Restructuring the Family Planning Program Change for Uniformity's Sake? by Brad Lamb

Public health officers have long recognized that family planning is an essential part of good preventive medical care. Here in North Carolina, we are proud to have been one of the first states to build family planning assistance into our public health programs. And where family planning is available to our citizens we find that many other medical needs and problems are reduced or eliminated, which in turn helps us accomplish more with our investment in other medical services.

Dr. Jacob Koomen, Former Director
Division of Health Services
N. C. Department of Human Resources

BY MOST ASSESSMENTS, North Carolina has succeeded in establishing a successful statewide family planning program. During the last year, nearly 120,000 women have received the medical, educational, and support services that make up family planning. Nevertheless, at the insistence of Dr. Sarah T. Morrow, Secretary of the North Carolina Department of Human Resources, the administrative structure of the statewide program is being altered, largely in response to the demands of local health directors.

Beginning July 1, the State Family Planning Branch began contracting for family planning services directly with local health departments instead of with regional organizations. By July 1, 1980, the regional organizations will have no role whatsoever in family planning, and the family planning coordinators who work out of regional organizations will be replaced by a smaller number of coordinators who will be assigned to the four Department of Human Resources regional offices.

Was a statewide policy change needed in this successful preventive health program? Are policy makers jeopardizing successful aspects of the program by implementing a full-scale administrative change?

AS DR. KOOMEN emphasizes in the passage reproduced above, family planning needs to be preventive in nature. North Carolina's application for renewed federal funding describes the program as providing "individuals and families the medical, educational, infertility, and supportive services they need to determine the size of their families and the spacing of their children. Family planning services help improve the health status of mothers and children by reducing the number of high risk births and contribute to the stability of the family unit by reducing the number of unwanted pregnancies and their accompanying social problems (e.g., abortion, child abuse, out-of-wedlock births, divorce, and financial dependency)."

That kind of preventive health program requires, if it is to be successful, a team approach. It must involve doctors, nurses, health educators, social workers, and other professionals working together. To encourage the team approach, the regional office of the U. S. Department of Health, Education and Welfare (HEW) which handles eight southeastern states, including North Carolina, developed the concept of a "coordinated delivery system." The concept was selected after successful pilot programs were conducted in North Carolina by the Carolina Population Center of the University of North Carolina at Chapel Hill and local providers. In the view of HEW officials, "it was necessary to find a system of units which would lend itself to efficient administration from the view of the regional offices and at the same time be related closely to local control of programs."

During the late 1960s, HEW tried awarding grants directly to local health departments or community action programs. But when an uncoordinated and poorly administered system of services developed, the federal agency turned to awarding grants directly to the states and permitting each state to choose its

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Dr. Morrow views the lead regional organizations as inappropriate instruments for the delivery of health services.

own administrative structure for achieving a "coordinated delivery system."

North Carolina chose to administer the family planning program through regional agencies. On June 29, 1974, Gov. James Holshouser announced that the state's 17 Lead Regional Organizations (LROs), most of them Councils of Governments (COGs) composed of municipal and county officials, would administer the program. The LROs were to have priority in receiving family planning contracts, but if they chose not to be involved in family planning, as some did, they were allowed to designate other agencies to administer the program.

In selecting the LROs as administrators, Governor Holshouser bypassed the state's own administrative structure. The Division of Health Services in the Department of Human Resources (DHR) normally contracts directly with county health departments to provide health services in the counties. It monitors the delivery of the health services through staff assigned to four DHR regional offices, which are located in Black Mountain, Winston-Salem, Greenville, and Fayetteville.

Under the arrangement announced by Holshouser, the arrangement that had been in effect until this July 1, family planning funds were distributed to the LROs, which, in turn, subcontracted with individual county health departments or local non-profit agencies. In two regions, the LROs chose not to be involved, and the State Family Planning Branch of the Division of Health Services contracted directly with the local providers. Two other LROs delegated their responsibilities to community action agencies.

