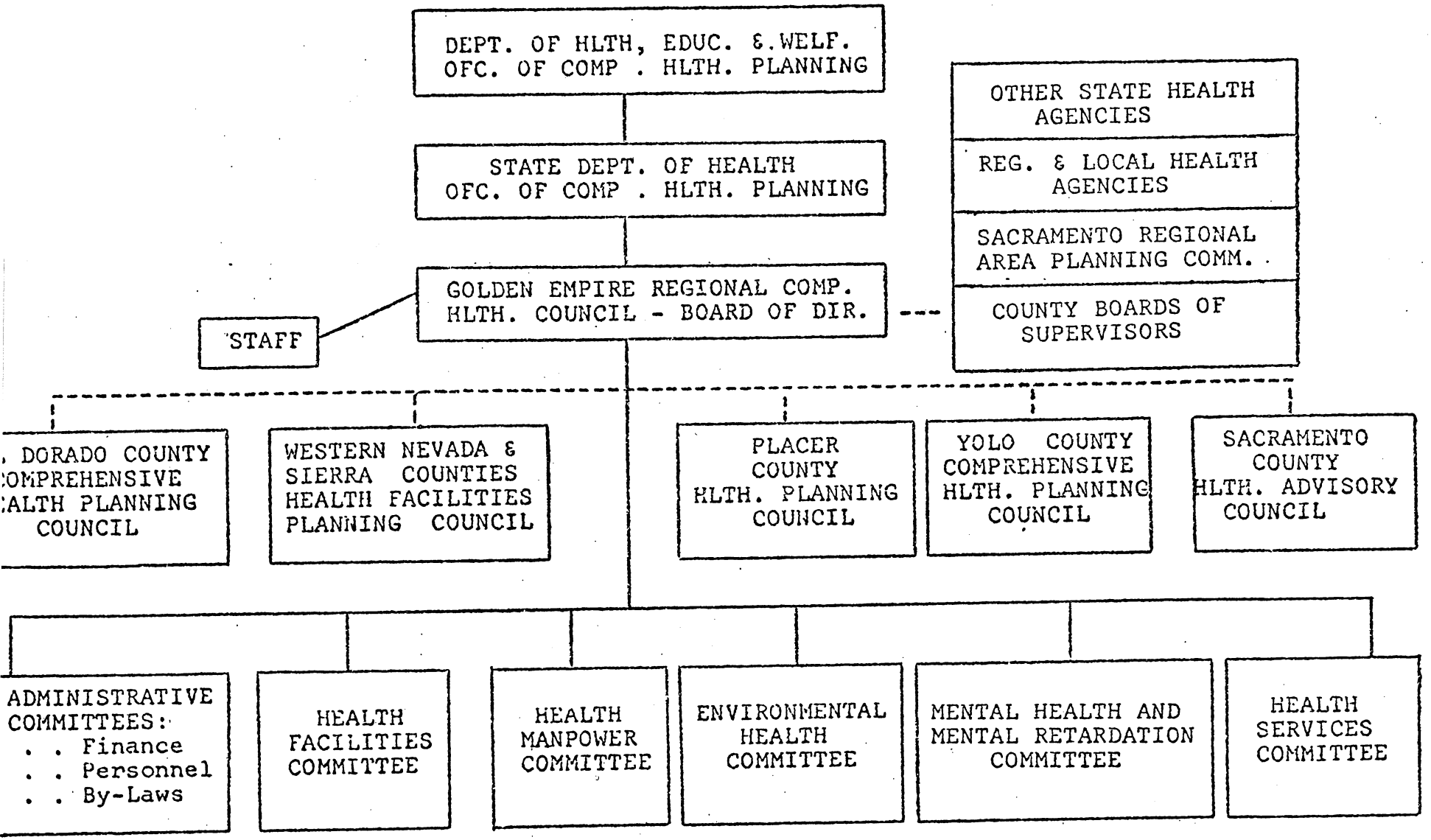
Hospital Discharge Planning Seminar Proceedings
Clark County Comprehensive Health Survey
The Development of Methodology for Evaluating Health Organizations
Health Manpower Inventory for 17 Counties
Hospital Utilization and Patient Origin Report
Morrow County Health Services Directory
Marion County Health Services Directory (ready in two weeks)
Knox County Health Services Directory (ready in two weeks)
An Areawide Plan for Water Planning
Mental Health Directory for Licking County
Health and Hospital Services Survey for Champaign County
Third Edition of News Media Guide to Hospitals
Health Planning Procedures Manual
Appalachia - Pike, Ross and Scioto Counties
Mental Health Services for Children
Fayette County Memorial Hospital Study
Mary Rutan Hospital Study

