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GRADUATE COLLEGE

ORGANIZATION AND ADMINISTRATION IN PUBLIC HEALTH

A CASEBOOK

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

DOCTOR OF PUBLIC HEALTH

BY

CHARLES L. JACKSON

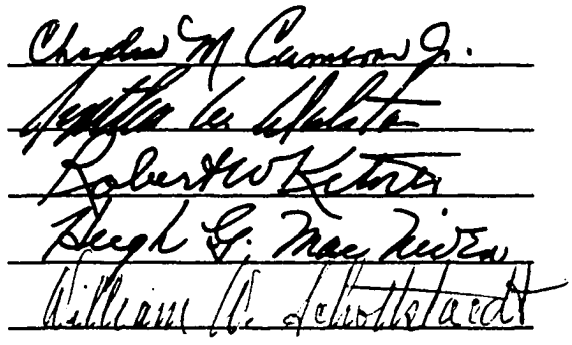
Oklahoma City, Oklahoma

1972

ORGANIZATION AND ADMINISTRATION IN PUBLIC HEALTH

A CASEBOOK

APPROVED BY



DISSERTATION COMMITTEE

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Appreciation is extended to the graduate faculty of the College of Health, University of Oklahoma Health Sciences Center, and especially to Dr. Charles M. Cameron, Department of Health Administration, Dr. Robert Ketner, Department of Human Ecology, Dr. Jeptha Dalston, Department of Health Administration, Dr. Hugh MacNiven, Department of Political Science, and Dr. William Schottstaedt, Dean, College of Health who served as my advisory committee for this dissertation.

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CHAPTER I

INTRODUCTION

This writer became interested in what is known as the case-study method of teaching while a graduate student in Public Health Administration at the University of Oklahoma College of Health.

Although the didactic method of teaching is the standard teaching method used, a few of my professors presented case study materials as a supplement to their lectures. This writer was continually impressed with the interest the case-study method created among my fellow students.

On the days a case report was to be analyzed, there was an intensity of interest not usually evident when the lecture method was used.

The didactic method is necessary in teaching the disciplines underlying health services—basic sciences, biostatistics, epidemiology, social psychology and economics.

In the study of health administration there is a need for the use of case study material in conjunction with

other teaching methods. Roy Penchansky and others have suggested that the use of the case method of study is superior to alternatives in realizing the objective most difficult to achieve—the development in students of problems and decision-making skills, the ability to plan for implementation, the ability to synthesize and apply theory to specific problems, skills in group process and verbal communication, and an action orientation.[1]

According to Lawrence, the case-study method helps maintain the balance of teaching administration as a skill linked inseparably to knowledge.[2]

Hamilton isolates five major points in the value of the case-study method to the student:[3]

1) Stimulates immediate interest with an accompanying desire to learn.

2) Develops a sense of relativity in management affairs.

3) Furnishes an opportunity of acquiring administrative values and attitudes.

4) Increases self-awareness and presents occasions to develop ability in management skills.

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[1]Roy Penchansky, ed., Health Services Administration: Policy Cases and the Case Method, (Cambridge, Mass: Harvard University Press, 1968), p. 396.

[2]Paul R. Lawrence and John A. Seiler, Organizational Behavior and Administration, Cases, Concepts, and Research Findings, (Homewood, Ill: Richard D. Irwin, Inc., 1965), p. 3.

[3]James A. Hamilton, Decision Making in Hospital Administration and Medical Care, A Casebook, (Minneapolis, Minn: University of Minnesota Press, 1960), pp. 13-61.

5) Develops an understanding of the individual's role in the group process.

Variation in the use of the case-study method is well accepted in many fields of study. In business administration, the Harvard Business School alone had produced more than 20,000 cases by 1954.[4] Thousands of cases have been prepared in the fields of public administration and education.

In recent years, the case method approach has been utilized in the teaching of health administration. However, there is a shortage of case material in the health administration field and this has slowed the use of the case method in all areas of health care administration.

There is also the problem of the lack of standardization in the terminology used to define specific elements of the case-study method. This problem will be discussed later in this paper.

The Problem

The problem is not whether the case-study method of teaching serves a beneficial purpose in the learning process. Variations of the case-study method is an established method of teaching in the schools of law, medicine, business

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[4]Malcom P. McNair, The Case Method at the Harvard Business School, (New York: McGraw-Hill, 1954), p. 282.

administration, social work, education, public administration, social research, and in recent years, health care administration.

The problem is the absence of carefully prepared case reports in the area of health care administration, and specifically in the area of public health administration. Hopefully, the ten case reports which comprise the contents of this dissertation will help alleviate part of the problem.

Need for the Study

Sagar C. Jain, in a short essay written in 1968, analyzed the use of the case method in the teaching of public health administration. The following are the major points in his essay:[5]

1) There is a great deal of confusion in the use of the term case, case report, case study, case problem, case records, case history, case method, and case-study method in the field of public health administration. Part of the reason is the lack of standardization of terminology in the case study field. The other part of the problem is that the field of public health administration draws from many disciplines, and people from different disciplines use different terminology in pursuing the same concepts.

2) Although the case method of teaching is becoming increasingly popular, the understanding and thinking regarding the case method are still not precise. In the field of public health

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[5]Sagar C. Jain, "An Essay on Terminology, Including a Note on the Use of the Case Method in the Teaching of Public Health Administration," in Health Services Administration: Policy Cases and the Case Method, ed., Roy Penchansky, (Cambridge, Mass: University Press, 1968), pp. 443-445.

administration, the confusion and misunderstanding is compounded because of a lack of exchange of ideas and discussions on this subject among people in public health and between people in public health and those in other fields who have used the case-study method for many years.

3) There is a great paucity of case study teaching material in the field of public health administration. No university, professional body, commercial enterprise or any other kind of institution has taken the lead in developing adequate case studies.

4) Rarely do the people in public health administration take advantage of the thousands of case reports in business administration. Although there are a number of related explanations, the major one appears to be the sharp line public health administrators draw between their work and the work of a business administrator.

5) The case studies used in the field of public health administration tend to be focused on "outside" forces, describing and analyzing how these forces bear on the effectiveness of the health agencies and the health personnel. There is little case material dealing with intra-agency dynamics.

6) Public health administrators have been well trained to recognize and cope with social and cultural conditions that tend to frustrate public health programs. Unfortunately, in many instances, this has led to the subconscious assumption that all of the problems faced by public health administrators come from outside their organization. A public health administrator needs multiple skills in both areas of community organization and organizational functioning. The university training programs have not been putting as much emphasis on the latter as the former. The situation should be the other way around.

Jain's paper on the case method in public health administration has demonstrated that a need exists for the development of case reports that are concerned specifically with intra-agency dynamics in public health administration.

The ten case reports presented in this paper were prepared to meet that need.

Terminology and Definitions

As mentioned earlier in this paper, the definition of the terms case-study method, case report, case problem, case study, case record, and case history have not been standardized. This has led to considerable confusion and misunderstanding among the disciplines using cases as a teaching method.

McNair's definition of the case method illustrates the point. He said:

> Indeed, the only discernible common thread running through these varied dissertations on the case method is the emphasis on student participation in the education process, on the extent to which the student is expected to carry the ball—assessing the facts, making the analysis, weighing the considerations, and reaching a decision.[6]

Jain has analyzed the terms case report, case problem, case study, case method, and case record.[7] He found that the terms case report and case study were of crucial conceptual significance. He placed all of the terms on a continuum and found that case report and case study were at polar ends.

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[6]Malcom P. McNair, The Case Method at the Harvard Business School, (New York: McGraw-Hill, 1954), p. xi.

[7]Sagar C. Jain, "An Essay on Terminology Including a Note on the Use of the Case Method in the Teaching of Public Health Administration," in Health Services Administration: Policy Cases and the Case Method, ed, Roy Penchansky, (Cambridge Mass: Harvard University Press, 1968), p. 439.

He identified the major elements of the two terms and then compared the two in relation to each of these elements in the following table:

TABLE 1

A CASE REPORT AS CONTRASTED TO A CASE STUDY[8]

Element	Case Report	Case Study
1. Purpose	Produced primarily for teaching and training purpose. Not intended to generate new theories, principles or formulations. Instead, it is to serve any one or more of the following purposes: (1) to illustrate an abstract argument; (2) to help students develop a general insight in the real life situations; and (3) to help students develop operational skills and mental faculties.	May be used as a teaching tool, but this is not its central purpose. The main purpose is to facilitate new insight in the current knowledge and theory in the field. May be undertaken to explore unknown research frontiers, to formulate or refine concepts in order to generate hypotheses or test a current theory.
2. Nature of the case	A. The cases are either typical (to help serve purposes number 1 and 2) or problematic (purpose number 3). Often a case will have both these characteristics.	A. There is no emphasis on typical and problematic cases. Often an atypical case or the one about which little is known better serves the research purpose than would a typical case. Generally, the selection of a case is dictated by the intended purpose of the case study.
	B. Events in the near past are preferred.	B. Concurrent events are preferred.

[8] Ibid. p. 440-441

TABLE 1--Continued

Element	Case Report	Case Study
	C. The case may be fictitious, although real life cases are preferred.	C. The case must be real.
3. Method of data collection	The emphasis is on obtaining the whole "story" and not on "how." The method used is not reported. Useful guidelines for locating appropriate cases, for securing cooperation of people concerned, and for reporting have been developed.	The methodology is a crucial consideration. A case study is only as good as its methodology of research. The description of the methodology is an important part of the report.
4. Content	A case is described to the end, and information is provided on (1) the event, (2) its background and (3) its conclusion. The author's analysis and conclusions are not included.	A case is described in full. In addition, analysis of the data together with the author's conclusions is included.
5. Length	Length is an important consideration. A very lengthy case is cumbersome and often unmanageable for class use. A case which may run to fifty pages is often considered too lengthy.	Length is not an important consideration. The important thing is to get all the data, analysis and discussion in. A case study reported in more than 1,000 pages is not too long.
6. Identity of the subjects studied	It is not important to identify the persons, places, organizations, and products by their real names. In fact, the fictitious names are preferred to the real names for two reasons: (1) to protect all concerned from any harm which might be caused to them if their real identities were made	Real identity of the subject is often crucial information without which verification possibilities are substantially reduced. The names may not be revealed only when this is justified on the grounds of research strategy or ethics.

TABLE 1--Continued

Element	Case Report	Case Study
	known; and (2) to permit a more objective and dispassionate discussion in the class.	
7. Identity of the author	Identity of the author is not crucial. When an author is identified it is to reward him for the trouble taken in preparing the case report.	Author's identity is very important. The findings are often evaluated in the context of the author's standing as a researcher. In those cases in which the subjects studied cannot be identified by their real names, the author's identity serves as the primary basis for evaluating the integrity of the research effort.

The above table identifies the major elements of the case study and the case report. The ten case reports presented in this paper were developed within the case report framework.

Objectives

During the development of the case method approach, the major objective for the development of case reports was the hope that they would lead to inductively derived "principles of administration." This has not occurred. Sagar C. Jain gave the following reasons why:

Lack of standardization and reduncancy of data in

> the case reports are only partly responsible for the nonrealization of the original hope. A more important factor responsible for this situation is a gradual but definite shift in the focus and the purpose of the case method. The inductively derived 'principles' are no more aimed at, and instead, the effort is to provide insight into real work situations and to develop skills and abilities to cope with them.[9]

Within the limitations of the definition and use of case reports, the following may be considered the major objectives of this study:

1) The preparation of ten original case reports designed specifically for teaching purposes in the field of public health administration.

2) The development of case reports in public health administration which focuses on the process of analysis and decision making.

3) The development of case reports in public health administration which gives the student insight into real life situation.

4) The development of case reports in public health administration in which the author's biases, analyses, and conclusions have been eliminated.

5) The development of case reports in public health administration that can be discussed adequately within a one or two hour class period.

Method of Data Collection

This writer did not begin by looking for case report material that illustrated a specific "principle of administration." The emphasis was placed on obtaining information on true situations involving decision making and administrative problems occurring at the policy making level within public health organizations.

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[9] Ibid. p. 440

Once the elements of a possible case had been identified, this writer gathered information on the "whole story." Two specific tools were used; taped interviews with as many of the people involved in the case as possible, and the analysis of the letters, reports, records, and memos involved. A framework of the case was prepared and as the case developed, the details were filled in.

Jain's essential elements of a case report were utilized; therefore, the ten cases presented in this dissertation included the following factors;

1) Events that occurred in the near past are used.

2) All of the cases evolved from true events or situations.

3) The cases are described to the end. Information is provided on the event, its background, and its conclusion.

4) The cases are not analyzed with regard to whether or not the action taken by the participants was correct.

5) The people, places, and organizations used in these cases are not identified by their real names.

Limitations of the Study

The limitations of this study correlates with the limitations of the use of the case method in the training of administrators.

The advantages and disadvantages of the case method have been described by many in the field of public health administration. The following outline was presented in a

recent book by Roy Penchansky.[10] Except for point number two under disadvantages, this outline is relevant to the case reports in this dissertation.

Disadvantages

1) Cases are not, in fact, the real life situation and they cannot provide the student with a complete picture.

2) Generally, the students do not have an opportunity to see the consequences of their decisions....

3) The case presents a prescribed amount of material. The student learns to select the relevant from the irrelevant information but this means that unnecessary information must be provided so that the important is not made obvious. Generally, the students do not have to seek information, which is an important part of the administrative process....

4) Continual concentration within the confines of a case can cause excessive orientation to specific incidents and inadequate attention to outside sources of information and theory.

5) It is difficult to develop the skills needed by the faculty....

6) The technique is very time consuming for both faculty and students....

7) It is costly to keep case material up to date.

Advantages

1) Case studies are a very pleasant form of education. There is considerable student involvement and interest with students using their experience.

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[10]Roy Penchansky, ed., Health Services Administration: Policy Cases and the Case Method, (Cambridge, Mass: Harvard University Press, 1968), p. 407.

2) The case method promotes an active rather than a passive orientation.

3) Case studies come close to duplicating the work situation in a number of ways....

4) Because the focus is on processes rather than content, the case method develops an approach or attitudes which foster acceptance of changing technology.

5) The focus on the processes of analysis and decision making forces a synthesis of the underlying disciplines.

6) Students develop at their own pace and to the limit of their own ability. The instructor does not have to set a level of presentation that may be above some and below others.

The case reports presented in the following chapters are designed for use in the education of administrators in the health care field. Within this field, they are designed specifically for use in the study of the intra-agency dynamics in public health administration.

For teaching purposes, each case study is divided into three parts. Part I is the case and provides background information regarding the issue or situation. Part I ends at a point where the reader is given the opportunity to decide what the essential issues of the case are before reading Part II which provides the actual conclusion of the case. Part III is designed for use as an instructor's guide.

The author's analysis of the important administrative and public health issues presented in each case are discussed. Complementary questions regarding the case are

provided in Part III rather than at the end of Part I so the instructor has the opportunity to use the questions presented or to develop his own.

CHAPTER II

A HEALTH DIRECTOR FOR BOONE AND WAYNE COUNTY HEALTH DEPARTMENTS

PART I—The Case

In January 1970, Dr. Gene Cummings became commissioner of health for a state health department in the southwest.

Before assuming the position of commissioner, Dr. Cummings had worked within the state health department structure for several years and was well aware of the health problems of the people of the state. Two things in the state and local health department system were of grave concern to him. One was the number of small counties in the state who were trying to support a health department without adequate funds, and the other problem was the absence of strong administrative leadership in other health departments.

Of the 88 counties in the state, 70 had full-time county health departments. There were six full-time county medical officers who usually served as medical officer for two or more counties. The remaining counties with health departments had part-time medical directors who were private physicians practicing in the community. These physicians

received from $50 to $200 a month for their services according to the tax income of the county. If they conducted special clinics such as family planning, diabetes, or well baby clinics, they received an hourly fee.

The administrative responsibility for many county health departments was inadequately defined. The medical director was supposed to be responsible for administrative duties, program direction, preparation of the budget, signing the payroll and the hiring of personnel. However, the responsibility was often delegated to a senior clerk or sanitarian within the department. The individual assigned this responsibility continued his regular duties at the same time and did not receive extra pay for the work.

In February 1970, Dr. Cummings assigned his special assistant, Mr. Ron Kolnik, the responsibility of investigating the feasibility of multicounty health departments in the state. He was also to consider the use of nonmedical health administrators to be in charge of such departments.

On May 19, 1970, Mr. Kolnik presented the following written report to the commissioner:

"May 19, 1970

"TO : Gene Cummings, M.D., Commissioner of Health

"FROM: Ron Kolnik, Assistant to the Commissioner

"SUBJ: SOME PROPOSED CONCEPTS FOR MULTICOUNTY HEALTH DEPARTMENTS

"Under no circumstances should a county be included for multicounty operations unless it meets with full favor of local boards of health, county commissioners, and county medical societies.

"In budgeting, a very clear understanding should be made assuring each county that local millage funds will not be used for any purpose other than county operation. There should be no set pattern for multi-county operations. In one area it might be only two counties; in others, it may be as many as five. In some instances the cooperative efforts might be limited to the use of a health director; in others, it might be in cooperation in the use of several types of technical and professional personnel.

"According to the State Public Health Code, Section 1-284: 'The director of a city-county health department shall direct and supervise all public health activities in the county; administer and enforce all municipal and county ordinances, rules and regulations related to public health matters; and he shall also administer state laws, rules, and regulations of the state board of health pertaining to public health, subject to administrative supervision of the state commissioner of health.'

"Under the above statutes, in a multicounty health unit, the county medical director, whether part or full-time, should be responsible for county health department activities in addition to making all medical and other major decisions.

"If, in a multicounty unit, the local medical director feels he does not have time for both the administrative and clinical duties, a 'health director' may be delegated administrative duties including program coordination, budget controls, administrative reports and liaison activities.

"When a health director is employed in a multicounty unit, it should be done in a way that would emphasize his responsibility to the county or counties in which he is employed. One way to assure his loyalty to a county is to have a portion of his salary paid from the county from local health funds in ratio to the time he is to spend there."

During the same month, Mr.Kolnik, with the assistance of the personnel department, was able to develop and gain approval from the state merit system for a new position classification entitled "Health Director." The state merit system description of the position is as follows:

HEALTH DIRECTOR

DEFINITION:

Under the general administrative direction of the commissioner of health, serves as the administrator of a local cooperative multicounty health department and is responsible for the planning and implementation of a health program in an assigned geographical area.

EXAMPLES OF WORK PERFORMED:

Establishes methods and administrative procedures for implementing, coordinating, and conducting programs in local health department.

Prepares budgets and makes financial presentations to the county board of health. Is responsible for all administrative decisions, procedures, and reports for the department.

Manages a staff of professional and technical personnel and assumes the responsibility for their supervision.

Enforces public health laws and regulations.

Establishes close relationships with professional and community groups.

Assumes the responsibility for public relations and liaison activities with the county board of health, local officials and local citizenry.

MINIMUM QUALIFICATIONS:

1) Possession of a doctorate in public health or a health related field and one year full-time paid employment in an administrative position in a public health program.

OR

Completion of all course work leading to a doctorate in public health, environmental sciences, hospital administration, or other health related field and two years full-time paid employment in an administrative capacity in a public health program.

OR

Possession of a master's degree in public health, environmental sciences, hospital administration, or other health related field and five years full-time paid employment performing increasingly responsible professional or administrative duties, two years of which shall have been in a public health program subsequent to receipt of master's degree.

2) Thorough knowledge of the principles and practices of public health administration; knowledge of the budgetary procedures; considerable knowledge of the principal functions of official and voluntary agencies available to public health and work relationships among these agencies; knowledge of current social and economic conditions, particularly as they relate to public health; considerable knowledge of public health problems, all as evidenced by a passing grade on a written examination.

3) Ability to get along with and work with people; to exercise good judgement in evaluating situations and in making decisions; to organize and execute work in an efficient manner; personal initiative and integrity, as evidenced by an investigation.

Later in May 1970, the part-time medical director of Boone County, located in the southeastern section of the state, resigned and left the county. Dr. Cummings felt that Boone County and the adjacent Wayne County would be a good area in which to try the health director concept. He asked Ron Kolnik, his special assistant, to look into the matter.

Boone and Wayne Counties have separate health departments. The region is characterized by a high level of unemployment, poverty, and inadequate health care. According to the latest census data, 93,417 people lived in the two counties. There were 47.9 physicians per 100,000 population as compared with a national average of 142.9

physicians per 100,000 and 110.4 physicians per 100,000 for the state.

The infant mortality rate, death from cancer, heart disease and stroke for the two counties was higher than state and national rates.

The Social Security Administration considers 80 per cent of all families in the area to have income below the poverty level.

Public assistance payments in 1970 totaled eleven million dollars. Medical assistance payments of five million dollars were made to provide care for 18,000 families. The area is rural with no towns over 10,000 population.

The Boone and Wayne County Health Departments are among the oldest in the state and were formed during the late 1930's. The 1970 health department staff for the two counties is as follows:

Boone County Health Department Staff - 1970

Medical Director - Part-time

1 Sanitarian II

1 Sanitarian I

3 Public Health Nurses II

1 Public Health Nurse I

1 Home Health Aide

1 Clerk Typist III

1 Clerk Typist I

Wayne County Health Department Staff - 1970

Medical Director - Part-time

1 Sanitarian II (Headquarters in Boone County)

2 Public Health Nurses II

1 Nurse Aide

2 Home Health Aides

During late May 1970, Mr. Kolnik visited Boone and Wayne Counties and filed the following report:

"June 2, 1970

"TO : Gene Cummings, M.D., Commissioner of Health

"FROM: Ron Kolnik, Assistant to the Commissioner

"SUBJ: PROPOSED USE OF LOCAL HEALTH DIRECTOR AS AN ADMINISTRATOR IN BOONE AND WAYNE COUNTIES ACCORDING TO MULTICOUNTY HEALTH DEPARTMENT CONCEPTS

"Local contacts have been made in Boone and Wayne Counties concerning the use of a nonmedical administrator on a one-fifth, four-fifths time basis; one-fifth in Wayne County and four-fifths in Boone County.

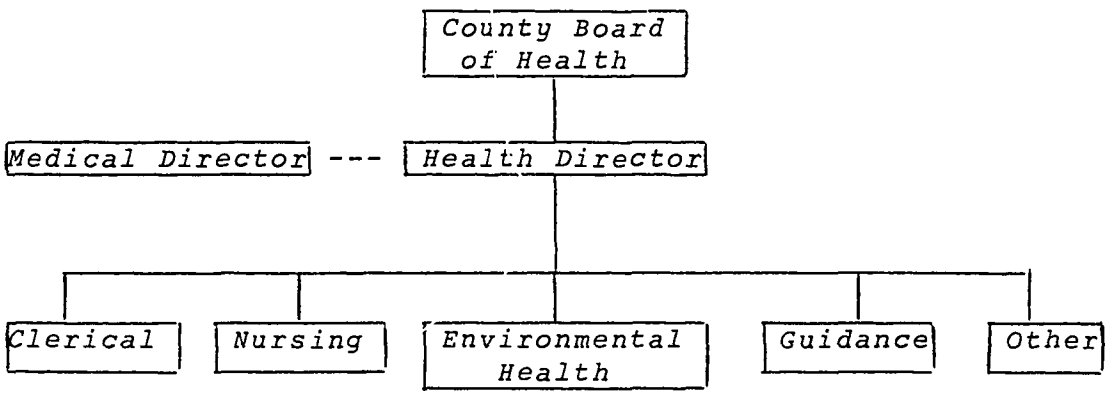
"In Wayne County, Dr. Sam Banton, the part-time county medical director, was contacted. The duties and responsibilities of a local 'health director' were explained, and Dr. Banton was in full accord stating he would welcome someone who could assume the administrative duties of the Wayne County Health Department. The personnel of the Wayne County Health Department were not contacted in regard to this proposal; consequently, is it not known how they feel about the matter individually or as a group.

"In Boone County, if such a change is to be made, now would be an ideal time. Boone County's part-time medical director just recently resigned. In contacting local physicians about a replacement, Dr. Frank Luner, a long time practicing physician, expressed interest in the position. His interest was as medical director and a clinician with no knowledge or expressed interest in the administrative responsibilities of the health department. The possibility of the use of a 'health

director' was fully explained to Dr. Luner and he stated that he would rather not have the administrative duties if appointed medical director.

"A conference was held with all Boone County Health Department personnel. The proposed use of a 'health director' was explained, and all agreed it sounded like a workable arrangement. Each employee expressed his willingness to work with such a person as an administrator.

