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DATE:

FROM : Regional Health Administrator
Region VII

SUBJECT: Area Designation Issues and Problems (HRP)

I shall comment by section as presented in the document developed by Committee on the above subject, dated September 30, 1974.

1. I favor maximum latitude following guidelines provided. It should be kept in mind that the basic purpose of HR 16204 is the establishment of a "Health System Plan (HSP)" and an "Area Implementation Plan (AIP)." The area must be able to provide feasibly primary and secondary health care services to its residents and make available tertiary health care services (highly specialized health services) considering that the latter may have to be provided outside the area. The population range is satisfactory, providing waivers can be made where appropriate and feasible. The point is that the guiding direction is the feasible development of a capacity or system to delivering comprehensive health services in an improved fashion and not to stick rigidly to "figures". If this is followed appropriate area designations to support feasible "health care systems" will result. To accomplish this maximum flexibility and latitude must be permitted.

The guidelines developed would, if followed, assure the development of appropriate areas for development of "health care systems". Although not all inclusive, some essential guidelines might be as follows:

- a. Basic resources for primary health care should be available or potentially available: clinics, outpatient centers, and acute and convalescent hospital beds, nursing and chronic care facilities.
- b. Recognizing that primary health care must be comprehensive, preventive health care services in addition to the above must be available in Public Health Clinics and services.
- c. Highly specialized health services, if feasible, recognizing that such might be available at only one area to all residents of the State but could be accessible and planned for.

d. The geographical area must be of a size which would allow the ready access to primary health care resources within 1/2 hour (some practical time). This is important to avoid extensive geographical areas developing to meet the population requirement. The geographical guideline can become a justification for an area of less than 500,000.

e. Population -- 500,000 -- 300,000 and not less than 200,000. Even here the other factors must be weighed.

f. Other Planning and Delivery Areas must be taken into consideration. Recognizing the impracticability of being coterminous with all such areas, at least the important areas should not be split. The areas I feel important are: 314(b), Mental Health catchment, and Health Department Districts or Regions in addition to SMSA and PSRO.

The Governors should be provided such guidelines in addition to a letter which identifies the purpose of such designations in terms of Health Systems and the importance of building on existing planning and development resources. This would be looked upon as assistance to the Governor in doing his job. In no way is this to usurp his authority. It may be appropriate to hold discussion with the Governor by the RO.

2. I am in support of waivers where indicated and appropriate. They assure needed "flexibility" and avoid inappropriate "rigidity" (the "round peg in the square hole" phenomenon). We should not encourage wholesale waivers; on the other hand we shouldn't make the waiver mechanisms so restrictive and difficult that we throw the State into an impractical and inappropriate area designation.

3. The approval process is a joint CO/RO activity. What is important is that the functions appropriate for the level be carried out at that level. The basic principle to follow, I feel, is: CO's functions are policy development and resource support; the RO's functions are operations (operational decisions within policy direct TA's and monitoring). What is carried out at CO and RO levels should be consistent with this principle and based on this I would recommend the following:

a. CO prepare documents and guidelines and procedures to follow with RO input and forward such to the RHA/RO.

b. RHA/RO would send to the Governor after due consultation with RD.

d. Proposed designations submitted to RHA/RO by Governor.

e. Designation proposals reviewed by the RO. A copy to CO for review and input into the RO for its consideration during its review. As feasible and appropriate CO staff person could be involved in the review process at the RO.

f. Final approval and funding made by the RHA.

CO should develop criteria to be followed by the RO in the review and approval process to assure basic conformity across the board. RO should have input into such criteria development.

4. All major exceptions which cannot be resolved at the RO level with appropriate CO input should surface to the ad hoc review panel recommended.

5. Whenever an exception occurs the usual time sequence should no longer apply. What is important is that sufficient time (30-60 days) should be allowed to establish the process that will assure the presentation of needed facts and sufficient information to permit the Secretary to make a decision. This could allow operations to proceed without loss of time while the nitty gritty is being negotiated out.

A special Appeals Board consisting of 3 persons could be established by the Secretary to review the findings and recommend to the Secretary action to take.

/s/ Holman R. Wherritt, M.D., M.P.H.

cc: Dr. Frank Ellis
RHA's - Regions I through X