APPENDIX T - Organizational Chart, Golden Empire Regional Comprehensive Health Council

(Source: GECHC Document, February, 1970)

GOLDEN EMPIRE REGIONAL COMPREHENSIVE HEALTH COUNCIL, INC.

ORGANIZATIONAL CHART



ATTACHMENT #6

APPENDIX U - Regulations Relating to Health Facilities Planning in California

(Source: California Administrative Code, Title 17, Public Health)

Regulations Relating to HEALTH FACILITIES PLANNING

Excerpt from the

California Administrative Code

TITLE 17, PUBLIC HEALTH

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
744 P Street
Sacramento, California 95814

CHAPTER 7. HEALTH FACILITIES PLANNING

Detailed Analysis

Introduction

Several years of experience in voluntary health planning have been augmented by recently enacted Federal and State legislation. The purpose of the legislation is to enhance, encourage and support the voluntary action of consumers and health professionals in the health planning process.

Most recently the State of California through Chapter 1451, 1969 Statute, has expressed a need for coordination in order that capital expenditures, operating funds and manpower utilization for health facilities will be made primarily in the best interest of the community. The State Health Planning Council has the responsibility of establishing guiding principles to assist voluntary area and local health planning agencies in the performance of their responsibilities for health facility planning.

The responsibilities of voluntary area and local health planning agencies are to assist in the coordinated development of hospitals and other health facilities of desirable size, location and commitment to community service purpose. The statute establishes a process for review of health facility applications to construct, expand or alter bed capacity or licensure category. Hearings and appeals are provided in the law.

Article 1. Definitions

40500. State Health Planning Council. (a) The State Health Planning Council, created in response to Public Law 89-749, is composed of 21 members; 12 members appointed by the Governor, three by the Chairman of the Senate Committee on Rules, three by the Speaker of the Assembly, the Director of the Department of Public Health, the Director of the Department of Mental Hygiene, and a state official concerned with health.

(b) The classification of members by profession or occupation or interest is shown in Section 437, Health and Safety Code.

NOTE: Authority cited: Sections 208, 437.7 and 437.8, Health and Safety Code. Reference: Sections 437.7 through 438.5, Health and Safety Code.

History: 1. New chapter 7 (Sections 40500 through 40532, not consecutive) filed 10-22-70 as an emergency; effective upon filing (Register 70, No. 43).

40500.5. State Health Planning Agency. (a) The State Health Planning Agency is defined by Section 437.5(a) of the Health and Safety Code as follows:

> "437.5. (a) The Governor shall designate a state health planning agency in order to comply with Section 314 of Public Law 89-749, after receiving the recommendation of the council. The council shall approve the comprehensive health plan to be submitted to the federal government. The budget of the agency for the expenditure of planning money and health grant funds shall be submitted to the council for its recommendation before its submission to the Governor and the Legislature."

40501. **Voluntary Area Health Planning Agency.** (a) For the purpose of this chapter, a voluntary area health planning agency is a nonprofit corporation meeting the criteria set forth in Section 437.7(a) to (g), inclusive, of the Health and Safety Code, approved by the Health Planning Council after notice and public hearing, to assure availability of objective and impartial review of proposed projects for new, additional, or revised hospitals and related facilities, including facilities licensed by the Department of Mental Hygiene.