"The responsibilities of the medical director were explained as follows: The county medical director would be used to make all medical decisions, act as liaison with the county medical society, be the medical consultant for county health department personnel in medical affairs and be clinician on a fee for clinical services by the hour in programs needing such services. The responsibilities of the 'health director' were explained as administrative responsibilities including program coordination, personnel supervision, budgets, payrolls, time reports, administrative reports, public relations and liaison activities with the board of health, state legislators and county citizenry, subject to administrative supervision of the state commissioner of health. Emphasis was placed on his responsibility to the counties in which he is to be employed. Although state funds are to be used for this position, the money will be placed in the county budgets of Boone and Wayne Counties. Each county organizational chart would be as below:"



On June 7, 1970, Dr. Frank Luner was appointed medical director of Boone County. On June 14, 1970, Mr. Ron Kolnik, special assistant to the commissioner, wrote the following letter to Dr. Luner:

"June 14, 1970

"Frank Luner, M.D.
"Box 689
"Boone County Health Department

"Dear Dr. Luner:

"First, I want to apologize for being so long about sending you the following information:

"The proposed operation of the Boone County Health Department is somewhat different than in the past; consequently, it has been necessary to contact not only the county health department but our local health services section at the state level and establish some policies for the use of a health director (nonmedical) as administrator.

"Enclosed please find a copy of the order of appointment filed with the Boone County clerk. This appointment as medical director of Boone County Health Department pertains only to medical and clinical responsibilities. You would not be involved in health department administrative matters. In detailing responsibilities, I understand you wanted this. As medical director, your position would be somewhat two-pronged. The first, as county medical director, you would make all medical decisions concerning county health department personnel, and act as liaison for the county health department to the county medical society. This portion of the position has no time requirement to be spent in activities and only a token salary of $50 per month.

"The other prong of this position would be acting as a clinician in the county health department on a fee by the hour basis @ $25 per hour. At the present time, because in the past physicians' time has not been available for health department clinics, funds are not set aside for anymore than a two hour clinic every other week. This clinic time arrangement is to be arranged between you and the other county health department personnel to your satisfaction and convenience.

"As I explained to you on my visit, a health director (nonmedical) should be in the field soon to assume administrative responsibilities of the Boone County Health Department. These would include program coordination, personnel supervision, budgets, payrolls, time reports, administrative reports, public relations, and liaison activities with the county board of health, state legislators, and county citizenry, subject to administrative supervision of the state commissioner of health. This health director

will be on a part-time basis in Boone County and also working in Wayne County.

"Trusting the above details will provide the information you desire. If not, please contact us.

"Sincerely,

"Ron Kolnik
"Special Assistant to the
"Commissioner

"cc: Boone County Health Department
"Dr. Ron Bruce, Director
"Local Health Services"

During June 1970, the proposed budget for the Boone County Health Department was prepared by the state health department's local health services (Table 2) and sent to the chairman of Boone County Board of Health with a cover letter stating that the $8,000 for the health director's salary would be shown as coming from local funds, but that the state would reimburse the county on a monthly basis for the health director's salary.

On June 21, 1970, the commissioner of health hired Ken Jacobson, age 33, as health director for Boone and Wayne Counties. Ken Jacobson had worked five years as a county health department sanitarian, returned to school and received a master's degree in public health administration. At the time of his employment he was working as a health planner for a state agency.

On June 28, Dr. Ron Bruce, director of local health services, received a phone call from Mrs. Ethel Merriman, long-time clerk in the Boone County Health Department and

"June 14, 1970

"Frank Luner, M.D.
"Box 689
"Boone County Health Department

"Dear Dr. Luner:

"First, I want to apologize for being so long about sending you the following information:

"The proposed operation of the Boone County Health Department is somewhat different than in the past; consequently, it has been necessary to contact not only the county health department but our local health services section at the state level and establish some policies for the use of a health director (nonmedical) as administrator.

"Enclosed please find a copy of the order of appointment filed with the Boone County clerk. This appointment as medical director of Boone County Health Department pertains only to medical and clinical responsibilities. You would not be involved in health department administrative matters. In detailing responsibilities, I understand you wanted this. As medical director, your position would be somewhat two-pronged. The first, as county medical director, you would make all medical decisions concerning county health department personnel, and act as liaison for the county health department to the county medical society. This portion of the position has no time requirement to be spent in activities and only a token salary of $50 per month.

"The other prong of this position would be acting as a clinician in the county health department on a fee by the hour basis @ $25 per hour. At the present time, because in the past physicians' time has not been available for health department clinics, funds are not set aside for anymore than a two hour clinic every other week. This clinic time arrangement is to be arranged between you and the other county health department personnel to your satisfaction and convenience.

"As I explained to you on my visit, a health director (nonmedical) should be in the field soon to assume administrative responsibilities of the Boone County Health Department. These would include program coordination, personnel supervision, budgets, payrolls, time reports, administrative reports, public relations, and liaison activities with the county board of health, state legislators, and county citizenry, subject to administrative supervision of the state commissioner of health. This health director

will be on a part-time basis in Boone County and also working in Wayne County.

"Trusting the above details will provide the information you desire. If not, please contact us.

"Sincerely,

"Ron Kolnik
"Special Assistant to the
"Commissioner

"cc: Boone County Health Department
"Dr. Ron Bruce, Director
"Local Health Services"

During June 1970, the proposed budget for the Boone County Health Department was prepared by the state health department's local [redacted] (Table 2) and sent to the chairman of [redacted] Health with a cover letter stating [redacted] health director's salary would be [redacted] al funds, but that the state would [redacted] a monthly basis for the health direct[redacted]

On June 21, [redacted] ssioner of health hired Ken Jacobson, age 33, as health director for Boone and Wayne Counties. Ken Jacobson had worked five years as a county health department sanitarian, returned to school and received a master's degree in public health administration. At the time of his employment he was working as a health planner for a state agency.

On June 28, Dr. Ron Bruce, director of local health services, received a phone call from Mrs. Ethel Merriman, long-time clerk in the Boone County Health Department and

TABLE 2

BUDGET FOR LOCAL HEALTH DEPARTMENT
COUNTY: BOONE COUNTY HEALTH DEPARTMENT Budget No. B-20

Period Covered by Budget July 1, 1970 - June 30, 1971

Item No.	Item	Source of Funds				
		Amount Budgeted 12 Months	State Funds	Local Funds	Source - Local Funds	
					Tax Sources	Home Health Fees
	Salaries					
	Medical Dir., part-time	$ 600	$ 600			
	Health Dir., 4/5 time (10 mo.)	8,000		$ 8,000	$ 8,000	
	Sanitarian II	9,120	8,120			
	Sanitarian I	8,220		8,220	8,220	
	Public Health Nurse II	7,740	7,740			
	Public Health Nurse II	7,740	3,960	3,780	3,780	
	Public Health Nurse II	7,740		7,740	7,740	
	Public Health Nurse I	6,600		6,600	6,600	
	Home Health Aide	4,440		4,440		$4,440
	Clerk III	6,060		6.060	6,060	
	Typist Clerk I	5,130		5,130	5,130	

TABLE 2 - Continued

Item No	Item	Source of Funds				
		Amount Budgeted 12 Months	State Funds	Local Funds	Source - Local Funds	
					Tax Sources	Home Health Fees
	F.I.C.A.	$ 3,580	$ 1,014	$ 2,566	$ 2,335	$ 231
	State Retirement	4,247	3,981	266		266
	Insurance	1,710	1,535	175		175
	Unemployment Compensation	206	185	21		21
	Physician's Fees	1,950		1,950	1,950	
	Professional Fees	480		480		480
	Travel (7 people)	7,940	560	7,380	6,660	720
	Maintenance & Operation	3,600		3,600	3,000	600
	Capital Outlay	5,000			5,000	
	TOTAL	$100,103	$28,695	$71,408	$64,475	$6,933

secretary to the Boone County Board of Health. She said she was calling on behalf of the chairman of the Boone County Board of Health who wanted to know if the $8,000 allotted for a health director could be used for other activities if the board so desired. Dr. Bruce replied that the money would have to be used for a health director or it would be withdrawn.

On July 6, 1970, Ron Kolnik received the following letter from Dr. Luner:

"July 5, 1970

"State Department of Public Health
"223 East 19th Street
"Capitol City

"Attention Ron Kolnik, Special Assistant to the Commissioner

"Dear Ron:

"In the two weeks since receiving my official appointment, I have made several trips to the local health department for orientation.

"The proposed budget has been studied and I find that I am to meet with the county board on this———. The clerical personnel have assured me that I have already been subjected to about all the administrative responsibilities, and if this is true, I cannot see a need for a nonmedical health director. With the excellent clerical personnel available, I believe I can accomplish all his duties as enumerated in your recent letter. In some instances, my availability might even make this more workable if he (the health director) is on a part-time basis.

"I have no idea where space would be made available for such a director, and I also notice the $8,000 annual item on the proposed budget from county funds that would be necessary. I will be happy to discuss this further if my information is insufficient.

"I will be out of town until around July 22, but I will make an effort to meet with the county board to discuss all matters including the budget. I

have been assured that this is compatible with their meeting dates.

"Sincerely,

"Frank Luner, M.D."

Mr. Kolnik realized the project was in jeopardy and made plans to attend the next county board of health meeting scheduled for July 23, 1970.

Like all county boards of health in the state, the Boone County Board of Health was composed of five members appointed to staggered terms of three years. Two members are appointed by the county commissioner, one of which must be a physician; two members appointed by the commissioner of health; one appointed by the county judge and he must also be a public school educator.

The Boone County Board included a county commissioner, a retired postman, a local lumber dealer, a public school principal, and an osteopathic physician.

Mr. Kolnik attended the July 23 meeting of the Boone County Board of Health. Only two of the board members were present. Since a quorum was necessary to do any official business, no action was taken on the budget and the two members present appeared to still be in general agreement with the health director idea. Dr. Luner was still on vacation and did not attend the board meeting.

The Boone County Board of Health met again three days later with all members present. Mr. Kolnik was not

invited to attend. On July 27, 1970, the commissioner of health received the proceedings from the meeting and a letter from the chairman of the board, Mr. T. A. Anderson.

In the minutes of the meeting as written by the secretary to the board, the following pertained to the health director concept:

"Boone County Board of Health Meeting, July 26, 1970

"Mr. Mosley brought up the subject of the health director shown on the budget and explained his duties as told to them on July 23 by Mr. Kolnik. He said: 'I'm definitely opposed to having this administrator; that the health department doesn't need him; that what the people or taxpayers need is more actual services and Dr. Luner has agreed and will give the actual services to the people, and he would know the needs of the health department and could relay these needs to the public.'

"Mr. Mosley's motion was seconded by Don Richards who said: 'I am absolutely against this health director or administrator. We do not need any more of this thing but actual services to the people who are supporting the health department with their tax dollars.' Mr. Anderson said he felt the same way, that this expenditure of money could not be justified regardless from what source the money came, and that it was still the taxpayers money. The motion carried.

"Mr. Anderson then requested that the clerk write a personal letter to the commissioner of health for him, as chairman of the board, telling him that the board, with the agreement of Dr. Luner also, did not want the administrator...."

On July 28, the following letter was received in the commissioner's office.

"July 27, 1970

"Gene Cummings, M.D.
"Commissioner of Health
"State Health Department
"223 East 19th Street
"Capitol City

"Dear Dr. Cummings:

"This is to inform you that the Boone County Health Board is in full agreement that our health department does not need or want a health director or administrator, and we do not feel the money spent for this salary could be justified. Therefore, we are asking that he be taken off the budget and the money used for a medical director.

"Sincerely,

"Tom A. Anderson, Chairman

"cc: Dr. Ron Bruce, Director
"Local Health Services
"State Department of Public Health

"Dr. Frank Luner
"Medical Director

"P.S. What we need is a medical director, and Dr. Luner will give us the service needed and we prefer the money being paid to him."

PART II—Conclusion

Ron Kolnik, in an effort to find out what happened, contacted several people within the state health department system and recorded the following notes to himself on July 28, 1970.

Dr. Ron Bruce, State Director of Local Health Services, "as surprised as I...heard no rumblings, feels nurses and probably the senior clerk were behind the Boone County Board of Health's action."

Mr. Walt Egger, R.P.S., State Chief of Environmental Health Services: Mr. Egger had received favorable reports from sanitarians all over the state in regard to the health director concept and was surprised at the negative action in Boone County. He is going to call one of the Boone County sanitarians and see if he can get any more information.

Mrs. Jean Everman, R.N., State Chief of Nursing Services: Called her at Ellenville last night and she felt that the nurses in the state were in general accord with the idea. I know she's in favor of the health administrator idea. I asked her if she could talk with the Boone County nurses who are also attending the meeting in Ellenville.

Wednesday, Mrs. Everman called back and said she had talked with the senior nurse from Boone County and asked her how things were and she replied, "Terrible. The state health department is trying to push an administrator on us and we don't need such a person."

Mrs. Ruth Getz, State Supervising Nurse for Boone, Wayne, and Moore Counties was not aware of any concern of the local health department personnel in regard to the local health director idea up to the time she left, July 1, 1970. She felt the concept was well accepted; however, the senior clerk at the Boone County Health Department did express some concern to Mrs. Getz about where the money was coming from to pay the health director's salary.

On August 2, Ron Kolnik prepared the following letter for the commissioner of health's signature:

"August 3, 1970

"Mr. T. A. Anderson, Chairman
"Boone County Board of Health
"County Commissioner's Office
"Courthouse Building

"Dear Mr. Anderson:

"We have received a copy of the board of health's minutes of July 27 in which action was taken not to accept the health director as was offered by the state department of health to be administrator for Boone County Health Department for FY 1971. The $9,603 placed in Boone County Health Department's budget by this department for the county's portion of the nonmedical health director's salary, travel, F.I.C.A., retirement, insurance and unemployment compensation has been removed for use in other counties desiring initiation of that type of administrative structure.

"I am personally committed to placing a high priority on developing a better health care system in the rural areas of our state. One of the obstacles encountered is the shortage of doctors in the clinic setting of rural health care services in the local health departments. Most of the doctor's time is being utilized in taking care of administrative duties rather than medical responsibilities. We feel a health director with administrative responsibilities in Boone County would relieve Dr. Luner for the much needed expansion of clinic care referred to in the minutes of the board meeting.

"As you know, the local tax structure does not allow any more funds for health services. The same is true at the state level, but through federal grants, funds are frequently available for extension of health services. A health director would be knowledgeable of these and other outside resources and would explore such for expanding local health services in your county.

"Even though this is a disappointment to us... in that the offer was made in good faith with the thought of assisting Boone County in its health problems...we believe the county board of health has the responsibility to represent the people of a county by choosing those health programs they think the county citizens need, then requesting funds to finance such programs through whatever sources are available.

"If, at any time, the board desires to discuss the potential of an administrative director or any other assistance, my staff and I are available.

"It is the desire of the state health department to promote and help to maintain better health care programs in all of the counties.

"Sincerely,

"Gene Cummings, M.D.
"Commissioner of Health

"cc: Frank Luner, M.D.
"Medical Director, Boone County Health Department
"All Members of the Boone County Board of Health

Four months later, Ken Jacobson became health director for Wayne and two other counties in the southeastern part of the state.

PART III—Instructor's Guide

Resistance to change is common to all organizations. This case illustrates the problems that can be encountered when the leadership of an organization attempts to make changes in the administrative structure without adequately preparing the employees in the organization.

The informal organization in the Boone County Health Department was a major factor in this case. The clerk and one of the public health nurses in the department were opposed to the health director concept. Although neither of these individuals were in position of authority, their influence in the decision of the Boone County Board of Health was significant.

This case also presents examples of the communication problems that can occur between administrative levels in the same organization. The downward flow of communication is evident; however, there was apparently little opportunity for communication back through to the state health department.

The administrative relationship between the state and local health departments presented in this case is not clear, and the students discussing the case should be able to recognize this as a problem.

The administrative relationship between the state health department and the local health department is basically decentralized. This case should encourage the discussion

of the advantages and disadvantages of centralized vs decentralized organizational structure.

This case should also serve as a base for the discussion of the different types of organizational structures now being used in state and local health departments in the United States.

Although nonmedical administrators are employed in many hospitals, the concept is relatively new in public health organizations. This case should lead to the discussion of the advantages and disadvantages of using nonmedical administrators in the public health field.

The instructor may wish to ask the following questions to facilitate class discussion:

1) Why did the state health department leadership encounter difficulty in their attempt to establish a new administrative structure in the Boone County Health Department?

2) What is meant by the term informal organization and was it a factor in this case?

3) How many administrative levels are evident in this case?

4) What is the administrative relationship between the state health department and the local health departments in this case?

5) What are the advantages or disadvantages of having a nonmedical administrator in a public health department?

6) What are the advantages and disadvantages of a centralized vs a decentralized organizational structure?

CHAPTER III

THE STATE HEALTH DEPARTMENT PLANNING OFFICE

PART I—The Case

In the spring of 1967, Dr. Frank Mensik, age fifty-five, retired from the United States Public Health Service after twenty years of service in various administrative positions within that organization.

In June 1967, he accepted an appointment as commissioner of health for the state health department in his home state. The state health department had been under the leadership of Dr. John Williams for the past twenty years. He was retiring and Dr. Mensik was taking his place.

The state health department had been created by the state legislature in the early 1920's as an independent state agency. A nine member board is responsible for establishing policy. This board is also responsible for the selection of the state commissioner of health who serves at the "pleasure of the board."

The department had been relatively free of political patronage and influence, and there had only been three state commissioners of health since its creation.

In 1967, the department had a $5,423,000 annual budget. Two million dollars was appropriated by the state legislature. Approximately $1,500,000 was provided by the United States Public Health Service as grants-in-aid for general and categorical health programs. The remaining health department funds were appropriated by counties for the operation of local county health departments.

Seventy of the ninety counties in the state have full-time county health departments. These seventy county health departments are tied administratively to the state health department organization. Control and direction of local health department activities is exercised through the local health services of the state health department.

During 1967, the state and local health departments employed approximately 650 professional, technical, and clerical personnel. There were 180 registered professional nurses and 220 registered professional sanitarians.

Most of the sixteen full-time physicians were in administrative positions. Clinical time was usually contracted with physicians in private practice. The remaining staff were in administrative, technical, or clerical positions.

The state health department is organized into six major services with numerous divisions and section. The following is a description of each of the six major service areas and information on the chief administrative officer of each service:

Maternal and Child Health Services

This service consists of the Mental Health Division, Maternal Health Division, Child Health Division, Pediatric Section, Child Development and Behavorial Section, and the Community Guidance Center Section.

The service chief is Charles Lowery, M.D., age sixty-four. Dr. Lowery has been with the department for twenty-five years. For the last two years, he has served as chief of this service.

Personal Health Services

This service consists of the Chronic Respiratory Disease and Tuberculosis Division, Chronic Disease Division, Epidemiology Division, Immunization Section, Venereal Disease Control Division, Emergency Medical Care Section, and the Chronic Disease Field Services Section.

The service chief is Emil McCoy, M.D., age thirty-eight. Dr. McCoy has been with the department five years. For the past two years he has been the chief of this service.

Public Health Laboratory Services

This service consists of the Laboratory Consultation and Approval Division, Branch Laboratories Division, Virology Section, Parisitology Section, Poison Information Section, and the Rabies Testing Section.

The service chief is Charles Adams, Ph.D., age forty-six. He has been service chief for the two years he has been with the department.

Local Health Services

This service has two major divisions and is the largest in the organization. It consists of a Nursing Division which exercises administrative control over all public health nurses in the state.

The Local Health Department Division has administrative and budgetary control over the seventy county health departments in the state.

The service chief is Paul Stein, M.D., age sixty-four. Dr. Stein has been with the department for twenty years. He has been chief of this service for the past twelve years.

Environmental Health Services

This service consists of the Water Quality Division, General Sanitation Division, Occupational and Radiological Health Division, Consumer Protection Division, Air Pollution Control Division, Public Water Supply Section, Plumbing Section, and the Solid Waste Control Section.

The service chief is Herschel Leitner, R.P.S., age sixty-three. He has been with the department for twenty-three years. For the past sixteen years, he has been chief of this service.

Administrative Services

This service consists of the Personnel Division, Central Services Division, Fiscal Services Division, Public

Health Statistics Section, Vital Records Division, Public Information Division, Accounting Section, and the General Budget Section.

In past years, new activities that were not program in nature were usually placed in this service.

The service chief is Mr. Matt Newman, M.A., age fifty-five. He has been a service chief for the eight years he has been with the department.

Prior to accepting the health commissioner position, Dr. Mensik had met with the board of health to discuss the activities and problems associated with the department.

The board members felt that the department was fulfilling most of the traditional public health functions very well. However, they were concerned because they felt the department was not keeping abreast of the changing health needs of the state.

As one board member put it: "Dr. Williams, our previous commissioner, was a fine old gentleman but he was seventy before we could get him to retire. The last few years the department has been like a ship without a rudder, trying to go in several different directions at once. What we need is somebody who can get all of the department's programs going in the same direction again."

The department had a position classification for assistant commissioner of health. For the past ten years the position had been vacant. Two months after Dr. Mensik's

appointment, he hired his old friend and colleague, Dr. Michael Phelps, as assistant commissioner of health.

Dr. Mike Phelps, age fifty-three, had several years of experience in health department administration. In addition to being a physician, Dr. Phelps also had a Ph.D. in public health. For the past four years, he had been teaching health planning in a school of public health on the West Coast.

After two months, Dr. Mensik was pleased that his observations indicated that all of his service chiefs seemed to run efficient operations. However, he was concerned about the lack of good program planning. He was also very concerned about the absence of overall planning for the department.

Dr. Mensik felt the organization needed a planning office. In October 1967, he asked Dr. Phelps to establish such an office and to function as its chief.

In December 1967, Dr. Phelps hired Mike Pierce, MPH, age thirty-one, as director of the state health department planning office.

Mr. Pierce had a master's degree in public health with emphasis in health planning. He also had five years public health experience. Three of these years were spent as an administrator in a voluntary health agency. For two years he worked as a health planner for a community council organization in another state.

Soon after, Roy Purdham, M.A., age twenty-five was hired as an associate health planner. Mr. Purdham had a master's degree in public administration. He also had some graduate training in city planning. He had no prior public health experience.

In January 1968, Mary Randell, age twenty-three, was hired as a research assistant. She had no previous public health experience.

The purpose of the planning office and the function of its personnel had been explained to the service chiefs by Dr. Mensik and Dr. Phelps in their weekly Monday morning staff conferences. Dr. Mensik explained that Dr. Phelps would function as chief of the planning office while retaining his other duties as assistant commissioner of health.

The planning office was established on the organization chart as a staff office, administratively responsible to the assistant commissioner of health (Figure 1).

The service chiefs seemed pleased with the establishment of a planning office. Dr. Stein, chief of local health services, had remarked at the previous service chiefs meeting, "Well, I'm certainly glad to see the establishment of an office that can give us some help with program planning in county health departments."

At a staff meeting in January 1968, Dr. Phelps presented the following description of the functions of the state health department planning office. This meeting was

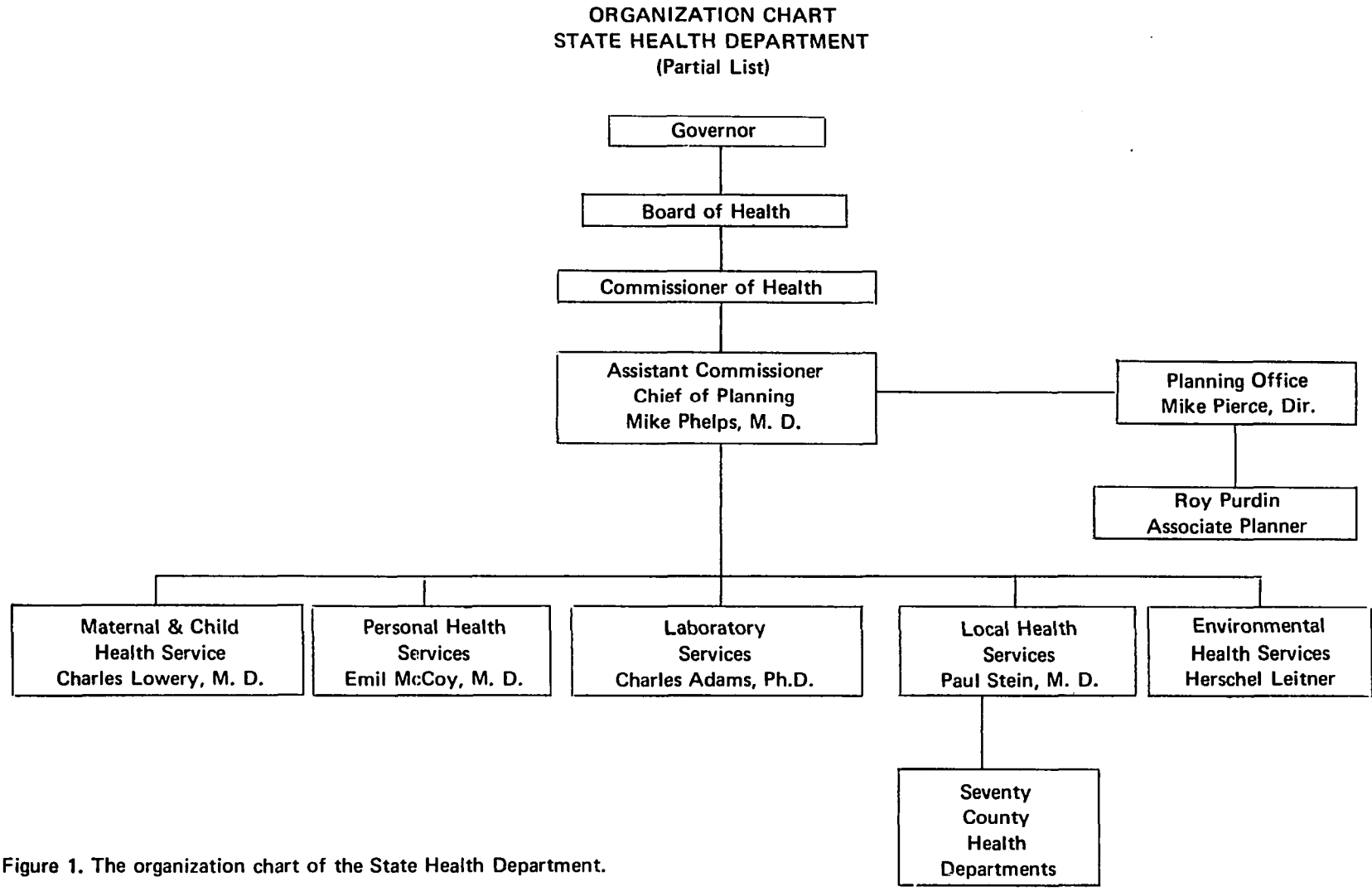


Figure 1. The organization chart of the State Health Department.

attended by all service chiefs, division directors, and section supervisors.