Dr. Sarah Morrow Photo by Jim Strickland

All but one of the LROs hired a family planning coordinator to provide technical assistance to the local service providers and to monitor the delivery of services. The coordinators worked closely with the State Family Planning Branch. The Family Planning Branch strongly emphasized community health education. To encourage community involvement and to meet federal regulations, each of the LROs or agency delegated by an LRO established a Regional Advisory Council. A majority of the members of each of the advisory councils were consumers who used the family planning services.

The administration of the program through the LROs was successful. And the regional approach had the strong endorsement of Dr. Koomen, who headed the Division of Health Services. In an April 28, 1977 memorandum to Dr. Morrow, the new Secretary of Human Resources, Dr. Koomen cited a number of advantages that had resulted from regional administration. Among them were: the broadening of the family planning program to include a comprehensive range of services, the increase in clinical services resulting from promoting the use of family planning nurse practitioners, the streamlining of grants management (the state had contracts with the regional agencies instead of with 86 health departments or districts), and the development of family planning advisory councils.

Dr. Koomen acknowledged that there were some problems in dealing with LROs, such as high administrative costs, but he concluded: "Regionalism contributes both to the effectiveness and manageability of the Statewide Family Planning Program. The substitution of a new system at this point would be disruptive in many aspects. I propose that we retain those features which have worked well to promote the tremendous progress of this program during its relatively short existence and pursue solutions to those problem areas which have been identified."

In a memorandum responding to Dr. Koomen, Dr. Morrow dealt first with one of the problem areas mentioned by the health services director. She said

Local health directors have pressed for removing LROs from the administration of family planning.

the requirement that LROs be given first priority for administering grants would be removed, thus permitting the Division of Health Services to bypass LROs with high administrative costs.

As for changing the administrative structure, Dr. Morrow said she agreed with Dr. Koomen that "arbitrary changes across the state for the sole purpose of achieving uniformity or process could be very disruptive . . . ." But she added: "I would like to see the family planning program regionalized along our DHR regional boundaries with maximum direct relationship with county health departments. Please give me your outline plan for implementing this concept . . . ."

The memorandum from Dr. Morrow marked the beginning of the move to take family planning administration away from the regional organizations and to give it to the individual county health departments.

At a January, 1978 meeting, officials in the Plans and Operations Division of the Department of Human Resources discussed Dr. Morrow's desire to work more directly with county health departments in administering the family planning program. A week after that meeting, Dr. Koomen told Dr. Morrow in a memorandum that the Division of Health Services agreed that the LROs were no longer the most appropriate vehicle for administration of the family planning program. According to Dr. Koomen, that memorandum represented his commitment to put the administration of family planning in the hands of the county health departments.

The administrative change will have an impact on the delivery of services. At the very least, it will prevent any expansion of the program during the next year. The application to HEW for the 1980 fiscal year funding says: "There is hesitancy to undertake new components this year both in view of ongoing program efforts and *the fact that staff of the Family Planning Branch is faced with the major task of implementing a new administrative structure.*" (emphasis added)

WHO, BESIDES DR. MORROW, supported the change? The initiative did not come from HEW. Federal officials in the Atlanta regional office say they were approached by state officials who wanted to make the change. Janice Maddox, an HEW official who covers North Carolina, said the federal agency had been pleased with the family planning program as administered by the LROs. "Many of us have thought," she said, "why change a regional program that is working well?"

Dr. Morrow is a firm supporter of family planning services. But the Secretary of Human Resources, formerly director of the Guilford County Health Department, is equally firm in believing that "health services are not appropriately placed in the COGs." She has strong allies in the Local Health Directors Association. The association has opposed LRO involvement in family planning from the beginning. Since Dr. Morrow's appointment, the local health directors have intensified their campaign to have the administrative structure changed.