(b) Only one voluntary health planning agency shall be approved for any designated area of the state.

40502. **Voluntary Local Health Planning Agency.** (a) For the purpose of this chapter, a voluntary local health planning agency is a nonprofit corporation meeting the criteria set forth in Section 437.7(a) to (g), inclusive, of the Health and Safety Code, approved by the voluntary area health planning agency for the purpose of more efficient health facility planning, or following an appeal by the local applicant (within 30 days) after an unfavorable decision or lack of a decision and after notice and public hearing and approval of the State Health Planning Council.

(b) The State Health Planning Council may not approve the designation of an area which creates a local agency serving less than one complete county unless the population to be served by a proposed local agency is at least 1,000,000 persons. In no event, however, shall the population within the remainder of such county be less than 1,000,000 persons.

40503. **Exemptions.** (a) Proposed construction, expansion, or alterations to increase bed capacity or to change license category for the following are exempt:

(1) Institutions which are not required by the Welfare and Institutions Code and Regulations of the Department of Mental Hygiene to have a medical director, an organized medical staff or resident medical staff, or to provide professional nursing services by a registered nurse or supervisor of nursing services by a licensed registered nurse, a graduate nurse, a licensed vocational nurse, or psychiatric technician.

(2) Facilities which have been approved for federal or state funds pursuant to Chapter 3, commencing with Section 430, Health and Safety Code.

(3) Applicants who have filed applications for licenses prior to January 1, 1970 which meet all requirements and regulations of the appropriate state agency existing at the time of the application, including at least preliminary plans, and who commence construction of their facility prior to July 1, 1971.

(b) The exemption provided for in (a)(3) above shall not apply to transferees of the application of such exempt applicants.

Article 2. Applications

40506. Application Required—Planning. (a) Any person, political subdivision of the state or governmental agency desiring a license to cover a new health facility, additional bed capacity or conversion of existing bed capacity to a different license category, except outpatient and emergency services shall file an application with the local voluntary health planning agency, if none, with the voluntary area health planning agency, containing the information required by Section 437.9 of the Health and Safety Code, as follows:

"437.9. Every application to a voluntary area or local area health planning agency shall include at least the following information:

(a) The general geographic area to be served;
(b) The population to be served, broken down by age and sex, as well as projections of population growth, broken down by age and sex;
(c) The anticipated demand for the health care service or services to be provided;
(d) A description of the service or services to be provided;
(e) Utilization of existing programs within the area to be served offering the same or similar health care services;
(f) The benefit to the community which will result from the development of the facility as well as the anticipated impact on other institutions offering the same or similar services in the area."

(b) Such other information as may be required for the proper review and planning for health facilities.

40507. Application Required—Health. Prior to establishing, conducting or maintaining a health facility to which persons may be admitted for overnight stay or longer, file with the Bureau of Health Facilities Licensing and Certification, State Department of Public Health, an application on a form prescribed, prepared and furnished by the Department containing information required by Section 252 (a)(1) to (9) inclusive, and (b), Title 17, California Administrative Code.

40508. Application Required—Mental. (a) Any person, association or corporation desiring a license to cover a new private institution for mentally ill or other incompetent persons, additional bed capacity or conversion of existing bed capacity to a different license category, except for outpatient and emergency services, shall file an application with the local voluntary health planning agency or, if none, with the voluntary area health planning agency, containing information as required by Section 40506(a)(1) to (7), inclusive.

(b) Prior to establishing or keeping for compensation or hire, an establishment for care, custody, or treatment of the mentally ill or other

incompetent persons referred to in Division 7 (Mentally Irresponsible Persons), file with the Division of Local Programs, State Department of Mental Hygiene, including the information required by Section 40, Title 9, California Administrative Code.