THE ROLE OF A STATE HEALTH DEPARTMENT PLANNING OFFICE

The office of planning amplifies the capacity of the commissioner of health to maintain and improve the health of the people of this state through developing and administering a program which coordinates the planning, evaluating and improving of all activities carried out by the department of health. The planning staff will maintain active communication with the state planning agency and other agencies engaged in health planning.

A first requisite in effective planning is the intelligent use of data with which to identify problems and on which to base recommendations for action. The planning staff will be involved in the orderly development of a central mechanism for collecting and analyzing health, statistical, cost operating, and relating data.

In order to coordinate the programs of the department, personnel will assist program directors to understand and identify problems, establish appropriate goals, utilize resources, influence attitudes, resolve conflicts, set priorities, facilitate decision making, and stimulate action.

The planning office will assist the commissioner and department program directors with reviews, evaluation, scientific planning on ongoing programs and stimulate the incorporation of evaluative techniques into new programs.

In order that the diverse programs of the department will be effectively coordinated, this office will provide direct and constant liaison with program directors in developing plans; provide for periodic follow-up program developments to make changes as necessary to comply with laws and regulatory requirements; keep the commissioner informed of the program planning trends and execute his suggestions and ideas to enhance the overall planning for the state.

At this same meeting, Dr. Mensik stated that for the first time, the United States Public Health Service was requiring the development of a comprehensive state plan for

public health services provided by the state health department. Dr. Mensik mentioned that all of the service chiefs were aware that the state health department received more than $800,000 a year in 314(E) Public Health Service funds for the development of general health in the state.

The state also received several hundred thousand dollars each year for specific categorical health programs in maternal and child health, environmental health and communicable disease control.

These categorical programs had always required a yearly project application which was used to explain how the federal money was to be spent. However, the Public Health Service general health funds had always been distributed to states on a per capita basis with few strings attached.

Now, the Public Health Service was requiring a comprehensive plan that would indicate in detail what was to be accomplished with the federal funds. The planning office staff had been assigned the responsibility of developing the plan.

In February 1968, Dr. Phelps called a meeting of all service chiefs and their division directors. The purpose of this meeting was to explain, in detail, the process that would be used to prepare the state plan for public health services.

Mike Pierce presided over the meeting and he explained the guidelines established by the Public Health

Service. These guidelines evolved around what was known as the POME Planning Process. Each program within each service was to identify the health problems they were attempting to solve. They were to set quantitative objectives that would help solve those problems. The methods of operation were to be defined and discussed. Each plan was to have evaluation procedures that would help determine how successful each program was in reaching its stated objectives.

In addition, each program was to prepare its budget requests in such a manner that they adequately reflected how the money was spent to reach their stated program objectives.

Dr. Mensik dropped by just before the meeting was ending. He spoke briefly about the Public Health Service planning requirements. He mentioned that he thought the POME Planning Process was excellent. Although these plans were required in order to get funds from the Public Health Service, Dr. Mensik stressed that he expected each program to use them as a working tool.

He closed the meeting by saying he thought the department had started on its first step toward organized and comprehensive health planning, and the planning office had his full support.

The final copy of the state plan had to be sent to the Public Health Service not later than May 1968 since the plan was to cover a July 1 to June 30 fiscal year period.

In early March 1968, Dr. Stein, director of local health services, came roaring into the office of Dr. Emil McCoy, chief of personal health services. Dr. Stein said, "Emil, I'm furious. Those whiz kids of Mike's are driving me crazy! Look at these POME's for my service. Red pencil markings all over them. Everyone of them was sent back to be done over.

"We have seventy health departments in this state and the planning office wants a POME on each of them, and they want these things perfect.

"I was just down talking with Mike Pierce, and he tells me my people don't know how to define a problem or quantify an objective. Can you imagine that? Twenty years in public health and this kid tells me I don't know how to run my own shop!"

Dr. McCoy said, "Calm down, Paul. I'm having the same problem. Those folk down in the planning office haven't had much program experience, but I think this planning process is really needed. My division directors are really having to take a real close look at the way they are running their programs."

Dr. Stein: "Okay, I'm in favor of program planning, but hell, its going a little too far when they (the planning office) start bouncing these plans back to my office because they are not worded correctly. Okay, look at this comment (Dr. Stein points to red pencil markings on a county health

department plan). Quote, 'This objective can't be quantified.' Of course it can't be quantified, but health education is an important objective of a county health department!"

Dr. McCoy: "What else did Mike Pierce say when you talked with him?"

Dr. Stein: "Well, he just sat there puffing on his pipe, trying to look like an intellectual. He said he would talk it over with Dr. Phelps as soon as he returned from Washington, D.C."

Dr. McCoy: "Herschel Leitner in environmental health called me this morning. He is pretty upset about the planning office also. Let's bring it up in the service chiefs meeting Monday."

At the Monday meeting, the problems with the planning office were discussed thoroughly. All of the service chiefs were having difficulty in preparing the plans.

Dr. Phelps defended the planning office. He said, "Gentlemen, I agree that these plans are difficult to prepare, but our program people are going to have to learn to write objectives and develop methods of operation that can be evaluated or we aren't going to know if we have effective programs or not. Please bear with me and I think you will find we can all gain by working with good program plans."

After numerous conferences and meetings, the service chiefs and their division directors were able to

develop program plans acceptable to Dr. Phelps and the planning office.

During the summer months of 1968, the state health department planning office began compiling statistical information on all programs within the state health department organization.

The planning office personnel were in frequent contact with the service chiefs and their division directors. Many different types of statistical reports were needed and a considerable amount of time was required to prepare them.

In August 1968, Dr. Charles Lowery, chief of maternal and child health, and Dr. Paul Stein, chief of local health services, came to Dr. McCoy's office.

Dr. Lowery: "Emil, you're the only one of us who seems to have any rapport with Dr. Phelps and the people in the planning office. We've got to do something! It seems like half of my staff is always preparing some type of statistical report for the planning office. They are doing a good job down there, but this is getting out of hand. We've tried talking with the commissioner and with Dr. Phelps. They keep telling us that all of these reports and evaluations are necessary and once they get the right type of statistical data, the problem will take care of itself."

Dr. Stein: "Who do they think they are kidding! That planning office is like a bottomless pit. We just keep pouring in reports and they just keep sinking out of

sight. Dr. Phelps thinks we are running a university here. He sent Roy Purdin (associate planner in the planning office) up to my office yesterday to see if we could run a cost benefit analysis in all of our county health departments this year. He already had a twenty-page questionnaire prepared. You should have seen some of the questions they wanted answered. It would take five cost accountants a year to prepare that report.

"I called Dr. Phelps on the phone and told him that if they wanted to do the study it was fine with me, but my people had more important things to do."

Dr. McCoy: "What did Dr. Phelps say?"

Dr. Stein: "He said it was just an idea and he wanted to get my impression."

Dr. McCoy: Well, I think we are going to be faced with doing cost analysis procedures in the future, but I certainly don't have a staff large enough to handle something like that now."

Dr. Lowery: "None of us do, that's the problem."

Dr. McCoy: "I'll talk with Dr. Phelps, but both of you know that Dr. Mensik feels we need a strong planning office, and I'm sure he will support them."

The following week Dr. McCoy met with Dr. Phelps, Mike Pierce and Ray Purdin. Dr. McCoy expressed how he and the other service chiefs felt about some of the activities of the planning office.

Dr. McCoy: "Dr. Phelps, you gentlemen know how I feel about the need for a planning office. We need an office that doesn't have program responsibility who can concentrate its activity on projecting the direction this organization needs to be going, but I think you have gone too far in your requests for data. There just doesn't seem to be an end in sight."

Dr. Phelps: "I know what you mean Emil, but we are trying to develop a central data base so we can make realistic evaluations and set some priorities around here."

Mike Pierce: "Dr. McCoy, your staff has always been very cooperative with us, but we have to beg and plead with Dr. Stein and Dr. Lowery to get any kind of information at all.

"Their program directors know how they feel about the planning office, and they go out of their way to make it tough for us."

Dr. Phelps: "We know we have made some mistakes in the past, and we are cutting back on the number of reports. You would be amazed at how often state legislators, the Governor's office, the board of health, the state planning agency and many other organizations ask for specific information on our program operations."

Mike Pierce: "We have been at this less than two years. Once we get all of the basic data we need, the rest will be routine. It's just a matter of time."

Dr. McCoy: "Well, you know how I feel, but I really think you should go a little slower. We can only take so much at a time."

In December 1968, Dr. Mensik suffered a heart attack. By January 1969, it was apparent that he would not be able to continue as commissioner of health.

Dr. Mensik resigned as commissioner of health, effective February 15, 1969. He recommended Dr. Phelps for the position to the state board of health.

Dr. Stein had considerable influence with the state board of health, and with the help of Dr. Lowery, was able to convince the board that it would be unwise to offer the position to Dr. Phelps.

On March 20, 1969, Dr. Stein was appointed interim commissioner of health.

The following week Dr. Phelps resigned and accepted a position with the medical school in a neighboring state.

The following Monday, Dr. Stein walked into Dr. McCoy's office. He said, "Well, Emil, I'm not interested in keeping this job for very long, but there is one administrative action I plan to take care of this week."

PART II—Conclusion

During the last week of March 1969, Dr. Stein, acting in his capacity as interim commissioner of health, formally abolished the state health department planning office.

All of the service chiefs except Dr. McCoy supported Dr. Stein's action. Dr. McCoy supported the planning office personnel and suggested that the office be maintained with its functions more clearly defined and with more control being placed on the activities of the planning office personnel.

Dr. Stein overruled Dr. McCoy's suggestions and the office was abolished.

The planning office personnel were given the choice of resigning or accepting reassignment to another section within the health department.

Mary Randell promptly resigned and returned to graduate school. Roy Purdham accepted reassignment to the budget section. Mike Pierce resigned and was hired as a health planning specialist for an areawide health planning organization in the same state.

In January 1970, Dr. Emil McCoy was appointed as the new commissioner of health.

In April 1970, Dr. McCoy began interviewing people with experience in health planning. He began each interview

by saying, "I'm looking for health planners, but for awhile the people filling these positions will be called administrative assistants to the commissioner of health...."

PART III—Instructor's Guide

Staff-line conflict is evident in many organizations employing technical experts who are not part of the actual production process. This case presents the dysfunctional aspects of such conflict. Resistance to change, to a different way of doing business is also evident.

Organizational and program planning is a crucial part of the management process. This case should serve as a base for the discussion of organizational and program planning as a management tool.

Federal grants-in-aid programs to state and local health departments has had significant impact on the planning capability of state health departments. An analysis of this case by students should lead to the discussion of the advantages and disadvantages of the federal grants-in-aid mechanism.

The state and area wide health planning agencies created as a result of the Public Law 89-749 Partnership for Health Legislation are often placed outside the administrative structure of state and local health departments. A discussion of this case should isolate some of the reasons why this has occurred.

The instructor may wish to present the following questions to facilitate class discussion:

1) What is meant by staff-line conflict? Was it a significant factor in this case?

2) Is it more difficult to introduce organizational change in a public agency than a private organization?

3) What is the difference in organizational and program planning?

4) In the public health field, what is the difference between categorical and generalized health grants from the federal government? What are the advantages and disadvantages of these two great mechanisms?

5) Do you feel that it is significant that most state and area wide health planning agencies created by the Federal Law 89-749 Partnership for Health Legislation, operate outside the administrative structure of state and local health departments?

6) What is meant by the term traditional public health programs?

CHAPTER IV

THE REED COUNTY VISITING NURSE ASSOCIATION

PART I—The Case

The Reed City-County jurisdiction includes a central city of 185,000 people. The metropolitan area encompasses almost all of the county, and the total area population is approximately 380,000 people.

The Reed County area is not unlike other communities in that there is a sharp contrast between the health care available to the more affluent citizens, and the health care available to the socially deprived.

For many years, the Reed City-County Health Department has provided preventive health care in the socially deprived sections of the city.

From 1916 to 1936, the county and city maintained separate health departments. In 1936, the two departments were combined and became the Reed City-County Health Department.

Policy for the Reed City-County Health Department is established by a nine member board of health. Five members of the board are appointed by the city's elected city

commissioners. By law, all five of these members must be physicians. The other four members are appointed by the elected county commissioners. No requirements are placed on the selection of these members other than they must be residents of the county rather than the city. Each member serves a six-year term.

The Reed City-County Board of Health has always been an active, informed board. However, traditionally, the board has given the medical director of the department wide scale authority in making policy decisions for the department.

Administratively, the health department is divided into four major services (Figure 2): personal health services, public health nursing services, environmental health services, and health information services. Each of these services is headed by a chief who is directly responsible to the director of health. There is a position classification for an assistant director of health which was filled for the first time in 1969.

In 1960, the Reed City-County Health Department staff and the Reed County Visiting Nurse Association (VNA) staff were combined into a single nursing service within the health department organization.

The Reed County VNA has a long and respected history of service. For many years, this nonprofit organization had conducted well baby and immunization clinics in the lower

ORGANIZATION CHART
REED CITY-COUNTY HEALTH DEPARTMENT
(Partial List)

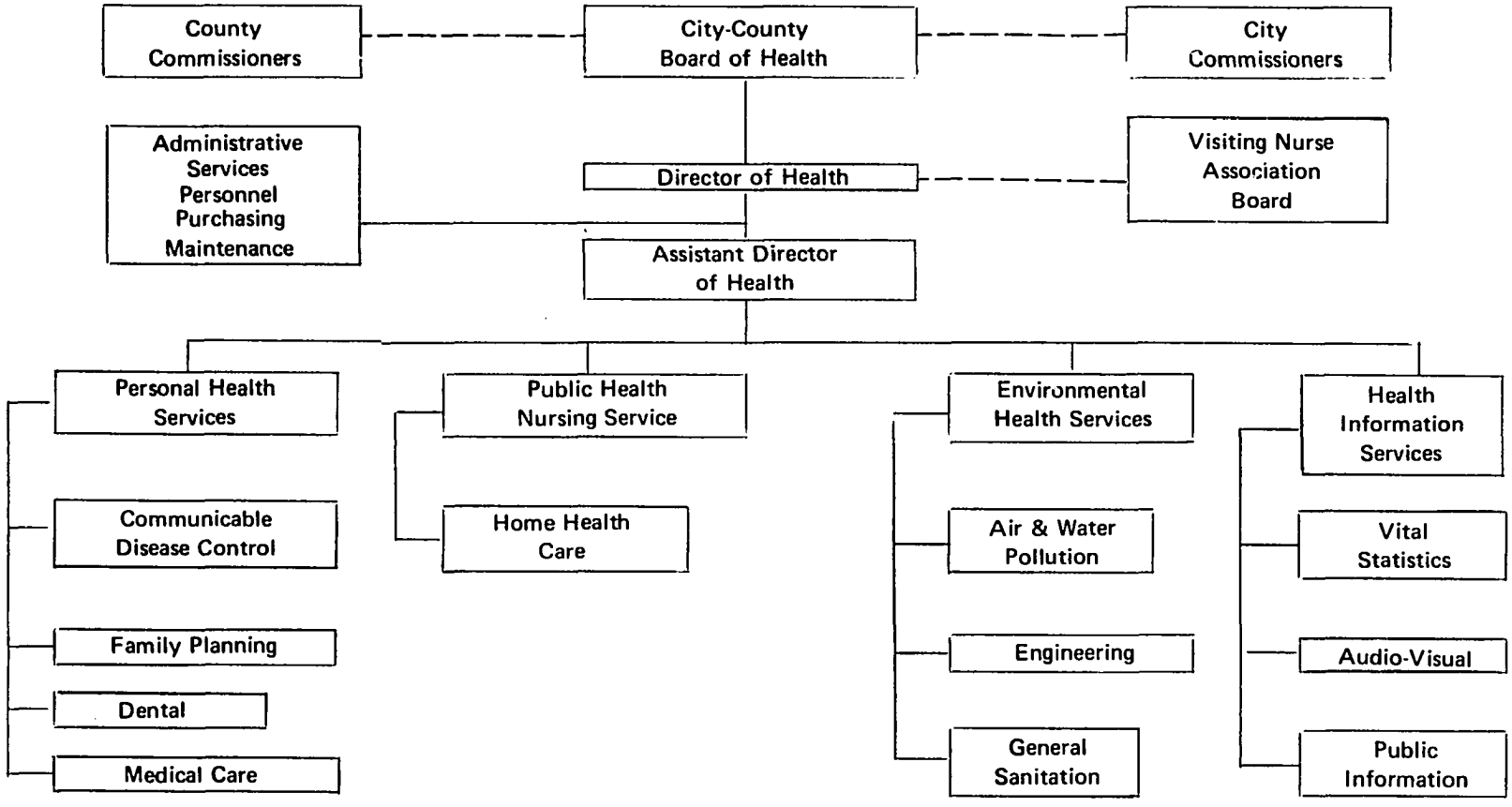


Figure 2. Organization chart for the Reed City-County Health Department.

income areas of the city and county. In addition, they provided skilled nursing care to home-bound patients in all areas of the city.

Although the Association charged for some services, the fees charged had always been less than the actual cost of the services provided. Each year the Community Chest for Reed County contributed money to the VNA to cover their operating deficit.

Organizationally, the VNA is responsible to a forty member board. From this board membership, a president, vice president, and secretary are elected annually.

These three officers are the executive committee of the board. A full-time executive secretary is employed by the board to handle public relations and administrative details. Dr. Robert Madewell is president of the board and has served in this position since 1963.

When the director of nurses for the VNA resigned, the VNA Board and the Reed City-County Board of Health met and worked out an agreement that combined the two nursing services. At the time of the merger, the VNA employed twenty registered professional nurses and two licensed practical nurses.

According to this agreement, the personnel of the two nursing services were placed under the direction of the medical director of the Reed City-County Health Department.

The VNA retained its board and executive secretary. As part of the agreement, the VNA Board was to serve in an advisory capacity to the medical director of the Reed City-County Health Department.

The Association retained its right to raise money through the Community Chest. Two payroll systems were maintained. The nurses paid with VNA funds continued to receive their pay checks directly from the Visiting Nurse Association.

The director of nurses for the health department received one-half of her salary from the VNA and the other half from the Reed City-County Health Department.

This agreement between the VNA and the Reed City-County Health Department worked satisfactorily from 1960 to 1968.

From March 1963 to January 1968, the Reed City-County Health Department had been under the direction of Dr. James Kelly. He was known in the community as a forceful public health leader. The Reed City-County Health Department had grown in size and prestige during his tenure as medical director.

The Reed City-County Health Department deserved its reputation as the most efficient local health department in the state. In addition to conducting a strong traditional public health program, the department had taken the lead in the development of a $100,000 model cities health project.

A project application for an Office of Economic Opportunity Neighborhood Health Center for the low income groups in the metropolitan area had been submitted, and notification of a $1,500,000 project award had been received by the department.

In January 1968, Dr. Kelly decided he wanted to return to the region in which he had grown up, so he resigned and moved back to the southeastern part of the United States.

From February to August of 1968, the Reed City-County Health Department was without a medical director. During these six months, a considerable amount of internal dissention developed between the nursing and the environmental health staff.

Also during this interim, the president of the VNA board, Dr. Robert Madewell, a retired physician, assumed personal control of the combined VNA-health department nursing service.

In August 1968, Dr. Kelly indicated he would consider accepting his old position as medical director again. He was promptly rehired by the board of health.

In November 1968, only three months after his return, Dr. Kelly resigned. Although it was never part of any official record, one of the apparent reasons Dr. Kelly resigned was the difficulty he encountered in attempting to regain control of the nursing service from Dr. Madewell, president of the VNA Board.

In Late December 1968, Dr. John Gillespie was offered the position as the new medical director for the Reed City-County Health Department.

Dr. Gillespie had more than ten years experience as a health administrator, and at the time of his appointment, was employed as assistant commissioner of health in a state health department.

Dr. David Hutson, Ph.D., a health administrator, was working for Dr. Gillespie during this period. Dr. Gillespie was aware that with the increase of federal health projects, there was a need for an assistant director of health for the Reed City-County Health Department. He offered the position to Dr. Hutson, subject to approval of the Reed City-County Board of Health.

Dr. Gillespie proposed to the board of health that he and Dr. Hutson be employed as an administrative team. The board accepted and both men were hired, effective January 1, 1969.

Because of previous personal and professional obligations, Dr. Gillespie was not able to arrive to accept his new position until February 1, 1969. Dr. Hutson arrived in early January 1969 and functioned as acting director of the department until February 1969.

During the month prior to Dr. Gillespie's arrival, Dr. Hutson had the opportunity to observe the operations of the Reed City-County Health Department.

He found that both the environmental health service and the public health nursing service had strong, effective directors. He was aware that ill feeling between the services had developed during the past year but he felt the difficulty could be resolved.

Mrs. Elizabeth Keen, R.N., was director of nursing. Mrs. Keen was thirty-one years old and had been director of the nursing service for four years. She had come to work for the Reed City-County Health Department in 1963. Within one year, she became director of the service.

She was known to be dynamic, aggressive, and somewhat tempermental. She was well prepared academically and understood the objectives of the health department very well. Mrs. Keen deserved her reputation as a leader of public health in the Reed County area.

Within her own service, Mrs. Keen maintained firm control. Almost all of the thirty-nine nurses working under her direction respected her leadership.

Dr. Hutson was to find there were those who did not admire Mrs. Keen, especially Mr. Ed. Simmons, chief of the environmental health services.

Mr. Simmons had been with the department for a number of years and was well respected for his competence in the environmental health field.

Two days after Dr. Hutson arrived, Mr. Simmons came by and asked for a conference. During this conference,

Mr. Simmons explained that he felt he should warn Dr. Hutson of the difficulty he and Dr. Gillespie could expect from Mrs. Keen.

Mr. Simmons explained that during Dr. Kelly's tenure, Mrs. Keen and Dr. Kelly were very close professionally and in many instances, Mrs. Keen unofficially assumed administrative authority outside the area of public health nursing.

Mr. Simmons mentioned that after Dr. Kelly left, he and Mrs. Keen often clashed because Mrs. Keen used her influence with the president of the VNA Board to establish health department policy. Mr. Simmons felt that the VNA Board now had more influence on department activity than the city-county board of health. Dr. Hutson thanked Mr. Simmons for the information and the conference ended.

During the next three weeks, Dr. Hutson was to discover that much of what Mr. Simmons had said was correct. In his initial meeting with Mrs. Keen, she quickly informed him that all nursing policy decisions would have to be cleared with Dr. Robert Madewell, president of the VNA Board.

Although concerned about Mrs. Keen's attitude, Dr. Hutson was very impressed with the "day-to-day" operations of the nursing service.

Mrs. Keen had initiated the team nursing concept and the system was proving to be very efficient and popular

with the nursing staff. All activities within the service were well supervised, and the staff had a strong esprit' de corps.

Dr. Hutson found that Mrs. Keen had frequent telephone contact with Dr. Madewell and sought his advice regularly in the operation of her service. She also apparently kept him informed of all other health department activity.

When Dr. Gillespie arrived in February 1969, Dr. Hutson informed him of the situation with Mrs. Keen. He also informed him that the VNA provided more than 40 per cent (about $200,000) of the nursing service budget for the Reed City-County Health Department.

In March 1969, Dr. Gillespie discovered that the VNA board had already met once since he arrived and neither he nor Dr. Hutson had been invited to attend. When he talked with Mrs. Keen about the matter, she told him that she always attended the VNA meetings for Dr. Kelly. Dr. Gillespie stressed to Mrs. Keen that he felt it was important that he or Dr. Hutson attend the VNA board meetings with her. Mrs. Keen said this was fine and she would let him know the date of the board meeting.