The basic issue has been control. Many health directors resent having to work with an intermediary non-health agency. All of their other health programs are administered directly from Raleigh. Furthermore, they see the LROs as another layer of bureaucracy which diverts program funds that could otherwise go directly to the local health departments.

"We basically feel," said Howard Campbell, president of the Local Health Directors Association, "that programs in the Division (of Health Services) should be carried out by the system." Homer Glover,

Dr. Hugh Tilson Photo by Tina Lachowitch

director of the health district that includes Martin, Tyrell, and Washington counties says: "Historically, our programs come from Raleigh and as a health person I would prefer state health people to be involved. I feel safer working with DHS people rather than with county commissioners (in an LRO)."

Campbell said local health departments are being required to provide more and more services and that LROs skimmed off funds that could be used for direct patient services. According to Campbell, the association takes the position that the state should hire a minimum number of supervisory personnel and channel all other funds directly to the local health departments.

Only one of eight health directors interviewed for this article had anything negative to say about the family planning coordinators assigned to their regions. One of them, Mitchell Sakey of Harnett County, said he had written a letter asking that the coordinator for his region be retained in the new administrative structure. The basic point the health directors make is that their departments are capable of assuming administration of the family planning program.

Three health directors were among the nine members of a task force that Dr. Koomen appointed to advise him on implementation of a new administrative structure. The other members were the head of the Family Planning Branch, a Division of Health Services regional health director, an administrator from the DHS personal health section, a health educator from a county health department, an executive director of a COG, and a family planning coordinator. According to the COG director and the coordinator, it was obvious from the beginning that their view---that the regional nature of the program should be maintained---was a minority position.

At its first meeting in March, 1978, the task force agreed to retain an HEW consultant to study the family planning structure. The consultant presented the results of his study on August 28, 1978. The consultant challenged the argument that LROs were skimming needed clinical funds. He wrote: "Movement away from LRO administration to either DHS Regional Office administration or direct county contracts may not 'buy' the service providers any more service. In fact, administrative realignment under whatever form may cost more in administration *and* direct services."

The consultant was aware of the strong bias toward returning to direct contracting with the county health departments. He wrote: "If administration were to be shifted to the DHS Regional Offices, all parties must ask themselves honestly whether or not 'services' being provided presently by the LROs could be administered as effectively and efficiently over wider geographic areas." *If this could be done*, the consultant recommended shifting family planning from the LROs to the regional offices.

The geographic issue is important. Under the regional system, each coordinator worked with three to eleven counties. Under the arrangement that gives coordination of the program to the four DHR regional offices, the staff of each office will have to service from 17 to 34 counties. Some county health departments are located far from a regional office. In Region K, for example, the regional coordinator under LRO administration was stationed in Henderson. Under the new structure, the coordinator will be based in the DHR regional office in Winston-Salem.

According to Dr. Moye Freymann, a professor at the University of North Carolina at Chapel Hill who has worked closely with the development of family planning administration, it is important to locate the coordinators close to the counties they serve in order that they can be aware of local conditions and be accepted as members of the communities. Frequently, says Dr. Freymann, state government employees are seen as "them" by local governments.

In January, 1979, a majority report of the task force was presented to Dr. Hugh Tilson, the new director of the Division of Health Services. Dr. Tilson had replaced Dr. Koomen, who had resigned. The report endorsed the concept of regionalism and recommended that the responsibility of the LROs be shifted to the DHR regional offices and that the state's Family Planning Branch contract directly with local provider agencies. It recommended that the changes be phased in between July 1, 1979 and June 30, 1980.

Dr. Tilson accepted the recommendations of the majority report after discussing the report with representatives of the task force, COGs, and health directors. He subsequently ordered all LRO involvement in family planning to cease by July 1, 1980.