(c) A verified statement on a form prescribed, prepared, and furnished by the Department containing information required by Section 40506(b)(8)(A) to (E), inclusive.

Article 3. Fees

40510. Fees. (a) In addition to application fees required by the Departments of Public Health and Mental Hygiene, each application to Health Planning Agencies shall be accompanied by a filing fee based upon demonstrated costs according to a schedule acceptable to the Department of Public Health.

(b) The fee shall not exceed $2,000.

(c) Each applicant's petition for appeal shall be accompanied by a fee of $50.

(d) Each applicant's petition to the Health Planning Council for a hearing on the decision or appeal shall be accompanied by a fee of $100.

40512. Special Fee. Each health facility licensed pursuant to Chapter 2 (commencing with Section 1400), Division 2, Health and Safety Code, and each facility required to be licensed by the Department of Mental Hygiene pursuant to Chapter 1 (commencing with Section 7000) of Division 7, Welfare and Institutions Code (except facilities exempted by Section 7003.3), shall annually on or after November 23, 1970, concurrent with application for licensure pay a special fee to the Department of Public Health or the Department of Mental Hygiene, as applicable. The amount of the fee shall be determined in accordance with Chapter 1906, Statutes of 1970, and not to exceed $4.00 per bed maintained for the use of patients, exclusive of bassinets, of hospitals, and not more than $1.50 per bed maintained for use of patients in nursing homes, similar mental facilities and intermediate care facilities.

Article 4. Organization and Duties

40513. Duties of the Health Planning Council. (a) The duties of the Health Planning Council include those specified in Section 437.5(b) and (c) of the Health and Safety Code, as follows:

> "(b) The Health Planning Council shall advise the agency in the conduct of its comprehensive health planning activities and in the setting of priorities. The council shall review all project grant applications for public funds that relate to health and which are administered either directly or indirectly by state agencies, except funds appropriated by the Legislature. Such review shall include the priority of each project, its relationship to projects funded under the provisions of the Comprehensive Health Planning Act, Public Law 89-749, and its relationship to statewide health needs.

"(c) The Health Planning Council may require state and other public agencies to submit data on publicly administered or financed health programs pertinent to effective planning and coordination under the provisions of Public Law 89-749."

(b) The Health Planning Council shall develop general principles to guide voluntary area and local area health planning agencies as shown in Section 437.8(a) to (e), inclusive, of the Health and Safety Code.

40514. Criteria for Approving Voluntary Area Health Planning Agencies. (a) A voluntary area health planning agency must be capable to fulfill the criteria provided by Section 437.7, Health and Safety Code:

"437.7. In order to assure availability of objective and impartial review by planning groups (referred to as voluntary area health planning agencies) of hospitals and related facilities, including facilities licensed by the Department of Mental Hygiene, or proposed projects for new, additional or revised hospital and related health facility projects, including facilities licensed by the Department of Mental Hygiene, the Health Planning Council, from time to time, shall approve no more than one voluntary area health planning agency for any designated area of the state, provided such group shall meet the following criteria:

"(a) Shall be incorporated as a nonprofit corporation and be controlled by a board of directors consisting of a majority representing the public and local government as consumers of health services with the balance being broadly representative of the providers of health services and the health professions.

"(b) Shall review information on utilization of hospitals and related health facilities.

"(c) Shall develop principles for the determination of community need and desirability to guide hospitals and related health facilities in acting in the public interest. Such principles shall be consistent with the general guidelines developed by the Health Planning Council in accordance with Section 437.8.

"(d) Shall conduct public meetings in which members of the health professions and consumers will be encouraged to participate.

"(e) Shall review individual proposals for the construction of new or additional hospital and related health facilities, the conversion of one type of facility to a different category of licensure or the creation or expansion of new areas of service, and make decisions as to the need and desirability for the particular proposal in accordance with the principles developed pursuant to subdivision (c).