All of the personnel who traveled on business for the Reed City-County Health Department received a monthly reimbursement of sixty dollars per month to cover expenses incurred while driving their private automobiles on health

department business. Each person received a maximum of sixty dollars monthly regardless of the actual miles traveled within the city-county area. Most of the staff appeared very satisfied with the travel reimbursement arrangement.

In late March 1969, Dr. Gillespie was notified by federal officials that all federal project funds utilized for travel expenses by his department had to be paid on a per mile traveled basis. Each individual had to prepare a monthly travel voucher which indicated the area visited, the miles traveled, and the total amount reimbursed at a rate not to exceed ten cents per mile. The vouchers had to be maintained for federal auditing purposes.

Since the department was receiving several thousand dollars in federal project funds for travel, Dr. Gillespie had no choice but to change the method of travel reimbursement for the whole department. He consulted with the Reed City-County Board of Health and they agreed with his decision.

At a staff meeting, Dr. Gillespie explained the travel fund situation to the health department personnel. None of the personnel was very happy about the change. The nursing staff were very upset, especially Mrs. Keen who pointed out that the extra paperwork was going to take up a lot of valuable nursing time.

Within two hours after the meeting, Dr. Gillespie received a call from Dr. Madewell, president of the VNA Board. He was angry and said that Mrs. Keen had just called and informed him that he (Dr. Gillespie) was trying to cut off the travel allowance for the nurses.

Dr. Gillespie explained the situation and mentioned that he would be happy to come to the next VNA Board meeting and explain the reason for the change in travel reimbursement procedures. Dr. Madewell replied that Mrs. Keen usually represented the health department at the VNA meetings and abruptly hung up.

After the travel allowance problem, communication between Dr. Gillespie's office and the nursing staff became extremely strained.

In May 1969, the VNA Board held its next meeting. Dr. Gillespie and Dr. Hutson were not invited but attended the meeting anyway. They found that Dr. Madewell totally dominated the proceedings.

At this meeting, Mrs. Keen requested that the board consider a $75 a month raise for those nurses being paid by the VNA. Mrs. Keen noted that even with the raise, the health department nurses would be making less than the pay scale for nurses working in local hospitals.

Dr. Gillespie objected, explaining that he had just finished preparing the new health department budget, and there was no way the department could give the health

department nurses more than a $55 a month raise during the next fiscal year.

A lengthy discussion of the health department budget was held between Dr. Madewell and Dr. Gillespie. Dr. Madewell accused Dr. Gillespie of expanding other health department activities, especially the environmentalal health service, at the expense of the nursing service. He also mentioned that the department had always gotten along without an assistant director of health, and he felt that money used for that position could have been better utilized as part of the nursing budget.

The meeting ended without any agreement being reached on the salary increase for the nurses. During the next two weeks, the relationship between the nursing staff and Dr. Gillespie deteriorated further. It was apparent that the nursing corps held Dr. Gillespie personally responsible for the problems with the travel vouchers and the salary increases.

On June 16, Mr. Sam Bronson, a county commissioner and a member of the board of health, called Dr. Gillespie and informed him that Mrs. Keen, Dr. Madewell, and Mrs. Mary Kapp, executive director of the VNA, had just left his office. He said they were there requesting a hearing by the board of health to determine if Dr. Gillespie and Dr. Hutson were doing an adequate job.

Mr. Bronson was extremely concerned because Dr. Madewell had threatened to pull the VNA program out of the health department if the situation did not improve.

Mr. Bronson indicated that he was under the impression that the group was going to talk with all of the other board members that day.

PART II—Conclusion

Dr. Robert Madewell, acting in his capacity as president of the Reed County Visiting Nurse Association, was able to demand a hearing with the Reed City-County Board of Health.

The meeting was held in late June 1969. The board of health unanimously supported Dr. Gillespie and Dr. Hutson. The board of health concluded that the VNA Board, and specifically Dr. Madewell, had gone beyond the limits of their agreement with the health department, and were involved in the "day-to-day" operations of the health department nursing service.

The board also pointed out that much of the difficulty could be resolved if contact between the VNA Board and the health department was conducted through Dr. Gillespie rather than Mrs. Keen.

The chairman of the board of health concluded that Mrs. Keen appeared to have mixed loyalties and suggested "that she either work out her difficulties with Dr. Gillespie or resign."

Dr. Madewell was not satisfied with the results of the meeting. In early July 1969, he called a special meeting of the VNA Board and urged the board members to consider pulling the VNA out of the health department. No conclusion was reached at this meeting, and Dr. Madewell's proposal was tabled for further study.

Representatives of the news media attended the VNA Board meeting and the details of the controversy soon became public knowledge in the Reed Metropolitan area.

Soon after this meeting, Mrs. Keen and Mrs. Kapp, the executive director of VNA resigned, effective sixty days after the date their resignations were submitted. In their resignations, they stated they could not effectively work with Dr. Gillespie and Dr. Hutson, and if the situation did not change, they were resigning within sixty days.

The controversy continued for a month. During this month, Dr. Gillespie met with a number of the VNA Board members individually and was able to convince them that the community would suffer the most if the two agencies divided their nursing service.

In August 1969, with most of the board members present, the VNA Board, over the objections of Dr. Madewell, voted to continue their association with the health department. Dr. Madewell resigned as president of the VNA Board the following day.

Mrs. Keen and the executive secretary of the VNA realized the battle was lost and vacated their positions the following week.

During the next six months, Dr. Gillespie worked out a new written agreement with the VNA Board. The crucial elements of the agreement were:

1) Dr. Gillespie would represent the health department at all VNA Board meetings.

2) VNA Board members would not make personal contact with the nursing staff.

3) All questions regarding nursing policy were to be directed to Dr. Gillespie.

4) The director of nursing for the health department was responsible only to Dr. Gillespie.

5) All nursing personnel were to receive their pay checks from the health department. The VNA was to continue providing funds, but the money was to be paid to the department rather than directly to the individual nurses.

PART III—Instructor's Guide

Almost all large organizations have boards. Many public organizations have boards as a result of legislative mandate. This case should stimulate the discussion of the history and the administrative relationship of both policy making and advisory boards to public organizations.

The structure and size of boards is often crucial to their effectiveness. A discussion of this case should lead to an analysis of the problems an administrator is likely to encounter in working with boards.

This case should also lead to the discussion of what constitutes employee insubordination and how to deal with the problem.

Significant to this case is the relationship between authority and power. Although the director of Reed County Health Department had the legal authority to make decisions regarding his nursing service, the actual power to make the decisions was in the hands of Dr. Madewell and Mrs. Keen. This case should serve as a base for discussion of authority-power relationships.

Competition for funds, recognition and power between departments, divisions, and units within the same organization is a common occurrence. A discussion of this case should lead to the analysis of the advantages and disadvantages of group identification and competition within organizations.

In this particular case, the nursing service of the local health department and the visiting nurse association were combined into a single service. In many communities they are separate agencies. This case should lead to the discussion of the history of the VNA in the health care field. A discussion of the advantages and disadvantages of a combined nursing service would also be pertinent.

The instructor may wish to present the following questions or comments to facilitate class discussion:

1) What is the desired administrative relationship between the organization and its board?

2) What is the essential difference between an advisory board and a policy making board?

3) Why is structure and size of a board crucial to its effectiveness?

4) Was there a communication problem between the medical director's office and the nursing division?

5) Why didn't Dr. Gillespie fire Mrs. Keen when it was obvious she was being insubordinate? What were the risks?

6) Individual identification with a group, department or professional discipline within an organization can be beneficial to that organization. It can also be dysfunctional. Discuss.

7) Historically, what has been the essential difference between the nursing service provided by the visiting nurse association, and that provided by public health departments?

CHAPTER V

JOHNSON GENERAL HOSPITAL

PART I—The Case

Andrew Kerns, M.D., M.P.H., was appointed state commissioner of health for a southwestern state in January 1970. Dr. Kerns had worked five years in various high administrative positions within the state health department system before his appointment as commissioner.

A week after Dr. Kerns' appointment, Mr. Frank Reynolds, chief of health facilities for the state health department, telephoned and said, "We need to get together and discuss the proposed regional health center for the western part of the state because some major decisions must be made in the near future." An appointment was set for a week later.

Dr. Kerns was only vaguely familiar with the proposed regional health center. He knew that most of the idea revolved around the best way to utilize two state-owned institutions located near the city of Johnson in the western part of the state. Dr. Kerns called in his staff assistant, Pat Buchanan, and said, "Pat, get me as much background

information as you can on the Johnson General Hospital, the Western State Tuberculosis Sanatorium, and anything that has been written on developing a regional health center in that area."

Background: Western Tuberculosis Sanatorium

The state board of health is responsible for the operation of two tuberculosis sanatoriums in the state. One is located in the town of Morning in the eastern part of the state with 190 beds, and the Western Tuberculosis Sanatorium with 270 beds is located near the city of Johnson.

Western Tuberculosis Sanatorium is located on a one-hundred-sixty acre campus, approximately two miles from the city of Johnson. It is currently licensed for 270 beds and has an average daily patient census of 90 patients. The average daily census for 1967 was 154 and for 1968, 106. With the continual decline in the patient count, the hospital will soon reach the point where it is ineffective as an independent unit.

Total expenditures for 1968 amounted to $767,580. The per diem cost went from $14.07 in 1967 to $19.84 in 1968. Proper maintenance of the physical plant and grounds and quality patient care will prevent meaningful, additional reductions in personnel.

The hospital is located on a hill and contains several buildings in a campus-type arrangement: the main hospital building, an auditorium-recreation building, a

former nurses' residence building, the central boiler plant building, a dairy barn and companion buildings, and several residences for staff and employees. The main hospital contains an old section, three-story with basement and a fairly new (1950's) southwest addition consisting of four floors and a basement.

The medical staff consists of two part-time staff physicians and the medical superintendent. Medical and surgical consultation is provided by the faculty of the state school of medicine located 200 miles away. A qualified radiologist is available in Johnson.

The nursing staff consists of three registered professional nurses, three licensed practical nurses, and thirty-five nurses' aides.

Staffing of other technical departments is also below recommended minimum. Personnel deficiencies have been primarily responsible for the hospital's not being eligible to participate in medicare programs. Approximately one-third of the patients are eligible; therefore, noncompliance has resulted in significant loss of income.

Recruitment has been active, but professional and technical people have not shown an interest in employment. Wages are lower than the average for the market area. There is no public transportation to the campus. Political controversy including those issues related to closing or combining the hospital with Eastern State Tuberculosis

Sanatorium, and a general professional disinterest in the hospital and its program have contributed to unsuccessful recruitment.

Limited physical, occupational, speech and other therapy programs are provided by untrained persons. There is no formal social service program and both the inpatient and outpatient programs are seriously handicapped. There are no educational programs offered by the institution.

Approximately one-half of the area available for patient care is not used. The east wing, east apartment area, dormitory, and auditorium are not utilized.

Background: Johnson General Hospital

The Johnson General Hospital is unique in that it is the only state-owned and operated institution in the state that serves as a non-teaching, short-term community hospital. The hospital was given to the state in the late 1930's by a private physician who had practiced for many years in the city of Johnson.

The Johnson General Hospital is discussed in the State Public Health Code in the following manner:

> *Article 16. Johnson General Hospital 1-4011.*
>
> *Administration of hospital--(a) The state board of health shall have the control of the Johnson General Hospital at Johnson and shall prescribe policies and procedures for its administration and operation, including rules and regulations of the board. The hospital shall be under the general supervision of the state commissioner of health and shall be managed by a director who has had*

training or experience as a hospital administrator, (b) Agricultural and dairy products and laundry service needed for such hospital shall, to the extent available and economical, be purchased from the Western State Tuberculosis Sanatorium.

1-4012 - Patients

There shall be admitted to the Johnson General hospital any indigent person in need of medical or surgical treatment upon recommendation of a physician licensed to practice medicine in the state. Certification as to indigency shall be made by the board of county commissioners of the county in which such persons reside. Preference in admission shall be as follows: (1) emergency cases, (2) indigent children who are afflicted with any deformity that may be cured by surgical operation or hospital treatment, (3) other indigent persons who will be benefited by hospital treatment, and (4) indigent obstetrical patients.

There may be maintained in the hospital a number of beds for such patients as are financially able to pay for their treatment and who may desire to enter the hospital. Such patients shall be charged hospital rates as may be prescribed by the state board of health. Any patient shall be privileged to use a physician or surgeon of his choice to treat his condition, provided the physician or surgeon has been approved by the state board of health to practice in the hospital.

1-4013

There is hereby created in the state treasury a revolving fund for the Johnson General Hospital. All fees or amounts thereafter received or collected by the director of such hospital for medical or surgical treatment, hospitalization or other purposes shall be deposited in and become a part of such Johnson General Hospital Revolving Fund which shall be used to purchase drugs and supplies for the hospital, to pay compensation to nurses for the care of patients paying for surgical or medical treatment or hospitalization, to purchase food and hospital clothing for patients, and to pay other expenses necessary for general maintenance of the hospital.

Johnson General Hospital is located on a one-half block area in the city of Johnson (population approximately 23,000). The hospital is currently licensed for 100 beds,

but fewer than this number are available due to inability to adequately provide for patient care because of the physical arrangement and absence of private room facilities. At any given time, semi-private rooms will be reduced to single occupancy to accommodate the equipment required to care for a patient. Utilization of the maternity service is extremely low and a major economic concern.

The patient care areas are connected by ramps. The split-level construction presents innumerable problems for patients and personnel. It is unlikely that anyone could intentionally design a more unsuitable physical facility.

The hospital proper is substandard in every respect. The size, arrangement, and location of nursing stations, surgery, central supply and similar areas make renovation highly impractical. Expansion is not feasible in the present location. The hospital is surrounded by privately-owned property that can be purchased only at a premium price since much of it was bought as investment property and kept in anticipation of hospital expansion.

The demand for service is growing. The hospital is accredited by the Joint Commission for Hospital Accreditation and certified as a medicare facility. Extended care is available and is also certified. The average daily census is 68, and 2,000 plus patients were served in 1968. Total expenses for routine and special services for the period ending June 30, 1969 were $1,059,287. The revolving

fund paid for $480,632, and the remainder was state appropriations.

The medical staff consists of the private physicians practicing in the city of Johnson and the immediate area, and three full-time physicians employed by the state to care for state supported patients. Two board certified physicians are active staff members. Radiology services are available locally, and pathology services are contracted with a laboratory in Capitol City.

There are 220 people employed at the hospital; all are state employees. This includes 26 registered professional nurses. Licensed or registered personnel are available in laboratory, X-ray, physical therapy, medical records, pharmacy, inhalation therapy, and food services. Social and psychological services are provided on a contract-consultation basis.

An analysis of admission at Johnson General Hospital for the fiscal year 1970 showed 3,771 admissions: 659 were medicare patients (17.5%); 1,417 were private patients (37.6%); 1,029 were patients whose hospital cost was paid by the state welfare department (27.3%), and 666 (17.6%) were state patients who did not qualify for medicare or welfare benefits. Fifty-eight percent of the total admissions were residents of the city of Johnson or Johnson County.

Admission records indicate that one or more indigent patients from 39 of the state's 80 counties received hospital

services indicating that Johnson General Hospital serves as the primary hospital only for the city of Johnson and Johnson County. Analysis of admission records since 1964 indicates that the ratio of state patients to private and medicare patients is going down as a result of medicare and expanded eligibility under the state welfare programs.

Johnson General Hospital is the only hospital in the city of Johnson and, in essence, serves as a community hospital.

Background: The Regional Health Center Concept

Johnson General Hospital has never served its full potential. As a state-owned and operated institution, it could serve to set the example for the western section of the state.

Although never advanced beyond the preliminary planning stage, the idea of a regional health center was supposed to involve primary participation by the state school of medicine, the state health department, and the liaison committee made up of health professionals and interested citizens from the western part of the state.

The facilities included were:

1) General hospital (200 beds).
2) Community mental health center.
3) A public health department.
4) Social services such as welfare and vocational rehabilitation
5) A physicians' office building.
6) A voluntary health agency building.
7) Other special services according to needs such as nursing home or extended care facilities,

tuberculosis care, children's day care center and emergency vehicle and communication facility.

Priorities beyond the need for a new general hospital have not been established.

Background: State Plan for Construction of Hospitals and Medical Facilities for the State

In order to obtain federal funds for the construction of health facilities, a state plan must be submitted by the state health department to the United States Public Health Service each year.

As discussed in the state plan, the state is divided into:

1) One central base area having a sufficient population to support a statewide medical center which includes teaching facilities for physicians, nurses and other paramedical personnel.

2) Five regions, each having sufficient population and geographic relationship to support one or more acute general hospitals having a minimum size of 100 beds. Each region also has within its boundaries at least one college or university in which there is a potential for the development of health related educational programs.

3) Nine service areas. Within each region are one or more service areas. Each service area contains sufficient population to support at least one acute general hospital of 100 beds or more and can provide a reasonable range of short and long-term inpatient and outpatient services.

The city and county of Johnson and six other western counties make up one of two service areas in the southwest region. The Johnson service area is described in the state plans as follows:

The Johnson service area had 13 general short-term hospitals with 339 out of the 488 beds meeting federal standards. Total beds needed for the service area is programmed at 589 beds. No new facilities are suggested, but 101 beds are scheduled to be modernized. The hospital bed use rate is slightly higher than the rest of the state.

The current population for the service area is 98,800 people with 11,240 over 65 years of age. The Johnson service area has 1,316 persons per doctor; the highest ratio in the state. The area is located along the western edge of the state and is almost totally agricultural. Little or no population growth is anticipated. Per capita income is somewhat higher than the average for the state.

Southwestern College, a four year state-supported college located in the Johnson service area, conducts one of two schools of pharmacy located in the state. This college has recently initiated a degree program for medical record librarianship, and steps are being taken to establish a degree program in nursing. Clinical facilities for these programs and others as may be developed can be made available at the primary hospital in Johnson and at various cooperating hospitals in the area. This state college, with the cooperation of the area hospitals, has proven to be one of the most innovative in attempting to develop a program for relieving the critical shortage of paramedical personnel.

Planning is underway to merge the state-owned Johnson General Hospital and the state-owned tuberculosis hospital, both located in Johnson. This is part of an ongoing program to make the most effective use of facilities and manpower in serving the general needs of the area. The present facilities are largely nonconforming buildings. Programming is presently in progress to develop Johnson and the state-owned hospitals as a seminar center for health occupations.

Background: Planning for the Merger of Johnson General Hospital and the Western Tuberculosis Sanatorium

With the concensus of practically every official concerned, it was considered uswise to attempt to modernize the Johnson General Hospital. The patient load at the Western State Tuberculosis Hospital had continued to drop

and many of the facilities at the complex were not being used.

Representatives of the state health department had conducted several meetings during 1968 and early 1969 with the civic, political, and medical groups in Johnson General Hospital service area to discuss the possibility of combining and improving services by moving Johnson General to the Western State Tuberculosis Hospital campus. Other alternatives, such as building a completely new community hospital, were also being considered.

In 1968, the people of the state had passed several building bond issues. Two hundred and fifty thousand dollars was appropriated for renovation of the Western Tuberculosis Sanatorium and $500,000 for Johnson General Hospital. In addition, it was anticipated that approximately $800,000 could be obtained through Hill-Burton funds from the Federal Government.

The state health department contracted with an architectural firm to prepare a feasibility report. The following is their analysis:

FEASIBILITY REPORT

PROBLEM: In relocating, should the Johnson General Hospital remodel or build a totally new facility?

REASON FOR REMODELING:

1) Available funds are limited. Some of the tuberculosis sanatorium facilities can be remodeled so that both hospitals can be combined. One million five hundred thousand

dollars is available and is contemplated for the first phase of an eventual 200 bed regional hospital for the western part of the state. On the other hand, if totally new facilities were built for a 100 bed general hospital, it would take approximately $4,000,000.

2) *Some of the existing facilities at the tuberculosis sanatorium are in fairly good condition. Other parts are antiquated but are structurally sound and can be reused.*

3) *Since the state must have title, the legislature would have to be asked to build a new hospital for a single community in order to build a new facility.*

REASONS FOR A TOTALLY NEW FACILITY:

1) *All the advantages of a new hospital are available if the funds could be raised.*

2) *There is a degree of risk in the proposed remodeling of the tuberculosis sanatorium. There may not be ready acceptance of the new idea.*

3) *A portion of a totally new hospital unit could be build now. Still, this would split the operation of the Johnson General Hospital into two locations separated by several miles.*

SUMMARY OF FEASIBILITY REPORT:

The options are to remodel or build a new unit. Since the buildings at the Western State Tuberculosis Hospital complex are sound, either route is architecturally feasible. The availability of funds appears to be the crucial factor.

With agreement from most of the parties involved, it was decided to consolidate and renovate the Western General Tuberculosis Complex to the extent that it would serve as a 200 bed community hospital with 60 beds allocated for tuberculosis patients. A total of $1,500,000 was available for the project: $750,000 through the Federal Hospital and

Medical Facilities Act (Hill-Burton), and $750,000 from the 1968 state building bonds.

During late January 1970, Dr. Kerns and Mr. Buchanan (Dr. Kerns' assistant) met with Mr. Reynolds.

Mr. Reynolds began the conference by saying, "Dr. Kerns, I need to give you a progress report on the consolidation project for Johnson General and the Western Tuberculosis Sanatorium. As you probably know, a contract has been awarded to an architectural firm to develop the renovation project. This contract was awarded in early 1969 and the firm was to develop an acceptable renovation plan for $1,495,000. About $750,000 was available from state building bonds and the state health department received another $750,000 through Federal Hill-Burton funds for the project.

"During July 1969, the firm notified us that the renovation plan could not be accomplished for $1,500,000. Well, there just wasn't any more money available. Dr. Neery, the previous commissioner of health, after considerable political pressure from the state senator from the Johnson area, obligated the interest money accumulated from the idle state bonds. This money is used to build other health facilities across the state. He was able to come up with about $450,000, and the firm started on the renovation plans again. About the time you were appointed commissioner, their chief architect called me and said it looked as if

they were not going to be able to develop an acceptable plan for two million.

"I met with them several times. Their total revised cost for the project is now up to $2,400,000."

Dr. Kerns: "Didn't the architectural firm get the project through competitive biddings?"

Mr. Reynolds: "No. Architectural firms get these projects through political influence. Most of the time this works okay and most of them really know their business, but these people don't have any experience in building hospitals."

Dr. Kerns: "What about the regional health center concept?"

Mr. Reynolds: "As you know, we could use a center of this type in the western part of the state. But the concept has never gotten past the preliminary planning stage. Frankly, the state medical center has been very cool toward the whole concept, and the medical and business community in Johnson have been hostile toward the idea."

Dr. Kerns: "Why?"

Mr. Reynolds: "Well, for more than 20 years, the state has provided Johnson with a free community hospital. Granted, it is not the best facility in the state, but it doesn't cost the community anything. They're afraid if we pursue this regional health center idea, they might end up without a state supported hospital."

Mr. Buchanan: "Isn't there a liaison hospital committee in Johnson who is working with us on the project?"

Mr. Reynolds: "Yes. The Chamber of Commerce in Johnson formed this committee about two years ago. Their primary activity to date has been to bring political pressure on us every time they think we are considering closing Johnson General or the tuberculosis sanatorium."

Dr. Kerns: "What do you think of the general idea of combining Johnson General and the tuberculosis sanatorium?"

Mr. Reynolds: "Well, for the seven years I've been director, the whole idea has been if we can't get rid of the facilities, let's try to utilize them."

Dr. Kerns: "What do you mean?"

Mr. Reynolds: "If you look at the patient utilization rates at Johnson General, you'll see that the number of indigent patients has been going down each year. A lot of this is because many patients are now covered by welfare or medicare. These patients can be served in any community-owned hospital in the state. There just doesn't seem to be a need for a state supported community hospital."

Dr. Kerns: "What about Western State Tuberculosis Sanatorium?"

Mr. Reynolds: "For the past five years, our recommendations have been to combine Eastern State Tuberculosis with Western, or to close both of them and put state supported tuberculosis patients in community hospitals near their homes. The way the case loads for both hospitals are dropping, the most feasible plan is to close them. If you want to create a political uproar, just suggest that to the state legislature. We're talking about 350-400 state jobs in areas of the state where jobs are scarce."

Dr. Kerns: "So you think the consolidation plan is a bad idea?"

Mr. Reynolds: "I've been more concerned with the 'how' rather than the 'why,' but I think we could pour three million dollars into this project and it would still be bad. You just can't make a silk purse out of a sow's ear. Also, I don't feel we should be providing Johnson with a free community hospital. We don't do this anywhere else in the state. The private physicians in that area take us for granted. They insist that the three state employed physicians out there assist them in surgery

on private patients. There's a lot of hostility building up because our men say they are treated like interns and don't like it."