"(f) Individual proposal review shall be in accordance with administrative procedures established by the Health Planning Council, which shall include, but need not be limited to:

"(1) A public hearing.
"(2) Reasonable notice.
"(3) Right to representation by counsel.
"(4) Right to present oral and written evidence and confront and cross-examine opposing witnesses.
"(5) Availability of transcript at applicant's expense.
"(6) Written findings of fact and recommendations to be delivered to applicant and filed with the State Department of Public Health as a public record.
"(g) Shall have a plan to finance the procedure which shall include, but not necessarily be limited to, filing fees and charges for processing and appeal."

40516. Administrative Procedures for Voluntary Area Health Planning Agencies. (a) In accordance with Section 437.7, subdivision (f) of the Health and Safety Code, "Individual proposal reviews shall be in accordance with administrative procedures established by the Health Planning Council, which shall include, but need not be limited to:

"(1) A public hearing."

A public hearing on an application to construct, expand or alter for the purpose of increasing bed capacity or changing licensing category of a health facility shall be held by the board of directors of the voluntary area or local health planning agency, or by a committee of such board, or by a committee designated by such board.

"(2) Reasonable notice."

A public notice at least 7 days in advance of all hearing and public meetings shall be provided by certified mail to applicants and be published in a newspaper of general circulation in the area involved.

"(3) Right to representation by counsel."

The applicant, the planning agency and persons so requesting have the right to representation by counsel.

"(4) Right to present oral and written evidence and confront and cross-examine opposing witnesses."

All persons so requesting shall be permitted to present written statements and, within the reasonable discretion of the hearing body, may present oral statements. Right to cross-examination shall be restricted to the applicant and the area health planning agency, or to their representatives.

"(5) Availability of transcript at applicant's expense."

Minutes and verbatim recording of each hearing must be maintained and provision made for transcript of hearing at applicant's expense.

"(6) Written findings of fact and recommendations to be delivered to applicant and filed with the State Department of Public Health as a public record."

All interested parties shall be entitled to prompt notice of and full access to the findings, recommendations, and decisions of hearing bodies and planning agencies. Reasonable means shall be used to accomplish the public notification of the findings, recommendations, and decisions of bodies participating in the health facilities planning process.

(b) The specific language of Section 437.7, subdivision (f), Health and Safety Code, implies the necessity for additional procedures:

(1) A public hearing must be held by a minimum of five persons, a majority of whom shall be consumers;

(2) The findings of fact and recommendations of the hearing body must be made by concurrence of a minimum of five persons, who were present at the hearing, a majority of whom shall be consumers;

(3) Subsequent to the filing of the findings of fact and recommendations, any person who presented an oral or written statement at the hearing may present to the planning agency written objections to such findings and recommendations.

(4) A decision of an area agency or a recommendation of a local agency must be made at a public meeting. A quorum shall be that established by the Areawide Agency bylaws but in no case less than one-third of the Board membership and at least 50 percent shall be consumers. Decisions or recommendations must be concurred in by a majority of the directors present; tie vote is a denial of the application.

(5) Any director or committee member shall be disqualified to participate in any consideration and for the purposes of a quorum if there exists a demonstrated or potential conflict of interest. Potential conflicts of interest shall include, but are not limited to:

(A) Any person having the following relationship to the applicant:

1. Ownership
2. Directors, trustees, or officers of the applicant's facility
3. Providers of professional services to or in the applicant's facility
4. Parents, spouse, children, brothers or sisters of 1, 2 and 3 above
5. Employees

(B) Any person with a relationship described in (A) 1 through 4 to any competitive health facility in the area served by the applicant.

(6) The Agency and committee shall keep written minutes recording the time, place, members present and all official actions taken.

40518. General Principles for Voluntary Area Health Planning Agencies. (a) As provided by Section 437.8 of the Health and Safety Code:

"437.8. The Health Planning Council shall develop general principles to guide voluntary area and local area health planning agencies in the performance of their responsibilities under Section 437.7. These principles shall provide for consideration of the following factors and may provide other guidelines not inconsistent herewith:"

(b) Guidelines for the consistent consideration of each of the five factors, (a) through (e) specified in Section 437.8 are set forth in (1) through (5) below:

(1) "The need for health care services in the area and the requirements of the population to be served by the applicant;"

(A) In determining the need for health care services in the area, the health planning agency shall afford an opportunity for the public, including representatives of both providers and consumers of health care to present their views for consideration by the health planning agency. Such representation may include providers, health insurers, prepaid hospital and medical care plans, government agencies that contract for health care for their employees or beneficiaries, labor and fraternal organizations, cooperatives and other groups of users of health care facilities and services.

(B) In assessing the need for health care services in an area, community requirements shall be considered, including those met by governmental and by nongovernmental facilities. The intent of these guidelines is to promote flexibility and relevance to local needs and requirements. Such community needs shall encompass medical, surgical, maternity, pediatric, psychiatric, diagnostic, emergency, rehabilitative and preventive health care, home care and other services recognized to be medically beneficial.

(C) The requirements of the population to be served by an applicant shall comply with a rational community plan which will encourage developments in the interest of improving effectiveness, convenience or comprehensiveness of services or quality of care.

(D) In considering the needs of the population, innovation in the organization and provision of health care and the making available of alternative methods of delivering health services shall be considered by the health planning agency.

(E) The "requirements of the population to be served by the applicant" shall include quality, effectiveness, efficiency, and value of the health care services and

facilities to be provided. Voluntary area and local area health planning agencies, in considering the "requirements of the population to be served", shall consider whether, presently or prospectively, the applicant:

1. Is fully accredited, if eligible for accreditation by recognized impartial nongovernmental accreditation organizations, or demonstrates the probability of achieving accreditation by such organizations when eligible therefor.

2. Utilizes professional, subprofessional and ancillary personnel so as to maximize their most skilled capacities; similarly employs labor-saving equipment and designs when economically justified; utilizes modern diagnostic and treatment devices to enhance the accuracy and reliability of diagnosis and treatment and to diminish the time required to perform them.

3. Encourages both ambulatory care in outpatient facilities and preventive health care so as to eliminate or reduce significantly the inappropriate use of acute inpatient services among the population it serves.

(2) "The availability and adequacy of health care services in the area's existing facilities which currently conform to federal and state standards;"

(A) The health planning agency shall maintain records which show the current status of State Department of Public Health determinations regarding which of the area's health care facilities and related services do not conform to Federal and State standards applicable to construction and equipment which are requirements for state licensure and for certification for participation in Medicare. In determining the needs of the area's population for health care facilities and services, the health planning agency shall be cognizant of such nonconforming facilities and services.

(B) A nonconforming facility shall present as part of its application a satisfactory plan for attaining conformity at the same time as its modification or expansion.

(3) "The availability and adequacy of other services in the area such as preadmission, ambulatory or home care services which may serve as alternatives or substitutes for the whole or any part of the services to be provided by the proposed facility."

(A) It shall be the policy of the health planning agency to encourage diagnostic and treatment services of high quality, using the resource of greatest value to the

patient and the community. To this end, the development of preventive, diagnostic and treatment services not requiring inpatient admission shall be furthered, preferably as part of a coordinated comprehensive health care program. Encouraging the desired coordination of such outpatient facilities and services also shall be a function of the health planning agency.

(4) "The possible economies and improvement in service that may be derived from operation of joint, cooperative, or shared health care resources;"

(A) To the extent that certain functions of a health care facility can be made more efficient, reliable, or less costly, through joint, cooperative, pooling or sharing arrangements, such relationships shall be considered by the health planning agency when appraising an application.