Dr. Kerns: "What do you propose?"

Mr. Reynolds: "Number one, I propose we suspend the whole project. I don't have any idea where we are going to get an additional $400,000 for the project. Number two, subject to approval from the United States Public Health Service, I suggest we reallocate the $800,000 Hill-Burton fund into other building projects. I strongly suggest we do so because if the Hill-Burton money isn't used this fiscal year, we will lose it. The way this consolidation project is going, there's not much chance of getting it started this year."

Dr. Kerns: "We are going to have to handle this problem very carefully. The state senator from that area is on the public health committee in the legislature. He can cause a lot of problems. After studying the background data on both Johnson General and Western Tuberculosis Sanatorium, I think the whole idea is very shaky. I agree we should suspend the whole project, but the crucial question is how to do it."

Mr. Buchanan: "Shouldn't we meet with the hospital committee in Johnson?"

Dr. Kerns: "Right, but I want to meet with the Governor and the state senators and representatives from that area first."

Mr. Buchanan: "The legislators from that area are all on the liaison committee, so we can take care of both meetings at the same time."

Dr. Kerns: "Okay, but I want to see the Governor first. See if you can set up an appointment."

Mr. Buchanan: "It is not going to be easy. He just took office this month and every politician in the state is trying to see him."

Dr. Kerns: "The state board of health is meeting next week; make sure this problem is put on the agenda."

After much debate, the state board of health approved Dr. Kerns' proposal to suspend the Johnson General Hospital building project, and in early February 1970, Dr. Kerns, Mr. Reynolds, and the chairman of the state board of health met with the Governor. He accepted their proposal to suspend the renovation plans and suggested they meet with the Johnson Hospital liaison committee at their earliest convenience.

During the same month, Dr. Kerns and Mr. Reynolds met with the Johnson Hospital liaison committee and discussed the renovation problems in detail and offered the following proposals:

1) Suspend the renovation plans indefinitely.

2) Use the state building bond money to build some of the other facilities mentioned in the regional health center concept.

They also suggested that the community start a fund drive to build a completely new community-owned hospital. Mr. Reynolds assured the committee that part of the money for a new hospital facility could be obtained from the federal government. In addition, they proposed that the Western State Tuberculosis Sanatorium be closed when the new community hospital was built. Adequate beds for tuberculosis patients could be contracted from the new hospital.

The meeting did not go well. All of the proposals were met with cool silence and several hostile comments.

After the meeting, a prominent physician from the area came up to Dr. Kerns and said, "Dr. Kerns, you're new at this job and I'm going to tell you something. The western part of this state gets very little in the way of services from the state government. We feel that the money we get to run Johnson General is less than a fair return on our tax dollars, but it is all we get and we aren't going to let it go that easy."

Senator Sorenson, who was standing nearby said, "Dr. Kerns, the way it looks to me, we have everything to lose and not much to gain and I can assure you, you haven't heard the last of this yet."

On February 28, 1970, the state board of health made the formal announcement that the renovation project for Johnson General Hospital and the Western State Tuberculosis Sanatorium was suspended indefinitely and the federal money involved would be used for other health facility construction.

On March 3, 1970, Dr. Kerns received a call from one of the Governor's staff assistants informing him that Senator Sorenson was demanding a senate subcommittee hearing on the Johnson General Hospital project and suggested that Dr. Kerns start preparing his case.

PART II—Conclusion

Dr. Kerns, in an effort to avoid a win-lose confrontation with Senator Sorenson, arranged a meeting with the Senator and five other members of the Johnson Hospital liaison committee with the Governor of the state.

At this meeting, the Governor firmly backed the state health department's decision to stop renovation plans on the Johnson General Hospital-Western Tuberculosis Sanatorium project. However, the Governor assured the group that:

1) Johnson General and the Western Tuberculosis Sanatorium would remain open until the Johnson community had a new hospital facility.

2) His office and the state health department would make every effort, short of committing state funds, to assist the Johnson community in building a new community hospital.

This meeting gave Senator Sorenson an opportunity to demonstrate to his constituents that he still had considerable influence at Capitol City. The next day, he cancelled the senate subcommittee investigation.

A month later, the chairman of the Johnson Hospital liaison committee informed Dr. Kerns by letter that the committee had retained a hospital consultant and was making preparations to begin a fund drive to build a new community hospital in Johnson.

The ultimate disposition of Western Tuberculosis Sanatorium is still not known.

PART III—Instructor's Guide

All public agencies are vulnerable to political pressure. This case should illustrate for the reader some of the problems a public administrator may encounter while pursuing a rational plan of action that conflicts with political reality. Political influence is a fact of life in public health care programs and should be analyzed and discussed.

In recent years, the concept of regionalized health facilities and manpower has been encouraged. This case should provide the base for the discussion of the advantages and disadvantages of the regional health center plan.

The guidelines for the control of tuberculosis in the United States have been changing rapidly during the last decade. This case should stimulate the discussion of the role of tuberculosis sanatoriums in a modern tuberculosis control program.

The impact of the Federal Hospital and Medical Facilities Act (Hill-Burton) on the number and quality of health care facilities in the United States has been significant. This case presents an example of the influence of this legislation.

The problem of providing adequate health care in rural areas is also evident in this case and should be discussed.

The instructor may wish to present the following questions to facilitate class discussion.

1) Does the background information on the Johnson General Hospital and the Western Tuberculosis Sanatorium indicate they should be closed? If so, why is the commissioner of health in this case encountering opposition?

2) Does this case present any examples of the problems faced in attempting to provide adequate health care to rural areas of the state?

3) Is the clustering of medical facilities and personnel a feasible plan?

4) What influence has the advance in medical technology had on the control of tuberculosis during the last twenty years? Are tuberculosis sanatoriums still needed?

5) What was the original purpose of the Federal Hospital and Medical Facilities Act? Since 1947, what impact has this legislation had in the public health field?

CHAPTER VI

SEVEN FLUID OUNCES OF ISOPROPYL ALCOHOL

PART I—The Case

Since 1959, the chronic disease division of a state health department in the Midwest had operated several mobile multiphasic screening units throughout the state.

The state health department owned four mobile units and they were in constant use. As of 1965, each unit had the capacity to offer the following battery of tests:

1) Vital capacity (spirometry)
2) Single lead electrocardiogram
3) Blood pressure
4) Primary and secondary diabetes tests
5) Papanicolaou smear
6) Glaucoma test
7) Hematrocrit and hemoglobin tests

As a standard operating procedure, a detailed medical history was taken on each individual before any tests were conducted.

The mobile screening units were refurbished trailer houses, about forty feet long and eight feet wide. They were pulled from area to area by truck. The units were used in all areas of the state, and a formalized method of operation had been established. Before a unit was moved to a new location the following activities were conducted:

1) A representative of the chronic disease division would meet with the county medical association in the area involved and explain the tests to be conducted and the method of referral to be used.

2) In those counties with health departments, meetings were held with the local health department staff and the screening operation was explained in detail.

3) Personal contact was made with various civic groups in the area to obtain assistance in publicizing the services offered by the mobile screening unit. In addition, the assistance of volunteers was used to make appointments for the units.

4) Standard news releases were sent to television, radio, and newspapers in the area giving the location, dates, and the services offered by the unit.

5) The mobile unit was moved into the area and disease screening tests were offered to selected age groups. The unit usually stayed in one area for six to eight weeks.

Each person screened was required to give the name of his private physician, or the physician he would go to if any of the tests conducted were positive. All individuals with positive tests were contacted, and the results of the tests were sent to the person's private physician. The personnel working on the unit did not provide medical consultation or treatment of any type.

During the early 1960's, the multiphasic screening operation gained wide acceptance in the private medical community and with the general population. Each mobile unit always had plenty of business.

In the fall of 1965, the chronic disease division of the state health department was organized in the

following manner (Figure 3). Dr. Albert Sills was director of the division and responsible directly to the commissioner of health. Dr. Jim Mead was associate director of the division with clinical responsibility for all of the chronic disease operations. Both physicians had been with the division for a number of years.

Mr. Ron Mathews was field supervisor of all chronic disease operations including the mobile screening units. Mr. Mathews had been with the department more than twenty years. There were eight public health nurses in the division. Two worked as consultants to all program operations; the other nurses performed specified duties on the mobile units. There were a number of medical technologists working with the units.

Because the mobile units were always on the road, employee turnover had been a constant problem. On many occasions it was necessary to use personnel from other chronic disease programs on the unit until vacancies could be filled.

In October 1965, the chronic disease division in cooperation with the Bevens City-County Health Department, the Bevens County Medical Society, and the Bevens County Diabetes Association, began preparation to conduct a special diabetes testing program for Beven County as part of the observance of National Diabetes Detection Week, November 15-19, 1965.

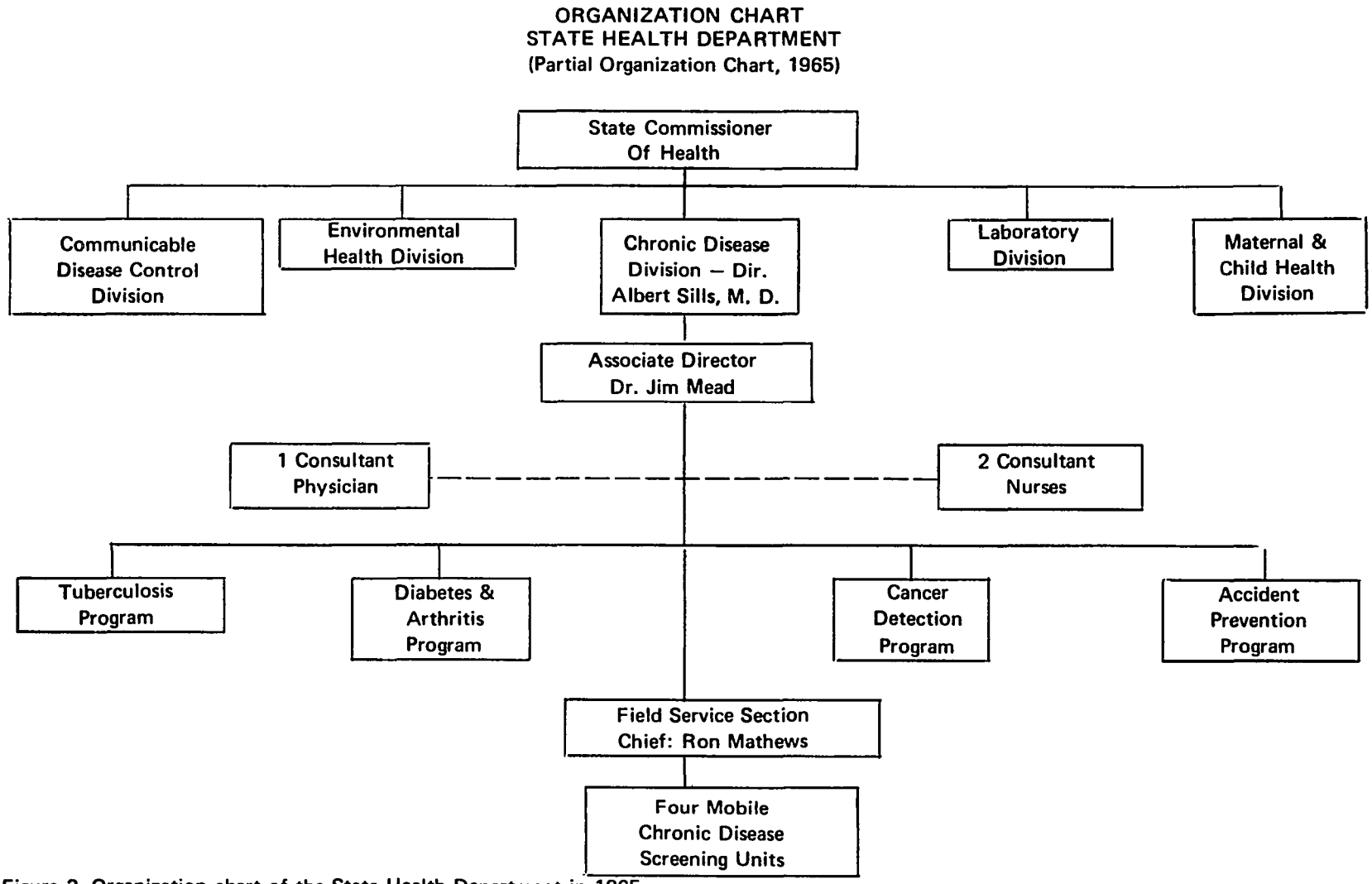


Figure 3. Organization chart of the State Health Department in 1965.

Bevens County included the capitol city of the state, and the metropolitan area had a total population of more than 300,000 people.

After several meetings with the cosponsoring organizations, it was decided to move the mobile screening units into four of the largest shopping centers in the capitol city metropolitan area.

During early November 1965, radio and newspaper publicity had been extremely heavy. The following is an example of the newspaper articles appearing during November:

DIABETES TESTING PLANNED—NOVEMBER 15, 1965

Diabetes, a condition that can lead to death if not controlled, will be the subject of a massive free campaign in Capitol City next week.

As part of the observance of Diabetes Detection Week, special tests will be given free at four mobile laboratories starting Monday, November 15.

State and local medical authorities called for the allout campaign to detect diabetes in the county, estimating that one out of forty-five persons have the disease. The screening for diabetes has been termed especially important for persons over forty years of age.

After being tested, all persons suspected of having this disease will be referred to their family physician for follow-up studies. This testing process is offered without charge to the individual.

Units will be in operation Monday through Friday at the following hours and locations...According to medical authorities, a history of diabetes in a family is reason for everyone to be tested periodically for the presence of sugar in the urine or blood.

"Since it is estimated that one person in every 45 has diabetes, we feel diabetic detection is a community concern. We strongly urge all adults to participate in this screening program," said Dr. Albert Sills, director of the chronic disease division of the state health department.

During the week of November 6, 1965, Mr. Ron Mathews, chief of the field service section, realized he was going to be short handed on the units. He borrowed clerical, technical, and nursing personnel from other chronic disease programs. One day was spent going over the entire method of operation which included taking a medical history and doing the primary and secondary screening tests for diabetes.

The primary test for diabetes consists of pricking the end of the finger with a lancet, squeezing a large drop of capillary blood onto the sensitive portion of a reagent strip called a dextrostix. The blood is left on the strip for sixty seconds and then washed off. The reagent strip is compared to a color chart for a quantitative reading.

If the primary test is positive, the secondary test is performed. This test consists of asking the patient to drink seven fluid ounces of glucose solution. The patient is asked to return within two hours. After two hours, a venipuncture is performed and a blood sample is sent to the state health department laboratory where a modified glucose tolerance test is performed. If the results are positive or suspicious, the patient is contacted and the results of the test sent to the person's family physician.

Most of the technicians and nurses attending the one day orientation session had worked on the unit at one time or another. Since the tests to be performed were

relatively uncomplicated, Mr. Mathews did not anticipate any problems.

On Saturday, November 13, 1965, all four of the units were brought into the state health department parking lot. Mr. Mathews and four technicians from the division cleaned the units and put the equipment needed for the diabetes screening operation on each unit.

Although prebottled alcohol and glucose solutions were available commercially, because of the cost difference, the chronic disease division prepared their own solutions. The alcohol used for cleansing fingers for the dextrostix test and for cleansing the arm for the blood test was purchased in fifty-five gallon drums of 100 per cent isopropyl alcohol. The alcohol was stored in the main state health department building. For use on the units, the alcohol was placed in one gallon plastic containers and diluted to 70 per cent alcohol with water.

With the help of state health department laboratory personnel, a glucose solution consisting of the proper combination of sodium benzoate, corn syrup, carbonated water, and phosporic acid was prepared and also poured into one gallon plastic containers.

Clear water used to wash the blood off the reagent strip used in the primary testing procedure was also stored in one gallon plastic jugs.

Six plastic jugs, two containing a 70 per cent isopropyl alcohol solution, two containing the glucose solution and two containing clear water were placed on each screening unit. As always in the past, masking tape was put on the face of the containers and they were marked either glucose solution, H_2O, or 70 per cent alcohol. The containers were stored in a closet in the rear of each screening unit.

On Sunday, November 14, Mr. Mathews and other members of his staff moved the screening units to the four shopping centers. Final preparations were made, the units were locked and everyone went home.

On Monday afternoon, November 15, 1965, the diabetes screening operation began. Each unit had one hostess from the County Medical Association Auxiliary directing traffic, three clerks taking medical histories in the front of the unit, three nurses doing primary testing in the middle part of the unit, and one technician working in the back of the unit. The technician was responsible for talking with each referral, giving him the seven ounces of glucose solution to drink, and asking the patient to come back within two hours. When the patient returned, a nurse would take a blood sample for the glucose tolerance test.

When the units opened at 2 p.m. there was a line of people waiting for tests, and the number of people coming to the units continued very heavy all afternoon.

On the day the diabetes screening program began, Dr. Albert Sills, director of the chronic disease division, was attending a seminar on chronic diseases at the state medical center in the same city. At about 4:45 p.m. he was called out of the meeting to answer an emergency phone call.

Mrs. Ruth McGuire, R.N., one of the nurses working on the screening unit at Highland Shopping Center, was on the phone. She was very excited. She said, "Dr. Sills, I've been trying to contact you for the last thirty minutes. There's been a big mixup down here; eight or ten people have gotten very sick after they were given the glucose solution. One of them was in an automobile accident; another is on her way to City Hospital; the police are here, and newspaper photographers are taking pictures of everything.

"Jim (the technician) says he thinks they may have been given alcohol instead of the glucose solution. The manager of the shopping center and the police are insisting that we close the unit. What are we going to do?"

PART II—Conclusion

Dr. Sills immediately instructed Mrs. McGuire to do the following:

1) Give the names, addresses, and telephone numbers of all the people who had received the secondary test to the police. Have them start with the last one tested and work backward until all of them have been contacted.

2) Have the police contact the other three units and see if any reactions had been reported and, if so, have the police contact all possible victims from these units. In any case, have the other units suspend the secondary diabetes testing procedure but continue the primary testing.

3) Instruct the unit personnel not to discuss the incident with representatives of the news media.

4) Close the unit but have all the personnel stay until he arrived.

Dr. Sills then called his secretary and had her call the director of the Bevens City-County Health Department, and Dr. Jim Mead, his associate director, and ask them to meet him at the Highland Shopping Center as soon as possible. He knew it would be impossible to reach the commissioner of health because he was still in Washington, D.C.

While driving to the Highland Shopping Center, Dr. Sills rolled the possibilities over in his mind. He knew the patients were getting ill from the glucose solution or they, indeed, had been given isopropyl alcohol. He knew that the glucose solution was supposed to be consumed before the patient left the unit for the two hour wait. He also knew that seven ounces of 70 per cent alcohol would make

almost anyone gag and couldn't understand how Jim Reynolds, the technician, could miss the reaction of the patients when they tried to drink the solution.

When he arrived at the unit, he found that most of the people waiting to be tested had left. The police, the unit staff, and about five newspaper reporters were outside the unit.

He was immediately surrounded by the newspaper people asking for a statement. He politely brushed them aside and told them he would have a statement later in the evening. As he proceeded toward the unit, he heard one of the reporters comment, "That's okay, doctor, we already know that eight people have been poisoned with alcohol."

After talking with Dr. Mead who had arrived earlier, and Jim Reynolds, the technician, he found that ten of thirty screenees could have been given the alcohol solution. Nobody was certain how the one gallon plastic jugs were switched but it had apparently happened.

Dr. Sills said to Jim Reynolds, "Didn't those people gag when they tried to drink that stuff?" Reynolds replied, "I didn't notice anybody, doctor. We were so crowded I was having the people step out on the sidewalk to drink the solution."

The police had been successful in contacting all the ten possible cases. Six were in the hospital; two were under a physician's care at their home, and two had not

drunk the solution after tasting it. The police had returned one solution still in the plastic container. Dr. Sills took one sniff and knew that it was almost 100 per cent alcohol.

Dr. Sills and Dr. Mead checked with the other three units and found that no report of reactions had been received.

That evening Dr. Sills, Dr. Mead, Jim Reynolds, Ron Mathews, the director of the Bevens City-County Health Department, the chairman of the diabetes association, and the president of the county medical society met at Dr. Sills' home to discuss the incident and to decide what action was to be taken.

By this time, 9:30 p.m. Monday evening, it was known that none of the patients were in serious condition and recovery was assured.

After some discussion, it was agreed that a mixup had been made in the secondary screening procedure at the unit stationed in the Highland Shopping Center. It appeared that the screenees were given alcohol instead of glucose. To be sure, Dr. Sills ordered all of the remaining jugs of glucose returned to the state health department laboratory for testing on Tuesday morning.

With the agreement of the cosponsoring groups, Dr. Sills made the following points in a press conference at 11:20 p.m. Monday night:

1) A mixup had occurred and eight people had been given alcohol instead of glucose. Six were in the hospital, but in satisfactory condition.

2) That this mixup had occurred only at the Highland Shopping Center operation and not at the other three units.

3) That all efforts would be made to see that such an accident did not occur again.

4) All four units would be open the next day, but only primary diabetes testing procedures would be performed, and people with positive tests would be referred to their family physician for the glucose tolerance test.

After the meeting, Dr. Sills asked all members of the staff involved in the mixing of the glucose solution and the personnel working on the Highland Shopping Center unit to have a written report of their part in the program on his desk not later than 5 p.m. the next day.

On Tuesday morning, November 16, 1965, the Capitol City Daily News carried the following headlines on the front page.

EIGHT STRICKEN AFTER DRINKING ALCOHOL IN DIABETES TESTS

The newspaper made the most of the story but accurately reported Dr. Sills' points made in the news conference.

On Tuesday afternoon, the diabetes screening units were back in business but not many people were coming.

By Wednesday, November 17, newspaper and radio reports indicated that all of the patients had been released from the hospital in good condition. By late Wednesday

afternoon, a steady stream of people were receiving primary diabetes screening tests at all four units.

The lab reports on the glucose solution indicated that the solution was absolutely safe. After reading the written reports and talking with Jim Reynolds, Dr. Sills could only conclude that, somehow, the plastic bottles were switched and the 70 per cent alcohol solution was used to fill some of the plastic cups rather than the glucose solution.

By working with the president of the Bevens County Medical Society and the hospitals involved, Dr. Sills was able to have all physician and hospital costs for the patients cancelled.

All the patients fully recovered and the incident was dropped.

About two weeks later, the chronic disease division began to use prepackaged, commercially prepared solutions for all of their screening procedures.

PART III—Instructor's Guide

The fact that the diabetes screening program was not using prepackaged testing materials is not the most important issue in this case. It is hoped that the reader will recognize that crisis producing situations can occur in almost any type of health care program and must be dealt with. This case should also serve to stimulate discussion of whether Dr. Sills handled the immediate problem correctly. Also, of importance is an analysis of how to handle the public relation problems created by the incident.

The number of people over age 50 is increasing in the United States each year. The need for chronic disease screening programs is also increasing. This case should stimulate the discussion of the present and future role of such screening programs in health care programs.

The instructor may wish to present the following questions to facilitate class discussion:

1) What would you do if you were Dr. Sills? Can you establish the priorities of the action you would take?

2) How would you have handled the news media if you were Dr. Sills?

3) Is the fact that the diabetes screening program was not using prepackaged testing materials the most important issue of this case?

4) Do you feel that chronic disease screening programs should be a significant part of public health programs? Why?

CHAPTER VII

RETIREMENT: POLICY VS TRADITION

PART I—The Case

Dr. George Anderson, age thirty-nine, had been employed at a state health department in the Midwest as chief of the community health services division for two years. Before that, he had served four years in the communicable disease field primarily as director of the venereal disease section of the state health department. Dr. Anderson was by far the youngest service chief in the department.

He had made several significant accomplishments during his six years with the department, and in October 1969, the commissioner of health for the state health department resigned, and Dr. Anderson was promoted to state commissioner of health over several senior colleagues.

In the few years Dr. Anderson had worked at the state department of health, he noticed that no one seemed to retire. When he assumed the position of commissioner of health, he noted that more than ten high ranking professional positions within the central office and in the county health departments were filled with individuals who were

approaching sixty-five years of age or older. An investigation of retirement policies revealed the state merit system required a person to retire at the age of sixty-five unless the health department is willing to sign a waiver stating that the person is qualified to carry on his duties for another year. This waiver must be signed each year.

The tradition of the department was to allow all individuals to work until they were seventy before any mention of retirement was made.

Dr. Anderson had been commissioner of health for about one month when Dr. Arnold Williams, director of the tuberculosis division at the state department of health, turned sixty-five and the personnel department sent Dr. Anderson an extension form to sign.

Dr. Williams was a vigorous, hard working public health physician who had been with the department since 1939. He was fully capable of continuing his work for another year; therefore, Dr. Anderson felt no misgivings about signing the extension.

About four months later, Dr. William McMasters, director of one of the state's county health departments, became sixty-seven years of age and the form for his extension was sent to Dr. Anderson's office. An extension had been signed twice before by Dr. Anderson's predecessor.