(B) Innovative measures taken or proposed by the applicant, directed towards promotion of economy, efficiency or reliability, shall be encouraged by the health planning agency, especially when they are part of a local, area or national system for utilizing pooled, joint, cooperative or shared health resources.

(5) "The development of comprehensive services for the community to be served. Such services may be either direct or indirect through formal affiliation with other health programs in the area, and include preventive, diagnostic, treatment and rehabilitation services. Preference shall be given to health facilities which will provide the most comprehensive health services and include outpatient and other integrated services useful and convenient to the operation of the facility and the community."

(A) In determining priorities among applicants, the health planning agency shall give preference to the applicant which, in its own facilities, in facilities under its control or under a common management, or through formal agreements of cooperation, can provide comprehensive health services in an area. In addition to inpatient care, such services may include outpatient diagnosis, treatment and preventive health care; emergency treatment; psychiatric care; rehabilitation services; and home health care.

Article 5. Appeals

40520. Appeals Body. (a) Section 438.1 of the Health and Safety Code states in part: "The Health Planning Council, on a periodic basis, shall designate the voluntary area health planning agency or agencies, the consumer members of which shall be the appeals body or bodies for another voluntary area health planning agency; provided that such agencies shall not be the appeals body or bodies for each other."

40522. Grounds for Appeal. (a) Failure of the voluntary health planning agency to comply with procedures required by the Health Planning Council or its own procedures in considering the application so as to deny the applicant due process and a fair hearing.

(b) Findings of fact and recommendations not sustained by substantial evidence.

(c) Action taken arbitrarily, capriciously or with prejudice.

(d) Action taken was not in accordance with principles for planning adopted by the Health Planning Council and the voluntary health planning agency.

(e) Allegation of grounds for disqualification of a director or committee member discovered after the decision was reached by the area planning agency.

40524. Notice of Appeal. (a) An appeal may be initiated within 30 days of the announcement of the decision of the planning agency, by a written notice of appeal sent by registered or certified mail to the Voluntary Area Health Planning Council which shall be responsible for forwarding the appeal to the designated appeals body.

(1) Such notice of appeal shall include the following:

(A) Designation of the proceeding being appealed.

(B) A brief statement of grounds for appeal

(C) A request for the completion of a transcript within 30 days, if desired

(D) A list of exhibits, written arguments and other evidence to be transmitted by the agency to the appeals body

(E) A statement as to the nature and basis for any additional evidence desired to be submitted

(F) Payment of the filing fee for the appeal and the estimated cost of any transcript requested by the appellant and reproduction of documents.

(b) On receipt of the notice of appeal the appeals body shall review:

(1) The application for appeal

(2) Affidavits and written statements or documents in support of application and appeal

(3) The original application and all modifications or supplements thereto

(4) The written evidence and written arguments submitted

(5) The minutes of the hearing and the transcript is supplied

(6) Any affidavits or statements submitted in relation to the appeal

(7) Any written statements filed by parties in interest

(c) Based upon such review the appeals body shall initially determine whether its review shall be based solely upon the record of (1) through (7) above or shall take additional written and/or oral testimony and designate the areas or points to be covered by the additional testimony.

(d) Upon such determination, hearing or meeting date shall be scheduled. A quorum at such hearing or meeting shall be one-third of the members of the appeals body. All actions by the appeals body shall require the concurrence of the majority of the members present, but in no event less than five members.

(e) The appeals body, upon the completion of its proceedings, shall:

(1) Affirm the original action; or
(2) Reverse the original; or
(3) Modify in part the original decision if it believes such action to be required in the public interest.

(f) Failure of the appeals body to act within 90 days of the receipt of the request for appeal shall constitute affirmation of the prior decision.

(g) A party in interest may request notice of an appeal and such notice shall be given by the Voluntary Health Planning Agency.

(h) Parties in interest on an appeal who may be represented by Counsel, are:

(1) The applicant
(2) The Voluntary Area or Local Health Planning Agency
(3) Any party who submitted an oral or written statement at the original hearing
(4) Representatives of local government

(i) The appeals body shall select its own chairman. At the discretion of the appeals body it may be advised by legal counsel who shall not be permitted to vote on any action taken by the body.

40526. **Petition for Appeal to Health Planning Council.** (a) An appeal may be initiated within 30 days of the announcement of the decision or the lack of a decision of the planning agency or of a designated consumer appeals body by a written petition for a hearing sent by registered or certified mail to the Executive Secretary of the Health Planning Council. Copies of the petition shall be sent to the applicant, area planning agency, local planning agency, and the consumer appeals body, as appropriate.

(1) Such petition for a hearing should include the following:

(A) Designation of the proceeding being appealed
(B) A brief statement of grounds for appeal
(C) A written transcript of the appealed hearing or action
(D) Exhibits, written arguments and other evidence presented at the appealed hearing or action, if requested

(E) A statement as to the nature and basis for any additional evidence to be submitted

(F) Payment of a filing fee, if required, for the petition and the estimated cost of any transcript requested by the appellant and reproduction of documents.

40528. **Council Procedures.** (a) On receipt of the petition for a hearing, the Health Planning Council shall review the petition for hearing and the supporting documents listed under Section 40526, and a copy of notice of appeal required by Section 40524.

(b) The Health Planning Council may certify that a hearing should be granted. Such certification shall be determined by written agreement by at least one-third of the members. A copy of the certification shall be sent to the petitioner and the concerned agencies by registered or certified mail within 60 days following the receipt of the petition.

40530. **Hearing.** (a) Hearing process shall be conducted in a manner to permit necessary notices, meetings and determination of Council recommendation and decision within 90 days following the date of certification to conduct hearing.

(b) Upon making a decision to grant the hearing, the Council shall issue a public notice to the applicant, the voluntary area planning agency, and the general public of the date, time, place, and designated hearing body. The Council may designate the full Council to act as the appeals body or may designate a chairman and members of the Council to a committee of at least three, the majority of whom shall be consumers.

(c) The Chairman or Vice Chairman of the Council or the designated committee chairman shall serve as chairman of the hearing body. The hearing shall proceed in accordance with the rules of appeal providing for public notice, conflict of interest, legal counsel, etc., referred to in the initial State Guidelines for Implementation of AB 1340, and included in this chapter.

40532. **Recommendations and Decision.** (a) A report of the recommendations of the hearing committee shall be sent to the members of the Council within 10 days. The Council shall render a decision in public hearing within 90 days following the date of certification by the Council to conduct the hearing.

(1) The Council in the public hearing shall:

(A) Affirm the appealed decision

(B) Reverse the appealed decision

(C) Modify in part the appealed decision.

(b) The Council shall determine findings of fact supporting its decision and shall notify, in writing, the applicant or petitioner within the 90-day period set forth above of its findings of fact and decision.

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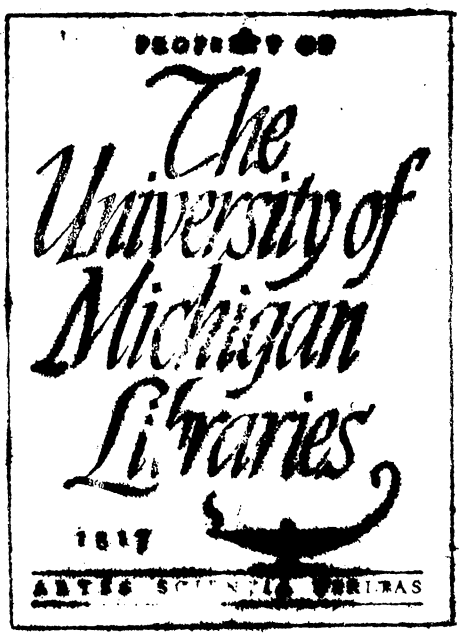
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