Dr. McMasters, like Dr. Williams, had worked for the department many years. Unlike Dr. Williams, he was

considered by many to be senile and his work, especially in the clinical area, was not adequate.

Dr. Anderson called Dr. McMasters in and informed him that he did not feel he could sign another extension and asked him if he would consider retiring immediately. Dr. McMasters retorted: "Hell, I've worked for this state health department for twenty-eight years, but do you realize that this state has only had a state merit system and a retirement program since 1962, and that my total monthly retirement would only be $172 per month?"

The commissioner informed the doctor that he was not aware of these factors and he wanted to think it over and would give him a call in a couple of days.

The next day Dr. Anderson received a phone call from the chairman of the county board of health asking that he reconsider and let Dr. McMasters stay another year. The chairman explained that the county had finally passed the millage bill that Dr. McMasters had been promoting for a number of years and they would finally have enough money to increase the department's activity. Dr. Anderson said he would consider the request and the next day he signed the extension.

The following week, a one-year extension request came to Dr. Anderson for Florence Elldner, age sixty-five, a clerk in Dr. McMasters' county health department. Dr. Anderson refused to sign the extension.

Two days later, he received a call from the state representative for Mrs. Elldner's district wanting to know why he felt justified in extending Dr. McMasters but not Mrs. Elldner. After some embarrassment, Dr. Anderson was able to convince the state representative that Dr. McMasters was being extended one year only and was done at the request of the county board of health. The state legislator accepted the explanation and Mrs. Elldner retired.

Dr. Anderson felt that the retirement policy established by the merit system was sound, but somehow the tradition at the department was out of hand and that some changes had to be made.

PART II—Conclusion

Soon after the incident regarding the retirement of Mrs. Elldner, Dr. Anderson changed the official policy for retirement procedures at the state health department.

All state health department personnel must now retire at age sixty-five. However, those individuals in a professional or administrative capacity may, if they desire, be retained for one year on a consultant basis in order to train and assist their replacement.

Although there was considerable bitterness at the beginning of the new policy, the consultant title and pay seemed to make it easier for long-time employees to adjust to total retirement. Two years later the program was still in operation.

PART III—Instructor's Guide

Public agencies in the United States have a reputation for allowing people to work years after the normal retirement age of sixty-five. This case should stimulate discussion of why this occurs.

This case should also present the opportunity for discussion of the history and development of merit systems in public health agencies and their advantages and disadvantages.

The value of mandatory retirement at a specific age for all employees of an organization is a debatable issue. This case should present a base for discussion of the advantages and disadvantages of mandatory retirement.

The following questions should facilitate discussion of the case:

1) The policy for retirement presented in Part I of this case is clear. Why did the commissioner of health find it difficult to exercise that policy?

2) Did the commissioner of health really need to change the retirement policy already in effect?

3) How do you feel about mandatory retirement at age sixty-five?

4) Public agencies often allow their employees to continue employment long after normal retirement age. Why do you think this occurs?

5) Do you feel it is the responsibility of an organization to help older employees prepare for their eventual retirement?

CHAPTER VIII

A MEDICAL DIRECTOR FOR SUMPTER COUNTY

PART I—The Case

During October 1970, Dr. Gene Cummings, commissioner of health for a southwestern state health department, attended the annual meeting of the American Public Health Association in Houston, Texas. Although Dr. Cummings was interested in the papers to be presented, he was more interested in obtaining the names of good candidates for a county medical director position in one of the state's largest counties.

The position had appeal. In addition to being the medical director of a health department with fifteen professional personnel on the staff, the position offered a faculty appointment to the state university's school of health and coordinator of the school of health's field training facility headquartered at the county health department.

The American Public Health Association has a placement station at their conference where health professionals interested in changing positions can let their interest be known.

Dr. Cummings noted the announcement of several possible candidates. Among them was the name of Dr. Roger Horn, deputy director of public health in a large metropolitan health department in the northeastern part of the United States.

In early November 1970, Dr. Cummings wrote Dr. Horn asking if he would be interested in submitting his resume for consideration for the position of medical director of the Sumpter County Health Department and coordinator of the field training unit for the state university school of health.

Dr. Horn was interested and sent his resume. He was thirty-nine years of age and was born and raised in the northeastern part of the United States. He received his M.D. degree in 1957, served a rotating internship, and after two years in the military service, went into private practice with one partner in New York State.

Four years later, Dr. Horn went into public health as the medical director of a medium sized city-county health department with twenty-three professional employees. He stayed in this position for three years and then returned to school and received his master's degree in public health administration.

After finishing his public health training, Dr. Horn accepted a position of deputy director of public health in a large metropolitan health department. He had been in this

position for approximately eighteen months when his correspondence with Dr. Cummings began.

After reading his resume, Dr. Cummings felt that Dr. Horn was qualified for the position. In early December 1970, he called the health officer in the state where Dr. Horn was employed.

Dr. A. B. Arnold, state health commissioner, told Dr. Cummings that Dr. Horn was a good health administrator; but, because of his youth and a somewhat aggressive attitude, he sometimes had difficulty in getting along with his peers. He did, however, maintain an excellent relationship with his subordinates.

Dr. Arnold also mentioned that Dr. Horn was having marital problems and was obtaining a divorce. His sympathy was with Dr. Horn, and he felt the doctor was doing the right thing. As a matter of fact, Dr. Arnold had offered Dr. Horn a high administrative post in the state health department but Dr. Horn refused stating that he wanted to relocate.

After this conversation with Dr. Arnold, Dr. Cummings called Dr. Horn and asked him if he would be willing to come to his state for an interview.

Dr. Horn arrived for the interview in late December 1970, and talked with Dr. William Bruner, chief of local health administration for the state health department. He also talked with the Sumpter County Health Department staff,

the dean and faculty of the state university school of health, and the state commissioner of health.

With the exception of Dr. Bruner, all the interviews were positive. In a memo to Dr. Cummings, Dr. Bruner noted that Dr. Horn appeared well qualified academically and that he had administrative experience; however, he appeared aggressive and had strong opinions about the desirability of certain administrative practices. He mentioned that Dr. Horn had said he was having personal problems, primarily marital. In a final comment, Dr. Bruner noted that Dr. Horn appeared quite cynical and, on the surface, it appeared he might have some emotional problems.

He also suggested that Dr. Horn's references be checked quite closely and stated he would be interested in knowing the Sumpter County Health Department staff's evaluation and the impression of the faculty at the school of health.

Two days later, Dr. Cummings received a letter from the associate dean of the school of health indicating that Dr. Horn was acceptable to the school, assuming his references checked out.

On January 6, 1971, Dr. Cummings wrote Dr. Horn offering him the position of medical director of the Sumpter County Health Department at $20,000 per year and coordinator of the school of health field training facility

at $10,000 per year. On January 13, 1971, Dr. Horn accepted the position and made arrangements to take the state merit examination.

On January 15, 1971, Dr. Cummings resigned as state commissioner of health, effective immediately. Dr. Andrew Sudreth, chief of maternal and child health, was appointed acting commissioner of health. On January 20, 1971, Dr. Sudreth called Dr. Horn and explained to him the change in leadership and confirmed Dr. Horn's appointment, effective February 1, 1971.

On February 14, 1971, Dr. James Cash, chief of community health services at the state health department, was appointed commissioner of health.

Dr. Cash had several meetings with Dr. Horn and the relationship between the state health department, local health departments, and school of health were discussed in detail. He found Dr. Horn to be very well informed, very aggressive, and very definite in the manner in which he wanted to conduct activities in his department.

During late March 1971, Dr. Cash received a call from a member of the Sumpter County Board of Health stating that, although the board liked the interest Dr. Horn displayed in the community, they felt he was attempting to make too many changes too quickly and there was considerable turmoil within the health department, especially among the nursing staff. He asked Dr. Cash if he would talk with Dr.

Horn about his relationship with the Sumpter County nursing staff.

During that same month, Dr. Cash did talk with Dr. Horn and was assured that everything was fine, but that the Sumpter County Health Department had been poorly managed in the past and he was having to make some drastic changes in order to get the department back on the right path. At this meeting, Dr. Horn mentioned that he felt his director of nursing was doing an extremely poor job.

About a week later, Mrs. Jean Bucholdt, R.N., director of nursing for the state health department, called Dr. Cash and said that Dr. Horn had just sent in the semiannual performance rating on the Sumpter County director of nursing.

Mrs. Bucholdt said, "This rating is so low in all categories that if we sent it on to the personnel board, we may have to demote or suspend her." Mrs. Bucholdt went on to say, "Dr. Cash, you are aware that Dr. Horn has just remarried, and that his new wife was once director of nursing in the city-county health department where Dr. Horn was previously employed?" Dr. Case said he understood what Mrs. Bucholdt was implying and assured her that the state health department had a policy stating that relatives could not work in the same department. He suggested that Mrs. Bucholdt hold the performance rating on the Sumpter County director of nursing for a couple of weeks until he looked into the matter.

In April 1971, Mrs. Patty Dennis, R.N., age twenty-eight, director of nursing for the Sumpter County Health Department for the last three years, resigned.

In her letter of resignation to Dr. Horn she stated she was leaving for two reasons: (1) "I was offered a better job, and (2) the working conditions since you (Dr. Horn) arrived have been most undesirable."

Two days later the personnel department received a letter from Dr. Horn stating that Mrs. Dennis had resigned, and suggested that she never be considered for employment by the state health department again.

In early May 1971, Dr. Horn came to see Dr. Cash and inquired if there was any reason he could not hire his wife as director of nursing for the Sumpter County Health Department since she was qualified for the position. Dr. Case informed him of the department's policy not to hire relatives in the same department. Dr. Horn said, "Okay," and left.

Later the same month, one of the sanitarians from the Sumpter County Health Department saw the administrative assistant to the commissioner at a social function and said, "Don, if you people don't get this guy Horn out of the Sumpter County Health Department, the entire staff is going to quit. He has the whole community in an uproar."

On June 10, 1971, Dr. Case received a carbon copy of a letter to Dr. Horn from the State Board of Medical Examiners. The letter stated that Dr. Horn was refused a

reciprocal medical license to practice medicine and surgery in the state. Dr. Cash felt some action had to be taken.

PART II—Conclusion

Dr. Horn was refused a medical license by the State Board of Medical Examiners because he had two civil actions pending against him in the state where he was previously employed. There was also a warrant for his arrest for failure to make alimony payments.

In regard to the board's actions, Dr. Horn had two options: (1) he could appeal the board's action, or (2) he could wait ninety days and submit his application again.

Dr. Cash met with Dr. Horn the following day and explained that he had no choice but to suspend him until Dr. Horn could get a medical license. Dr. Horn became very angry and said, "It looks like somebody in this state is out to get me."

Dr. Cash and Dr. Horn met with the Sumpter County Board of Health two days later. The board unanimously requested and received Dr. Horn's resignation.

PART III—Instructor's Guide

This case should stimulate class discussion as to whether the acute shortage of physicians in public health is a contributing factor in this case. Also of issue is the question of at what point does the personal problems of an employee become the concern of his employer.

The value of checking references on prospective employees is a debatable issue. A point of discussion is whether the commissioner of health and the director of local health services made an adequate check of Dr. Horn's background.

As presented in this case, the administrative structure between the state health department and the county health department is decentralized. The commissioner of health is not in frequent contact with Dr. Horn. It is possible that Dr. Horn was only guilty of trying to make too many changes too quickly.

The instructor may wish to ask the following questions to facilitate class discussion:

1) How would you handle the situation if you were the commissioner of health?

2) Do you feel that Dr. Bruner, chief of local health services exercised his responsibility adequately?

3) Whose responsibility was it to check further into Dr. Horn's background?

4) Do you feel that the rapid turnover of commissioners of health was a contributing part of this case?

5) Did the commissioner of health act soon enough in handling the problem with Dr. Horn?

6) Do you feel Dr. Horn was given a fair hearing?

7) At what point do the personal problems of an employee become the concern of his employer?

CHAPTER IX

BIG JIM HALEY

PART I—The Case

In the fall of 1962, Dr. Les Kaserman, age fifty-six, accepted the position of commissioner of health for a state health department in the southeastern part of the United States.

The health department had been created by the state legislature in 1923. It functions as a separate, independent state agency.

The commissioner of health is the administrative head of the agency. He, in turn, is responsible to a seven member board appointed by the Governor of the state.

The state health department is located in the capital city of the state. The agency is housed in an old remodeled hospital building. A state bond issue was passed in 1961 to build a new building for the department. The new building is to be completed by late 1964.

In 1962, the agency employed 412 people in various medical, nursing, environmental, administrative, technical and clerical positions. The organization had a $5,672,468 state budget in 1962.

The sixty-eight county health departments in the state are linked administratively to the state health agency. Each county health department has a separate board of health, but depends on the state health department to prepare their budgets and to provide supervisory personnel.

Dr. Kaserman's immediate predecessor, Dr. James H. White had resigned rather unexpectedly after eighteen months in the position. He had left the state for a medical post with an international health agency.

Dr. Kaserman did not have an opportunity to talk with him before accepting the position. However, he talked with the state board of health on several occasions before accepting the post.

Mr. Arnold Simpson, president of the state board of health, had explained that Dr. White left because he felt the state health department's budget appropriation from the legislature was inadequate to develop new health programs.

Mr. Simpson had also mentioned that there had been a severe "personality conflict" between Dr. White and Mr. Jim Haley, director of administrative services for the department.

Dr. Emmit Marshall, secretary of the board, mentioned that many people did not like Jim Haley, but he was the only man in the health department who really knew anything about getting money from the legislature. According to Dr. Marshall, if it had not been for "Big Jim" (Haley's nickname)

the state welfare department would have taken over the state health department years ago.

Within two weeks after Dr. Kaserman's arrival, he became aware that he faced several administrative problems.

At the first meeting of the service directors (Figure 4 for Organization Chart), Dr. Kaserman was quite upset by the apathy and low morale of his six service directors. The one exception was Mr. Jim Haley, age sixty-four, director of administrative services.

Mr. Haley was one of two service directors who was not a physician. He was a big man physically, six feet, five inches, who spoke and moved with authority. He dominated the meeting because he seemed to have all of the necessary information on administrative procedures, budgets, personnel and health programs at his finger tips.

After the staff meeting, Dr. Tom Gordon, age thirty-nine, director of personal health services, came to the commissioner and asked if they might meet privately. Dr. Kaserman set up a meeting for later that day.

At the meeting, Dr. Gordon informed Dr. Kaserman that previous to his arrival he had decided to resign and had accepted a position with the state school of medicine. Dr. Gordon gave Dr. Kaserman a few reasons why he was leaving the organization.

He began by filling Dr. Kaserman in on some of the history of the state health department.

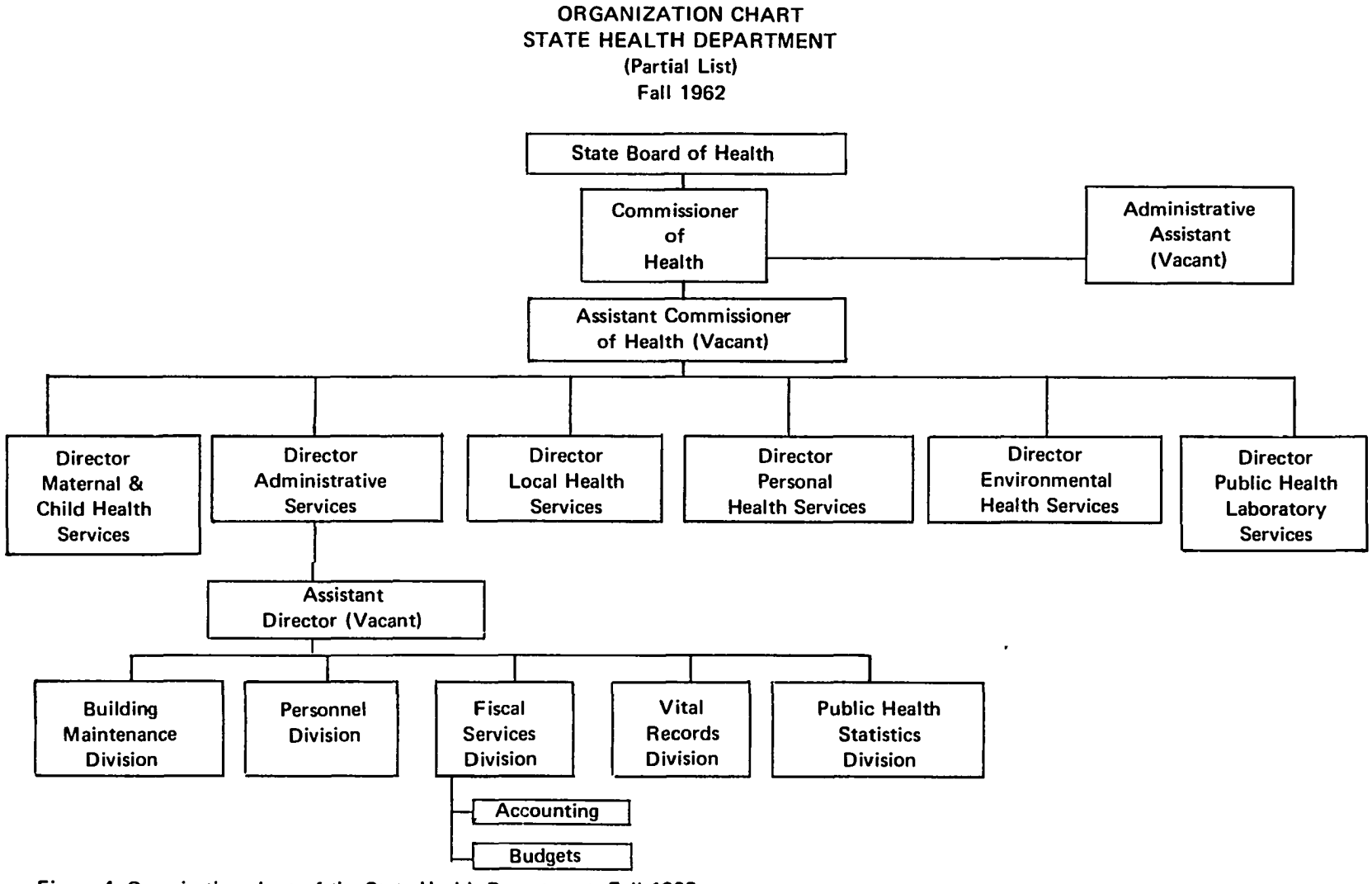


Figure 4. Organization chart of the State Health Department, Fall 1962.

In Dr. Gordon's opinion, the agency was in a chaotic state of affairs and had been for several years. He said that Dr. White had given up in disgust, primarily because he could not handle Big Jim Haley, director of administrative services.

According to Dr. Gordon, Mr. Haley really ran the organization and had done so for the last fifteen years. Dr. Gordon laid most of the blame on the previous commissioners (there had been four in the last thirty years) who would not provide adequate leadership.

Dr. Gordon emphasized that Jim Haley used the power of his office not only to control staff functions, but the department's health programs as well.

Some of the methods used were that Mr. Haley personally reviewed and judged the validity of every purchase requisition made by the agency. Those he felt were not necessary were returned to the service director marked "funds not available," or the requisition simply disappeared.

Although each service in the department had an operating budget, the directors were not consulted on the preparation of the budget for their service, nor were they given periodic expenditure reports.

Dr. Gordon explained that about three months before the end of the fiscal year, no purchase requisitions were approved so that the department's "books" could be balanced. Each year, Mr. Haley turned back between two and three

hundred thousand dollars in lapsing funds to the state budget office.

Dr. Gordon mentioned that the personnel division was in Mr. Haley's service and he controlled who was hired. Dr. Gordon said that for the last six months he had been without a secretary and when he inquired about the situation, the personnel director said they were still looking.

Dr. Gordon closed by saying that Mr. Haley's concept of a good health department was based on the amount of lapsing funds he could turn back to the legislature each year.

Dr. Gordon was convinced that Mr. Haley's authoritarian behavior affected the productivity of the organization all the way down to the clerks and secretaries.

Dr. Kaserman thanked Dr. Gordon for his frank appraisal of the organization and reluctantly accepted his resignation.

During the next week, Dr. Kaserman met separately with the other service directors. All of them expressed similar opinions about Mr. Haley. Several other enlightening comments were made.

One was that in the past, Mr. Haley had served a couple of terms in the state legislature and still had considerable "influence" with many of his old friends who were still members of that body.

It was also mentioned that Mr. Haley was known to have considerable influence with one of the members of the state board of health.

Dr. Arthur Cox, age fifty-nine, director of the maternal and child health service, put it more succinctly: "Hell! All of us have fought with Haley at one time or another and found if we were going to get anything done at all, we had better go along with him."

During the following weeks, Dr. Kaserman had several meetings with Mr. Haley regarding budgets, personnel policies, legislative appropriations, and the operation of county health departments. Much to his surprise, he found Mr. Haley to be cordial, respectful, and well informed about the total organization. However, during the next month, the commissioner found that Mr. Haley "wore many hats."

Although there was a position for administrative assistant to the commissioner, the position had not been filled for years and Mr. Haley handled the duties of that office.

Within his service, Mr. Haley had a position for an assistant director. This position had also been vacant for a number of years.

There was a position for director of the fiscal services division. The position was vacant. In addition, the position for director of public health statistics division had been vacant for more than two years.

Instead of recruiting qualified personnel for these positions, Mr. Haley appointed a person already in the division as acting director. Almost all supervisory decisions within administrative services were made by Mr. Haley.

Through his control of the budget and personnel divisions, Mr. Haley also controlled the scope and direction of most of the health programs conducted by the department.

Dr. Kaserman found that the personnel division often took months to fill routine positions for clerks and typists. When he inquired into the situation, he was told that Mr. Haley did not approve of advertising vacant positions because too many unqualified people showed up to take the tests.

The public health statistics division was more than two years behind in official publications such as the annual birth and death reports.

When the commissioner started making inquiries into various program operations, the stock answer to his question was, "I'll have to check with Mr. Haley on that."

After three months as commissioner of health, Dr. Kaserman was convinced that some action had to be taken in order to improve the productivity and morale of the organization.

He began by calling Mr. Haley in and pointing out that he felt Mr. Haley was damaging the effectiveness of the whole department by over controlling the state health

department's budgets and by his reluctance to fill vacant positions within the department.

Mr. Haley's reply was that administrative services had to have control over the budgets if the department was going to maintain fiscal responsibility.

Dr. Kaserman agreed that it is certainly true that staff operations must, at times, act as a control on program activity. However, he emphasized that their main function is to provide the type of support necessary for the programs of the department to meet their objectives.

He also emphasized to Mr. Haley that each service chief was to get quarterly expenditure reports on their budgets. He also recommended that Mr. Haley hire qualified personnel to fill some of the vacant positions within his service.

Other points were stressed such as Mr. Haley's strained relationship with other service directors, and the problem of lapsing state health department funds that were not being utilized.

Dr. Kaserman was surprised at how quietly Mr. Haley absorbed his rather pointed criticism and suggestions for improvement of his service. Mr. Haley's only comment was that he would study the situation and see if some of the commissioner's suggestions could be carried out in the near future.

Within the next two months, the commissioner became aware that Mr. Haley had no intention of changing the

operation of his service and that a state of "undeclared war" existed between Mr. Haley and himself.

Dr. Kaserman also knew that the whole agency was now aware of the conflict, and in fact, had expected it since, in all probability, they had witnessed such a struggle before.

PART II—Conclusion

Dr. Kaserman was aware that he was rapidly being pushed into a win-lose situation. One alternative seemed clear. He could fire Mr. Haley or could he? Dr. Kaserman knew his relationship with the board of health was not firmly established, and that Jim Haley had been director of administrative services for the past fifteen years.

Dr. Kaserman avoided a direct confrontation with Mr. Haley by taking the following action:

He filled the vacant position of assistant commissioner of health with an experienced physician-administrator from outside the department.

The assistant commissioner of health was given direct administrative authority over all of the personnel within Mr. Haley's service. In a meeting attended by all of the personnel within administrative services, Dr. Kaserman announced that until further notice, all supervisory personnel would be required to make weekly progress reports directly to the assistant commissioner of health.

Utilizing the funds from the vacant assistant director of administrative services position, Dr. Kaserman created a new service called program support services. He hired a new administrator for this service and transferred the vital records and public health statistics division into it (Figure 5).

ORGANIZATION CHART
STATE HEALTH DEPARTMENT
(Partial List)
Spring 1963

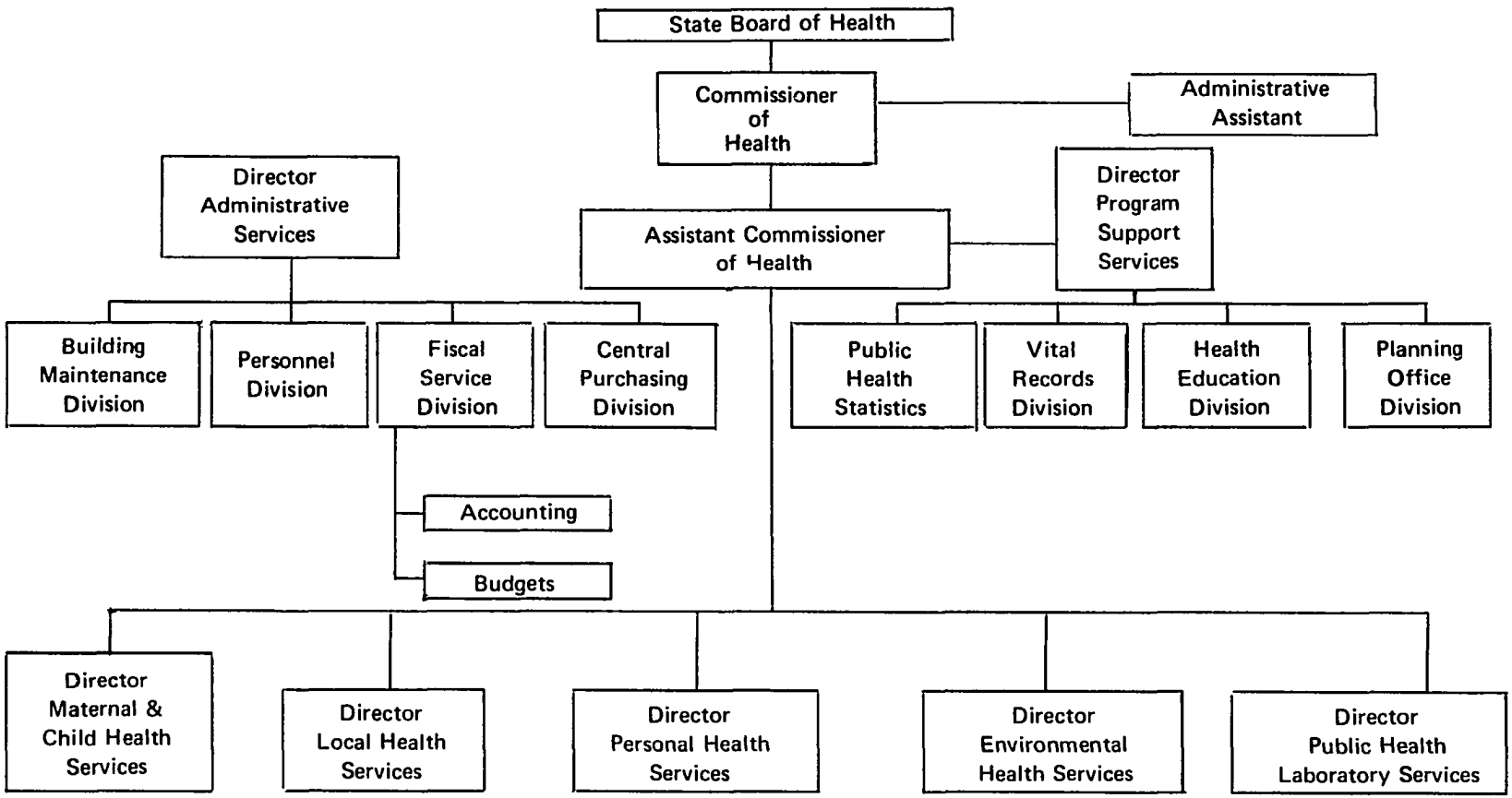


Figure 5. Organization chart of the State Health Department, Spring 1963.

A month later, to the surprise of many of the state health department staff, Mr. Haley transferred from the state health department to a similar position within another state agency.

The transfer of Mr. Haley solved the major problem. However, a number of division heads within administrative services could not function adequately without Mr. Haley to make final decisions for them.

For six months a considerable amount of turmoil was encountered as the informal organization within administrative services broke down.

Those individuals who could not function in their present positions were either transferred or asked to resign.

PART III—Instructor's Guide

The initial reaction of most students discussing this case will be the recommendation of the immediate dismissal of Mr. Haley. It is hoped that further discussion of the case would indicate that such action would probably be a disasterous move for Dr. Kaserman.

There were several alternatives to handling the administrative problem presented in this case. The essential purpose of the case is for the student to be able to determine what those alternatives were.

Another important aspect is for students to understand that staff operations such as budgets, personnel, maintainance, and purchasing are extremely important and do have a control function in the management of organizations. It is also important for the student to understand the importance of a proper balance of power between staff and program operations.

The instructor may wish to present the following questions or comments to facilitate class discussion:

1) What options do you feel Dr. Kaserman had in handling the situation with Mr. Haley?

2) How do you feel the state board of health would have reacted if Dr. Kaserman had fired Mr. Haley?

3) The term goal displacement is often used to describe the situation presented in this case. Discuss.

CHAPTER X

A HOME HEALTH CARE PROGRAM WITHIN A STATE HEALTH DEPARTMENT 1966 TO 1971

PART I—The Case

The medical Insurance for the Aged Act, Title XVIII of the Social Security Act, became law in late 1965. This federal act made available to nearly every American, sixty-five years of age or older, a broad program of health insurance designed to assist the nation's elderly to meet hospital, medical, and other health costs. The program included two related health insurance programs; Hospital Insurance (Part A of the law) and Voluntary Supplementary Medical Insurance (Part B of the law). The program was to be administered by the Social Security Administration of the Department of Health, Education, and Welfare. This program provided numerous types of health insurance coverage for care in hospitals, extended care facilities, and for medical care in the home.[1]

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[1]For more detailed information see: David Allen, "Health Insurance for the Aged: Participating Home Health Agencies," Social Security Bulletin, September 1967.

Dr. Walt Armonds, chief of community health services in a southwestern state health department, had followed the proceedings on this legislation for more than two years. He felt certain that his state and local health departments could play a contributing role in providing certain medical services to the aged as provided in the Title XVIII legislation. He was particularly interested in the section of the legislation that provided insurance payment for home health care services.

In 1966, the state health department employed approximately 180 registered public health nurses in 69 county health departments in the state. Since the early 1960's these nurses had provided a considerable amount of skilled nursing care to home bound patients of all ages. However, they were severely limited in the scope and depth of services they could provide because of the lack of funds.

Dr. Armonds was aware that there were considerable unmet medical needs among the aged in his state. He knew that the Title XVIII legislation provided for the establishment of home health agencies. He was confident that most of the local health departments in the state could be certified as providers of home health care.

Title XVIII legislation described a home health care agency as either a public agency or private organization which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services such as physical, speech, or occupational therapy, medical, social, and home health aide services. A public or voluntary non-profit health agency may qualify by:

1) Furnishing both skilled nursing and at least one other therapeutic service directly to patients or,

2) Furnishing directly either skilled nursing service or at least one other therapeutic service, and having arrangements with another public or voluntary non-profit agency to furnish the services which it does not provide directly.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.[2]

Dr. Armonds knew the state health department could provide skilled nursing care, but that it was unlikely the department could obtain adequate personnel in the area of physical, speech, or occupational therapy or medical and social services.

Since it was necessary to provide more than one service to qualify as a home health agency, Dr. Armonds felt that using home health aides was the most feasible solution.

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[2]For more detailed information see: Health Insurance for the Aged. Home Health Agency Manual, U.S. Department of Health, Education, and Welfare, Social Security Administration 1968.

The enabling federal legislation (Title XVIII) described the home health aide services as follows:

> *The primary function of a home health aide is the personal care of a patient. The services of a home health aide are given under the supervision of a registered professional nurse, and if appropriate, a physical, speech, or occupational therapist. The assignment of a home health aide to a particular case must be made in accordance with a written plan of treatment established by a physician which indicates the patient's need for personal care services to be provided by the home health aide. This must be determined by a registered professional nurse and not by the home health aide.*
>
> *Personal care duties which may be performed by a home health aide include assistance in the activities of daily living; for example, helping the patient to bathe, to get in and out of bed, to care for his hair and teeth, to exercise and to take medications specifically ordered by a physician which are ordinarily self-administered, and retraining the patient in necessary self-help skills.*

The rationale of the home health care services is that it is much less expensive to provide custodial care in the home than to provide such care in a hospital when the specialized services of these institutions are not needed.

Although Dr. Armonds felt the home health aide concept would work, he was faced with a major problem. There were no trained home health aides working in local health departments or anywhere else in the state.

Dr. Armonds was aware that funds were available from the Social Security Administration to establish public non-profit home health agencies. These funds were known as "seed money grants" since they provided money for a one year period to public agencies to organize, develop and

train personnel for a home health agency operation.

In December 1965, Dr. Armonds sought permission from the state commissioner of health and the state board of health to establish a home health care program within the structure of the state health department.

Dr. Armonds was given permission to develop a program of this nature only if it could become self-supporting and did not alter the delivery of other health services provided by the state and local health departments.

In early 1966, Dr. Armonds received a federal grant of $93,844 to establish the framework of a home health care agency.

A home health care division was established within the community health services section of the state health department (Figure 6). A physician was hired to head the program, and recruitment of administrative staff for the central office began. Of primary importance was the recruitment of a consulting nurse, a nutritionist, a social worker and the short-term assistance of specialized health personnel who would be able to help train a cadre of home health aides.

With assistance from the State Department of Adult Education, the home health care division developed a 200 hour training course specifically designed to train individuals to become home health aides.

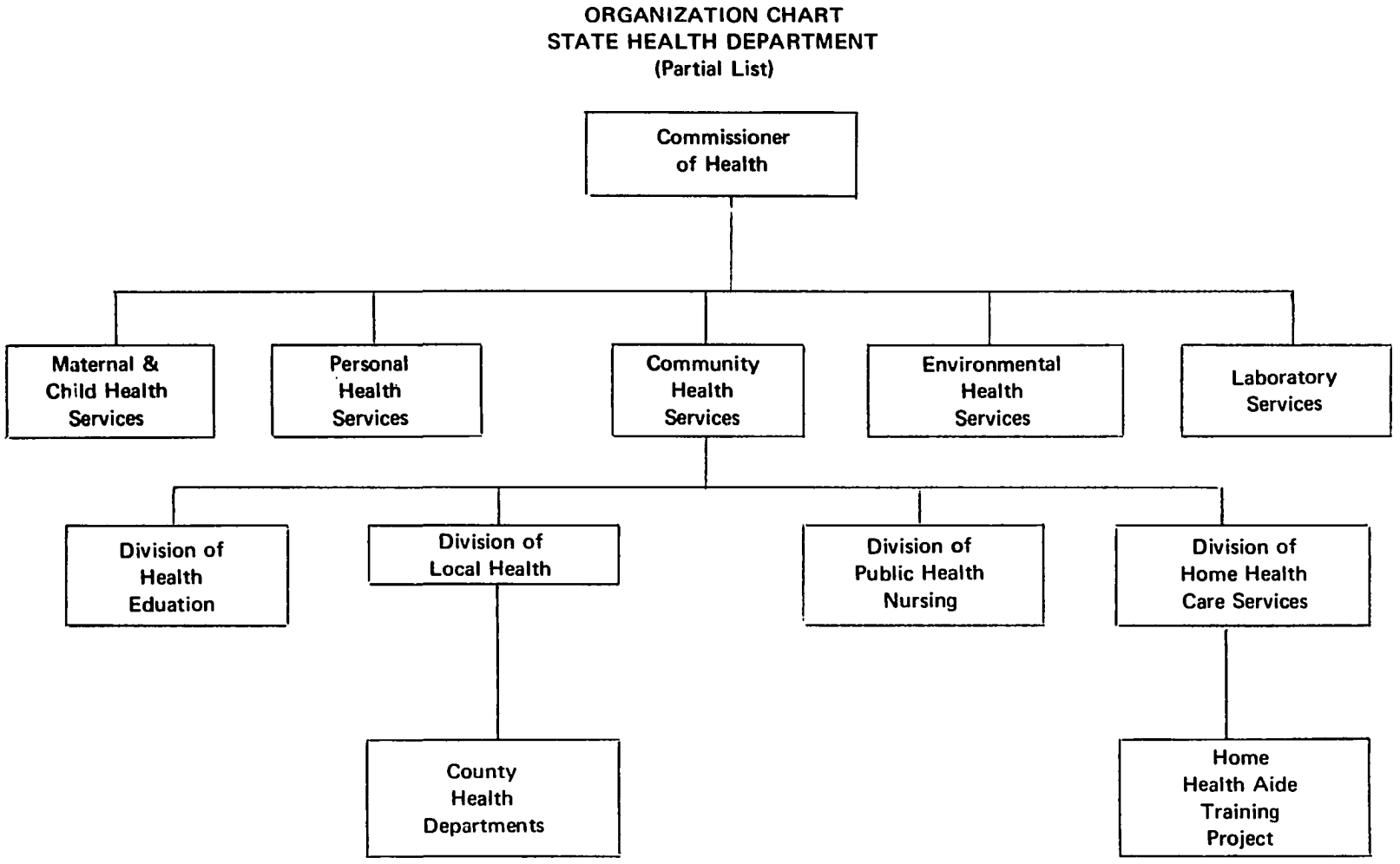

Figure 6. Organization chart of the State Health Department.

Forty training sessions were held throughout the state during the spring of 1966. Specific job offers could not be made, and no pay was provided to the participants during the training period. With these limitations, the training sessions attracted the low-income, middle aged female who was interested in supplementing the family income.

A total of 450 home health aides were trained during the spring of 1966. The state health department could not use this number of home health aide personnel but other agencies such as hospitals, extended care facilities, and nursing homes were anxious to employ many of them.

On July 1, 1966, the Health Insurance for the Aged Act, Title XVIII went into effect. On July 6, 1966, the state health department was certified as a home health care agency. The State Blue Cross Association was designated as the fiscal intermediary for all hospital and home health care agencies in the state.

As the fiscal intermediary, the State Blue Cross Association was responsible for:

1) *Determining if a medicare patient was eligible for home health services. This was accomplished through the review of what is known as a "start of care plan" furnished by the provider for each new patient.*

2) *Developing an acceptable method of payment for services.*

3) *Periodic re-evaluation of the home health care patients receiving care.*

4) *Conducting an annual audit of home health care cost to determine a fair and reasonable cost for each home visit made by the provider.*

Under the law, the state health department could choose to act as its own intermediary with the Social Security Administration. However, federal guidelines were still very vague and the Social Security Administration was encouraging all agencies to use the State Blue Cross Association as their intermediary. Under this arrangement, when an eligible patient who needed home health care was released from the hospital, the patient's physician could request such services from a certified home health agency.

In the state health department home health care operation, a public health nurse, at the request of the patient's physician, would visit the patient at home and prepare a "start of care plan." This plan was then submitted to the State Blue Cross Association for approval.

If approved, the patient could receive up to a maximum of 100 visits per year. Periodic recertification was required by both the patient's physician and the Blue Cross intermediary.

The Blue Cross Association paid for each visit by a nurse or home health aide based on a "fair and reasonable cost" for each visit.

Earlier in 1965, Dr. Armonds, with the assistance of the United States Public Health Service and the National League of Nursing, had conducted a nursing visit cost

analysis in one of the state's largest counties. A $9.20 per visit cost had been established. This figure was acceptable to Blue Cross. However, as required by law, Blue Cross must conduct an annual audit of each home health agency to determine if the per visit cost set by the agency is the true allowable cost based on total annual expenditures for the home health agency operation.

Dr. Armonds was somewhat concerned about the annual auditing procedures since the home health care program was to be integrated into the generalized nursing program provided at the local level.

This appeared to be the only acceptable method since it was highly impractical to hire professional nurses to do only home health care visits. In many of the state's rural counties, one or two nurses made up the health department staff. As the number of home health care patients increased, an additional home health aide or professional nurse was employed. The whole staff provided home health care in addition to assuming other duties within the health department structure.

This generalized nursing service approach was discussed with representatives from the Blue Cross Association. The Association deemed it acceptable if the state health department would be able to show the true total cost of the home health care program for the annual audit.

After some initial resistance from the public health nursing staff, forty-two home health aides were employed in forty county health departments and home health care became part of the nursing services of local health departments in the state.

Private practicing physicians were reluctant to use the service at the beginning since the total medicare package was still new. However, by January 1967, the state health department's home health care program was doing a booming business.

For the first time, many middle and upper middle class citizens were exposed to the activities of the public health nurse and their local health department. In most counties, the image of the county health department was greatly improved as a result of the home health care program.

From the period July 1, 1966 to June 30, 1967, public health nurses and home health aides made 26,351 home visits under post hospital plan part A for a cost of $242,796. Under medical plan part B, 14,971 visits were made for a cost of $137,942. The state health department had received $243,547 under plan A and $91,918 under medical plan B during this period.

As required by law, the state health department submitted a home health care agency statement of reimbursable cost for the fiscal year ending June 30, 1967, to their fiscal intermediary, the State Blue Cross Association. As

mentioned above, the Blue Cross Association had already paid $243,547 under plan A. Net cost under plan A was $242,796 and the state health department submitted a balance owed statement of $751. Under plan B, the state health department had received $91,918 and total allowable costs were $92,674. Blue Cross was billed for an additional $756, plus $21,574 that was reimbursable because of bad debts not paid by health insurance program patients.

The Blue Cross Association paid the additional billings with the understanding that the total cost of the home health care would have to be audited in the near future and financial adjustments might be necessary after the audit.

During the second year of operation, July 1, 1967 through June 30, 1968, the state health department's home health care program continued to grow and acceptance by practicing physicians was exceptional (Table 3).

In September of 1968, 14 months after the close of the first year's operation and 26 months after the home health care program began, an accounting firm employed by the State Blue Cross Association began the auditing procedure for the fiscal year ending June 30, 1967.

There was difficulty from the beginning. The auditing firm was extremely concerned with regard to the accounting procedures used to calculate cost for the home health care program and other health programs in the state.

The five major sources of funds utilized within the state health department are: (1) federal funds for general

TABLE 3

HOME HEALTH CARE VISITS
STATE HEALTH DEPARTMENT
Fiscal Years 1967, 1968, 1969, 1970, 1971

		Post Hospital Plan Part A		Medical Plan Part B	
Nursing & Home Health Aide Visits Combined	Average Cost Per Visit	No. of Visits	Cost	No. of Visits	Cost
Fiscal Year 1967	$ 9.21	26,351	$242,796	14,971	$137,942
Fiscal Year 1968	11.66	44,999	524,796	27,006	314,890
Fiscal Year 1969	12.17	54,625	664,786	39,316	478,476
Fiscal Year 1970	13.65	65,608	774,064	43,258	590,472
Fiscal Year 1971	16.97	33,210	563,574	19,582	332,307

health (commonly known as PHS 314 Formula Grants); (2) federal funds for specific categorical health programs such as maternal and child health, communicable disease control, chronic disease, and others; (3) state appropriations; (4) local county appropriations, and (5) federal funds received through the home health care program.

In a highly complex accounting procedure, federal and matching state and local funds were used to support a generalized health program at the local level.

For example, it was not unusual for a nurse in a local county health department to receive fifty per cent of her salary from a state maternal and child health fund and fifty percent of her salary from the county health department funds. Yet, in the performance of her duties, she usually participated in a number of programs including home health care.

For three months, the auditing firm worked with the fiscal office in the state health department in an effort to determine the actual cost of the home health care program.

In December 1968, they released their final report to the fiscal intermediary, Blue Cross and to the state health department.

There were sixteen audit exceptions but only two were of major importance. These two exceptions indicated that total allowable cost for the home health program was considerably less than the original state health department

calculations and that the department had been overpaid by $19,961. The major exceptions were as follows:

Item (A) estimated rental value on donated space of local health is not allowable cost as set out in the Social Security Administration Health Insurance Manual -15, Section 610. Amount included in original cost report was $175,731 gross before allocations.

> *Section 610 of the SSA-HIM reads as follows: Donation of the use of space..."A provider may be donated the use of space by another organization. In such case, the provider may not impute a cost for value of the use of the space and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs...."*

Item (I) federal funds received under Section 314 of Public Law 89-749, Public Health Service Act were, except for "home health services seed money," offset against the allowable cost in the proportion which allowable cost beared to total costs. The rule for offset of federal funds is outlined in SSA-HIM-15, Section 612. Section 612 of the SSA-HIM reads as follows:

> *Public Health Service Grants...General..."Public Health Service Grants are authorized under the Public Health Service Act on a fiscal year basis. In general, the purpose for which the grant was authorized will determine if any of the funds received are applied as a reduction of allowable costs. If, for example, the grants are authorized for a provider of health services to be used as the provider deems proper and necessary, the grant would be considered unrestricted and would not be used to reduce allowable costs. However, if the grants were authorized for certain costs or groups of costs, the grant would be considered restricted and would be deducted from the costs of services for which the grant was made.*

"The intent of this principle is to avoid duplication of recovery by the provider for costs incurred from the medicare program and other sources, such as Public Health Service grants...."

Within three months after the completion of the initial audit, the state health department was audited for the fiscal year 1968 home health care operation. The same major audit exceptions appeared. Since the home health care program had expanded rapidly during the fiscal year 1968 (Table 3), the total amount owed by Blue Cross for the fiscal year 1968 was $76,594.

During the fiscal year 1967, the state health department had a total operating budget of $6,575,217; $5,085,633 was state and local appropriations and $1,489,584 was federal funds allocated for general health programs, mental health, tuberculosis control, chronic disease programs, water pollution, radiological health, cancer control, air pollution, and maternal and child health (Table 4).

The crux of the accounting problem revolved around the $1,489,584 received from the federal government. Blue Cross Association would not accept data presented by the state health department which showed that the $1,489,584 had not been used to help support the home health care program.

During fiscal year 1968, the state health department had a total operating budget of $7,413,423; $5,112,919 was state and local appropriations and $2,300,504 was federal funds. During this one year, federal appropriations

TABLE 4

CATEGORIES OF FEDERAL FUNDS
STATE HEALTH DEPARTMENT
Fiscal Year 1967

Category	Amount
General Health (PHS 314D Funds)	$ 149,268
Heart Disease	148,720
Cancer	47,526
Mental Health	77,878
Tuberculosis	39,342
Chronic Disease	189,854
Water Pollution	64,656
Dental Health	9,567
Radiological Health	23,767
Hospital Administration	14,205
Air Pollution	3,990
Venereal Disease	24,642
Home Health Care (Seed Money Grant)	93,844
Maternal & Child Health	602,325
Sub Total	$1,489,584
State and Local Appropriations	5,085,633
Total State Health Department Budget Fiscal Year 1967	$6,575,217

to the state health department increased about one million dollars over the previous year. This added to the home health care division's accounting problems.

In January of 1969, the state commissioner of health wrote the State Blue Cross Association a letter objecting to the audit exceptions. In this letter he explained the rationale of the state health department's generalized program in the following narrative:

HOME HEALTH CARE SERVICES AS PART OF LOCAL HEALTH DEPARTMENT'S GENERALIZED HEALTH SERVICES

Prior to the health insurance for the Aged Act, Title XVIII of the Social Security Act, the state health department was performing certain ongoing health programs. When the state and local health departments became providers of home health services through the Health Insurance for the Aged Act of 1965 (effective July 1, 1966) more space and personnel were needed in addition to that already established. Such additional space and personnel became part of the generalized health services already available through the state's local health departments. The local health departments did not discontinue any of the ongoing programs; home health care services became an additional program and more personnel were hired.

Nurses and home health aides were not used exclusively for home health care. To do so would result in exorbiant costs. Existing personnel, along with the new personnel, participated in giving generalized health services, the theory being that costs of services funded in one area would be offset by costs of services funded in another area.

The intermingling of personnel, equipment and space did not limit or mitigate the ongoing programs of the health department. In fact, the same level of service was maintained in the health programs being carried on prior to the implementation of home health care. The time which was spent on home health care, the equipment and space services which were used and charged to the home health programs were available over and above that purchased by other federal funds for programs already established.

The auditing firm employed by the State Blue Cross Association, for want of earlier guidelines, made rigid application of the Social Security Administration, Health Insurance Manual -15, Section 612 as published in August 1968, twenty-six months after implementation of the home health care services program and fourteen months after the close of the 1967 fiscal year. In doing so, the auditing firm erroneously considered that a proportion of the funds used for home health care purposes, in addition to the "seed money grant" which was allowable, were federal funds from grants authorized to pay for certain specified costs.

The implication is that the provider (state health department) had received funds from the federal government to conduct certain health programs, had used these funds for home health care services and had now collected from the federal government again by applying for cost reimbursement for home health services.

The state health department maintains that, except for the "seed money grant," funds used in home health care services were not federal funds--that they were, in fact, state and local funds and that there were more sufficient state and local funds poured into the home health care programs to satisfy the reimbursement reconciliation.

To exclude or disallow federal funds from the reimbursement costs in the proportion which allowable costs bear to total costs of each federal budget program is an unfair and incorrect application of the 1968 regulation.

The state health department feels that we have complied in every way with the provision of the Title XVIII Act in determining "reasonable cost," and will let the record stand to show that there is no duplication of federal funds if reimbursement is allowed to stand as shown.

We ask that points (A) and (I) of the audit exception be cancelled and that a subcommittee be named to arbitrate final settlement.

It is not the desire of this agency to "reap a profit" from the operation of the home health care program. In the interest of maintaining a proven and effective program, it is the desire of this agency to be reimbursed for actual costs to state and local funds in the use of time and space which might otherwise have been used in the development of other state and local programs.

During the same month, the state commissioner of health appealed to the Regional Health Director, Department of Health, Education, and Welfare, and to the Regional Representative of the Social Security Administration, Bureau of Health Insurance, for a ruling in the case.

Response from both of these agencies indicated that the state health department would have to go through the Blue Cross Appeal Process.

Acknowledgement was received from the State Blue Cross Association indicating that it was possible to appeal an audit exception through what is known as the Blue Cross Association Medicare Provider Appeals Procedure.

On March 20, 1969, Dr. Armonds wrote the State Blue Cross Association stating that "informal or formal methods of conciliation, conference and persuasion had been exhausted at the local level and that it was the state health department's wish to apply for a review through the Medicare Provider Appeals Procedure."

The Medicare Provider Appeals Procedure is provided in the contract between the Social Security Administration and the National Blue Cross Association, In essence, it states that the president of each State Blue Cross Association shall establish a provider appeals committee composed of five members to hear and decide appeals from providers dissatisfied with the local handling of complaints. Three members of the committee are appointed by the president of

the State Blue Cross Association and the other two members are to be chosen from representatives of certain national associations of providers.

The State Blue Cross Association's Provider Appeals Committee consisted of:

1) Three trustees of the Board of Trustees of the State Blue Cross and Blue Shield.

2) The president of the State Blue Cross and Blue Shield Association.

3) One committee member selected by the president of the State Blue Cross Association from a panel of five nominees to be submitted by each state association of providers.

Dr. Armonds took one look at the membership of the appeals committee and felt certain that the state health department's appeal would be unsuccessful.

After consulting with the state commissioner of health, Dr. Drmonds wrote a letter, dated April 7, 1969, to Mr. Robert Finch, Secretary of Health, Education, and Welfare, objecting to the manner in which the Blue Cross Appeals Committee was selected and asking that other arrangements be made. On the same date, he wrote a letter to the Regional Representative of the Social Security Administration, Bureau of Health Insurance, in which he stated, "...We would like to know the method by which we might apply for or handle our own fiscal operations directly with the Social Security Administration. In other words, can we act as our own fiscal intermediary, or if not, could some other state agency do so?"

Both requests were turned down by the Department of Health, Education, and Welfare.

The state health department presented its side of the case before the Medicare Provider Appeals Committee on April 22, 1969. The committee was unable to resolve the issue and another meeting was scheduled for May 5, 1969.

The appeals hearing was subsequently held on that date. The state health department lost its appeal. In its summary, the appeals committee stated:

> *Based upon the facts which were available to the intermediary (State Blue Cross) at the time of the audit, its determination to statistically prorate a portion of the Public Health Service grant funds received by the state health department for the home health care program was not unreasonable. Therefore, without some documentation of supportive information regarding the specific uses for which the funds were given to the state department of health, this committee is unable to conclude that the Blue Cross Association was erroneous in its auditing analysis.*

The committee advised the state health department that they had the right to appeal the decision to the Regional Blue Cross Association in Chicago, Illinois. The committee also suggested that the state health department obtain "outside" supportive documentation that the Public Health Service federal funds were restricted to programs other than home health care, and that the programs using these funds do not provide assistance to medicare patients.

After this decision, the relationship between the State Blue Cross Association and the state health department became extremely strained.

On June 12, 1969, the state health department again appealed to the Social Security Administration for a change in their fiscal intermediary for home health care. No response was received.

On June 13, 1969, the state health department appealed to the Regional Health Director of the U.S. Public Health Service for assistance in providing supportive documentation to demonstrate that federally supported health programs were being carried out as stipulated in the agreement between the Public Health Service and the state health department.

The Public Health Service agreed to assist the state health department. In September 1969, two consultants from the Public Health Service Regional Office came to the state and assisted the state health department in reviewing the nursing service operation, the accounting procedure used, and the development of a more detailed cost analysis system.

The nursing time study lasted two months. In December of 1969, Dr. Armonds received a letter from the Public Health Service Regional Health Director supporting the state health department's contention that federal funds were not used to support the home health care program.

> The letter said in part, "*...It is apparent to us that Public Health Service funds granted to the state department of health were not intended to be used to pay the costs of the Title XVIII Home Health Care Program, and in our opinion, appropriate steps were taken in early 1966 through the request for*

review of validation procedures that they were not so used. In view of this, we cannot accept the decision of the Blue Cross Provider Appeals Committee which states that the Public Health Service funds will be used to reduce the reimbursable costs of home health services in the county home health agencies of the state department of health..."

Dr. Armonds felt that the department needed more outside supportive documentation and in January 1970, appealed to the Director of the Community Health Service, Public Health Service in Washington, D.C., for assistance.

After a review of the state health department's documentation which now weighed several pounds, the Director of the Community Health Service, Public Health Service, responded in a letter dated April 24, 1970. In this letter he supported the state health department's position. In essence, he said that federal Public Health Service funds are not awarded unless a state health department submits a plan which describes the health services to be accomplished and the Public Health Service must approve the plan.

In view of the above, federal PHS funds could not have been used to support home health services to people who were receiving services paid for from Medicare funds.

In May 1970, Dr. Armonds again appealed to the Blue Cross Association for a review of the home health care audit exceptions for fiscal years 1967 and 1968. The Blue Cross Association in Chicago replied that a provider appeals procedure at the regional level had not been worked out but that a hearing would be held within 120 days as required by law.

In January 1971, the state commissioner of health resigned, effective February 1, 1971.

He was replaced by Dr. Louis Besheirs, who had served as chief of maternal and child health for the state health department for nine years.

During Dr. Besheirs first week in office, Dr. Armonds came to his office and reviewed the home health care dilemma with him.

Dr. Besheirs studied the situation that evening and the next morning met with Dr. Armonds. Dr. Armonds began the conference by saying, "Louis, I'm at my rope's end on our home health care program. For the last four months, we've had to borrow from other state health department funds to keep the program out of the red. We are going to have to let at least ten public health nurses and most of the central office staff go.

"If we could get the $280,000 Blue Cross owes us, the program would be in good shape, but there doesn't seem to be much chance of that."

Dr. Besheirs agreed that part of the nursing staff and most of the home health care central office staff would have to be terminated. However, he felt they had one avenue left open that might work in regard to the state health department's conflict with the Blue Cross Association.

PART II—Conclusion

In March 1971, the state health department began the painful process of reducing nursing staff, home health aides and home health care administrative staff. These three categories were reduced by about fifteen percent. The reduction would have been much greater but state and federal appropriations for family planning services had increased tremendously during this period, and the state health department was able to absorb nursing and home health care personnel into the family planning program with a minimum of retraining.

During the same month, Dr. Besheirs appealed to the state's two United States Senators and ten United States Representatives for assistance.

From April 1971 until August 1971, correspondence between the state health department and the state's congressional delegation continued. Both of the state's United States Senators put considerable pressure on the Social Security Administration to review the case.

The case was reviewed by the Social Security Administration in August of 1971, and the following letter was received from the Social Security Administration on August 30, 1971.

> *"...We have been in touch with the Blue Cross Association in Chicago, with the Public Health Service, and with the Department of Health, Education and Welfare and also the regional office in your area to determine the exact nature of the federal grant*

funds which your State Blue Cross has deducted from the allowable costs of the home health care program of the state health department. We have concluded from our review of the case that the Blue Cross interpretation of the applicable program regulations and policies was incorrect in this instance and that the terms of the Public Health Service grants in question did, in fact, preclude their use in paying the cost of services to home health care patients.

"Your State Blue Cross Association will be advised to reverse its determination and to make the appropriate adjustments in the final cost settlement for fiscal years 1967, 1968, and 1969 to conform with our conclusions in the case...."

On September 15, 1971, the state health department received a check for $280,000 from the Blue Cross Association.

In October 1971, Dr. Armonds went to work to put his shattered home health care program back together again.

PART III—Instructor's Guide

The major issue in this case is the struggle of the state health department to continue to provide a generalized public health program at the local level in the face of federal budgetary regulations that virtually force the categorization of health care programs.

This case also illustrates the complicated bureaucratic situations that can develop between states and the federal government. Two branches of the federal government, the Social Security Administration and the Public Health Service were involved in this controversy, but there is little evidence of communication between them.

The role of the Blue Cross Association should give the student the opportunity of analyzing and discussing some of the problems of third party payment of medical care.

This case should also present the opportunity for students to discuss the different types of federal grants-in-aid received by state health departments.

The fact that this state health department was willing to take the step from traditional public health programs into the field of primary health care is significant. It is hoped that the discussion of this case will lead to the analysis of whether a state and local health department can play a significant role in providing primary health care in the future.

The instructor may wish to ask the following questions to facilitate class discussion:

1) What are the major issues in this case?

2) What impact has the Title XVIII legislation had on public health programs in the United States? On other health care delivery systems?

3) Do you feel the Blue Cross auditors were wrong in their decision?

4) The concept of a generalized public health program is mentioned several times in this case. What does it mean to you?

CHAPTER XI

THE STATE HEALTH DEPARTMENT VACCINE BUDGET

PART I—The Case

In July 1963, an immunization section was created within the personal health services division of a state health department in the Midwest.

The section was created as a direct result of a $200,000 grants-in-aid project from the United States Public Health Service.

The project provided funds to the state health department for personnel, supplies, equipment and vaccine for the development of a statewide comprehensive immunization program.

Under the guidelines established by the Public Health Service, the immunization section was to utilize the federal funds to:

1) Initiate surveys to determine the levels of immunization within the state population.

2) Conduct intensive immunization campaigns on a community wide basis, or in preselected areas where low immunization levels were identified.

3) Develop promotional and educational programs to stimulate public and professional awareness of immunization needs and services.

4) Develop and improve immunization programs for school children and adults.

5) Develop and improve surveillance of diseases for which effective immunization materials are available.

6) Provide all local health departments and other agencies with adequate vaccine for the development of special immunization campaigns and the maintenance of routine immunization clinics.

An immunization program of this scope was needed in the state. The state health department had never developed a statewide immunization program and sporadic outbreaks of preventable diseases were a common occurrence. The largest outbreak of diphtheria in the nation occurred in the state during the winter of 1962.

Although live virus oral poliomyelitis vaccine was licensed for use in the United States early in 1962, all of the local county health departments in the state were still using Salk polio vaccine as late as the fall of 1963. Immunization levels for poliomyelitis were known to be extremely low in many rural areas of the state.

During the years 1963 to 1969, the Public Health Service immunization project grant awards averaged approximately $200,000 per year. Matching state funds were not required; however, the state health department allocated approximately $16,000 each year for the purchase of some of the less expensive vaccines such as combined diphtheria-pertussis-tetanus vaccine and smallpox vaccine.

Utilizing the PHS funds, the state health department had been successful in immunizing large numbers of susceptible children in the state. In 1963, the immunization section, with the help of various civic groups, had conducted polio immunization campaigns in all eighty counties in the state. The programs were successful and more than 210,000 doses of polio vaccine were given to children and adults.

A similar campaign for rubeola immunizations was held in 1967 with more than 156,000 children receiving the vaccine.

A statewide disease surveillance system was established and disease trends in the state were followed closely by the immunization section. By the spring of 1970, immunization levels among the preschool and school age children were adequate. The immunization section was now concentrating its attention on maintaining the levels by following up on infants born in the population each year.

As part of the maintenance program, each of the state's eighty county health departments offered smallpox, DPT, DT, poliomyelitis, and rubeola vaccine on a regularly scheduled basis. Most of the county health departments conducted at least two immunization clinics weekly.

Since the beginning of the grants-in-aid project, the local health departments had depended on the state health department to supply all vaccines.

Each year the state health department obtained competitive bids for vaccine and a state contract was written with the pharmaceutical companies submitting the lowest bid for each vaccine.

Large quantities of DPT, DT, smallpox, polio, and rubeola vaccines were stored at the state health department and shipped to local health departments upon request.

Traditionally, the local health departments provided immunization services to residents of their counties free of charge. In many counties, the free immunization clinics were considered part of the service county residents were receiving for their tax dollars.

On January 10, 1970, Dr. Charles Harbert, chief of the personal health services division of the state health department, called Mr. Mark Kenworth, director of the immunization section into his office. Dr. Harbert explained that he had just received a letter from the Public Health Service indicating that because of a change in federal legislation, the service would no longer be able to provide funds for the purchase of DPT, DT, poliomyelitis and rubeola vaccine to any state health department after June 30, 1970.

The letter emphasized that PHS project funds would continue to be available for personnel, supplies, and equipment. Also, funds would continue to be available to purchase the newly licensed rubella vaccine, but money for the

purchase of other vaccines would have to come from another source. Dr. Halbert and Mr. Kenworth discussed the situation and decided the only alternative was to meet with Dr. Fowler, commissioner of health, and request that he seek additional funds from the state legislature to support the immunization program. A meeting was set with the commissioner for the following day.

Mark Kenworth went back to his office and began to prepare the necessary information on vaccine utilization. He found that the number of doses of vaccine used in the state's eighty county health departments had been very consistent for the past three years. A breakdown of the types and number of doses of vaccine used during the past fiscal year was prepared (Table 5).

TABLE 5

VACCINE UTILIZATION FOR EIGHTY COUNTY HEALTH DEPARTMENTS
July 1, 1968 to June 30, 1969

Type of Vaccine	Number of Doses Used	Cost Per Dose	Total Cost
Combined Diphtheria-Tetanus-Pertussis	69,700	.05¢	$3,485.00
Smallpox Vaccine	28,800	.04¢	1,112,00
Combined Diphtheria-Tetanus	40,040	.05¢	2,022.00
Poliomyelitis Vaccine	109,589	.31¢	33,975.38
Rubeola Vaccine	32,200	1.32	42,504.00
	TOTAL		$83,078.38

A total of $83,078.38 had been spent for various vaccines. The state health department had spent $6,599 for the DPT, DT, and smallpox vaccines. The Public Health Service project grant had provided $76,479,38 for the purchase of poliomyelitis and rubeola vaccine.

Based on the vaccine utilization information, Mark Kenworth prepared a request for an increase in the state health department budget for vaccine from $16,000 to $85,000.

The meeting with the commissioner of health was held the next day. Dr. Harbert and Mr. Kenworth explained the dilemma and showed the commissioner the vaccine utilization data. They asked the commissioner to submit an immunization budget request to the state legislature for $85,000. The commissioner was sympathetic but explained that the department had already been informed by the state budget office that only a five per cent increase in existing budgets could be accepted for the next fiscal year.

The commissioner also explained that any additional state funds for the department would have to be placed in the new environmental control program or the new family planning program. The state legislature was very interested in these two programs and was putting pressure on the commissioner to expand the department's activity in these two areas. The meeting ended with the commissioner of health promising to explore all avenues to obtain additional state money for the immunization section.

On April 12, 1970, Dr. Harbert walked into Mark Kenworth's office and said, "Mark, here's the new budget allocations for the next fiscal year. As you can see, we're only getting $20,000 for vaccine. The commissioner says we can use the money to set up any kind of system we want, but $20,000 is the maximum amount we can expect next fiscal year. See if you can work out the best way to use the money we have."

PART II—Conclusion

Mark Kenworth knew that the difference between the $20,000 available and the $83,000 needed would have to come from local health department budgets or from charging the people who used the local health departments immunization services.

He immediately informed the local health departments of the situation and suggested they request additional funds from local county appropriations.

Protest came from all areas of the state. Most of the county health officers pointed out that local health department budgets had already been submitted for the next fiscal year and very little additional money was available at the local level.

A delegation of local health officers demanded a meeting with the commissioner of health to protest the situation. The commissioner of health met with all of the state's local health officers in May 1970 and explained that it was simply a matter of financial priorities, and it was the responsibility of Dr. Harbert and Mark Kenworth to develop a feasible plan with the $20,000 they had available.

In June 1970, Dr. Harbert and Mark Kenworth presented the following plan to the county health officers:

1) The state health department would continue to make state contracts with pharmaceutical companies in order to obatin the best price possible for vaccine.

2) A portion of the $20,000 would be used to buy all of the smallpox, DPT, and DT vaccine needed for local health department use. This vaccine would be provided free to local health departments as in the past.

3) Thirteen thousand of the $20,000 would be used to establish a special revolving fund to purchase rubeola and poliomyelitis vaccine at state contract prices. This vaccine would then be sold to each local health department at the same price the department paid for it.

4) Each local health department was given the alternative of paying for the polio and rubeola vaccine from local health department funds or charging their clients for the vaccine.

5) Since funds for rubella vaccine were available from the Public Health Service, rubella vaccine was to be provided to local health departments free of charge.

The plan was accepted but with considerable protest. Eight of the state's counties in the poverty stricken southeastern area of the state simply stopped giving polio and rubeola immunizations.

Mark Kenworth quietly worked out an unofficial agreement whereby the eight departments were billed for the polio and rubeola vaccine they ordered but simply didn't pay the billings. The cost of the vaccine for these eight counties was taken from the revolving account.

Although all of the local health departments continued to offer rubeola and polio vaccine, most of them charged their clients for the vaccine. The number of rubeola immunizations given in the state dropped from 32,000 in the fiscal year 1970 to 14,016 in the fiscal year 1971.

The number of poliomyelitis immunizations dropped from 109,589 to 68,216 during the same period.

The plight of the immunization program did not go unnoticed. Newspaper editors, county medical societies, and civic organizations put considerable pressure on the state legislature to increase state allocations for vaccine.

The following year, the budget of the state health department was increased to $80,000.

PART III—Instructor's guide

The basic underlying issue in this case is that for many years state health departments have depended too heavily on the Public Health Service for funds to support their communicable disease control programs. When the federal legislation supporting the immunization program expired, the state immunization program almost expired with it.

This case gives the student the opportunity to define the problem presented and to develop alternatives for solving the problem.

The development of priorities in community health practice is difficult since almost all health programs have merit and the availability of funds is limited. This case should lead to the discussion of methods of evaluation that should be used in establishing priorities for a public health agency.

The instructor may wish to ask the following questions to facilitate class discussion:

1) How would you have handled the problem if you were Mark Kenworth? What is the basic problem? What is his range of alternatives?

2) What is the major underlying issue of this case?

3) Establishing priorities is a management process basic to all organizations. Do you feel the commissioner of health made the right decision in placing the control of communicable diseases so far down on his list of departmental priorities?

CHAPTER XII

SUMMARY AND RECOMMENDATIONS

The case-study method is an established method of teaching in the schools of law, medicine, business administration, social work, education, public administration, social research and in recent years, the field of health care administration.

There are advantages and disadvantages to the method. The major disadvantage is that the cases are not, in fact, the real life situation and they cannot provide the student with a complete picture. Cases usually present a prescribed amount of material. The student learns to select the relevant from the irrelevant information, but generally does not have to seek additional information which is an important aspect of the administrative process.

Another disadvantage is that continual concentration within the confines of a case can cause orientation to specific incidents and inadequate attention to outside sources of information and theory.

The major advantage is that the case method approach to teaching is superior to others in helping students of administration develop and improve basic administrative skills.

The case method is also a very pleasant form of education. There is opportunity for considerable student-to-student and teacher-to-student interaction.

The method promotes an active rather than a passive orientation and the study of cases comes close to duplicating the actual work situation in a number of ways. Also, the focus on the processes of analysis and decision-making forces a synthesis of the underlying theory of administration.

Review of the literature indicates there is a great need for carefully prepared case reports in the field of public health administration that focuses on intra-agency dynamics rather than on the problems faced by public health administrators from outside their organization.

The original case reports presented in this study are directed toward two major objectives. One, the case reports presented in this study will help students in the field of health administration develop and improve basic administrative skills such as the ability to apply theory to specific problems, the ability to define and solve problems, the ability to synthesize factual and value premises in decision-making, improved verbal and written communication, and the ability to effectively plan and evaluate programs. Two, for the student with limited experience in the field of public health, the case reports presented in this study provide information on and examples of generalized vs

categorical health programs, administrative structures of state and local health departments, the problems of federal and state relationships, the impact of changing medical technology on public health programs and the impact of federal health legislation in the field of public health.

Each case report presented in this study is divided into three parts. Part I provides background information regarding the issue or the situation. Part I ends at a point where the reader is given the opportunity to determine the essential issues of the case before reading the actual conclusion of the case.

Several of the cases present the reader with the opportunity to place himself in the role of the decision maker; to make his decision and then to be able to compare it with the actual decision made by the administrator in the case. Part II provides the actual conclusion of each case.

Part III is designed for use by the instructor presenting the case. The author's analysis of the important issues presented in each case is included. The use of questions at the end of the cases has advantages and disadvantages. Questions encourage student involvement and more effective class discussion. Unfortunately, the use of specific questions has the disadvantage of excluding the irrelevant material from the relevant for the student. Therefore, the questions are presented in Part III rather

than at the end of Part I so the instructor has the opportunity to decide if he wants to use the questions.

Student interaction is essential for the effective use of the case method. These cases are of limited value unless there is an opportunity for student-to-student and teacher-to-student interaction.

This writer would like to recommend that students be given adequate time to study the case and prepare their analysis before the cases are discussed in class. It is also recommended that Part I of each case be adequately discussed before the student is given Part II of the case.

BIBLIOGRAPHY

Andrew, Kenneth R. The Case Method of Teaching Human Relations and Administration. Cambridge: Harvard University Press, 1960.

Apple, Dorrain, ed., Sociological Studies of Health and Sickness. New York: McGraw-Hill, 1960.

Bock, Edwin A., ed., Essays on the Case Method in Public Administration, Brussels: International Institute of Administrative Services, 1962.

Cabot, Hugh, and Joseph A. Kahl. Human Relations: Concepts and Cases in Concrete Social Science. Cambridge: Harvard University Press, 1953.

Conant, Ralph W. The Politics of Community Health, Report of the Community Action Studies Project. Washington, D.C. Public Affairs Press, 1968.

Glover, John D., and Ralph M. Hower. The Administrator: Cases on Human Relations in Business. Homewood, Ill: Richard D. Irwin, Inc., 1963.

Hamilton, James A. Decision Making in Hospital Administration and Medical Cases: A Casebook. Minneapolis, Minn: University of Minnesota Press, 1960.

Jaco, Gartley E., ed., Patients, Physicians and Illness. Glencoe, Ill: The Free Press, 1958.

Jain, Sagar C. "An Essay on Terminology: The Case Study, the Case Report, and Similar Terms with a Note on the Teaching of Public Health Administration," in Health Services Administration: Policy Cases and the Case Method, ed., Roy Penchansky, Cambridge, Mass: Harvard University Press, 1968.

Lawrence, Paul R., and John A. Seiler. Organizational Behavior and Administrative Cases, Concepts, and Research Findings. Homewood, Ill: Richard D. Irwin, Inc., 1965.

McNair, Malcom P. The Case Method at the Harvard Business School. New York: McGraw-Hill, 1954.

Merry, Robert W. "Course Development," in Health Services Administration: Policy Cases and the Case Method, ed., Roy Penchansky, Cambridge, Mass: Harvard University Press, 1968.

Mosher, W. E. "Case Studies in Public Administration," American Political Science Review, 33: 66-68, February 1939.

Paul, Benjamin D., ed., Health, Cultures, and Community: Case Studies of Public Reactions to Health Programs. New York: Russell Sage Foundation, 1955.

Penchansky, Roy., ed., Health Services Administration: Policy Cases and the Case Method. Cambridge, Mass: Harvard University Press, 1968.

Penchansky, Roy. "The Case Method and the Training of Health Service Administrators," In Health Service Administration: Policy Cases and the Case Method, ed, Roy Penchansky. Cambridge, Mass: Harvard University Press, 1968.

Pigors, Paul, and Faith Pigors. Incident Process: Case Studies in Management Development. Washington, D.C. The Bureau of National Affairs, 1955.

Pigors, Paul, and Faith Pigors. Case Method in Human Relations: The Incident Process. New York: McGraw-Hill, 1961.

Renthal, A. Gerald. "Considerations on the Use and Nature of Case Studies in Teaching Medical Care Administration" in Health Services Administration: Policy Cases and the Case Method, ed., Roy Penchansky, Cambridge, Mass: Harvard University Press, 1968.

Sherwood, Frank P. "Some Aspects of Case Method Teaching," in Frank P. Sherwood and William P. Storm, eds., Teaching and Research in Public Administration: Essays on Case Approach, Los Angeles: School of Public Administration, University of Southern California, 1960.

Social Research Council, Special Committee on Research Materials. Case Reports in Public Administration, Chicago: Public Administration Service, 1940, 1941, 1944.

Sperle, Henryetta D. The Case Method Techniques in Professional Training. New York: Bureau of Publications, Columbia University Teachers College.

Towle, Charlotte. The Case Method of Teaching Social Work. New York: National Association of Social Workers, 1959.