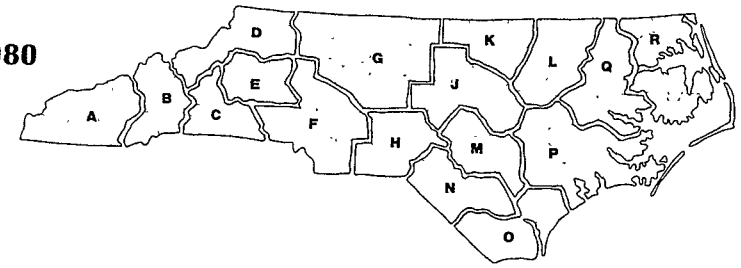
ON JANUARY 31, 1979, the majority report was submitted to the Local Government Advocacy Council, which has responsibility for reviewing policy changes that affect local governments and LROs. It was at that meeting that a minority report from the task force surfaced.

The minority position was written by John Sutton, executive director of the Region M Council of Governments, with the help of Susan McIntyre, a family planning coordinator, and other COG executive directors. The authors said they had prepared it because the decision to change the administrative structure had been made "without adequate input by elected officials of local government."

They challenged the assumption that "a change in administrative structure would automatically strengthen and improve comprehensive family planning services." They said the majority members of the task force had not done what the HEW consultant had suggested: honestly ask themselves whether the four DHR regional offices could do as good a job as the existing program. The minority report took issue

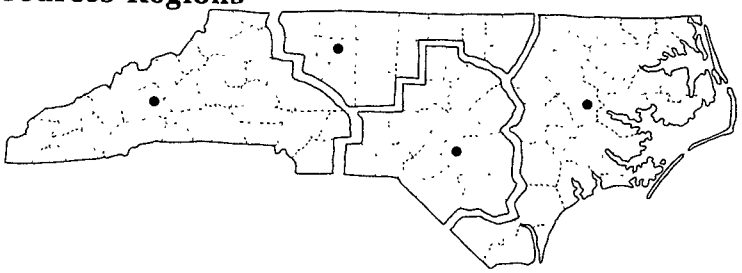
Family Planning Program Regions

LRO Districts
July 1, 1974 — July 1, 1980



Department of Human Resources Regions
As of July 1, 1980

- Black Mountain
- Winston-Salem
- Fayetteville
- Greenville



with the majority report on several issues: "1) that the family planning program will be strengthened and improved by a shift in administration from the present 17 multi-county regions to the 4 DHR Regional Offices; 2) that a single statewide administrative model, with no options for flexibility, is best for the program and the people it serves; and 3) that the proposed change would drastically reduce administrative costs of the program, thereby making more funds available for local service delivery."

Both the majority and minority reports were distributed at the meeting of the Local Government Advocacy Council. After about 20 minutes of debate, the majority report was accepted on a voice vote.

The DHR regional health directors, the head of the Family Planning Branch, and representatives of the Local Health Directors Association met subsequently to discuss how many employees the four DHR regional offices should hire to replace the 25 existing LRO employees and coordinators involved in administration of the program. According to Campbell, president of the health directors association, the health directors wanted no new employees. They wanted maximum dollars for the health departments. The final decision was that three persons, at most, would be hired by each of the four regional offices.

It had now been 20 months since Dr. Morrow had originally requested that family planning conform to the existing departmental structure. In a letter accompanying the state's application for federal funds for fiscal year 1980, Dr. Morrow wrote that the new administrative set-up would "strengthen local level service provision and delivery" and result in "significant savings in our administrative costs."

THE EXACT AMOUNT of the "savings" referred to by Dr. Morrow is difficult to pin down. With a limit of 12 regional employees, the Division of Health Services will certainly realize savings simply because fewer people are being hired to replace those who are leaving. How much is debatable. At the meeting of the Local Government Advocacy Council, members of the task force and representatives of the Family Planning Branch cited figures ranging from $200,000 to $700,000. The council stopped discussing the issue after they failed to get a satisfactory answer. The most recent estimate from the Family Planning Branch is $200,000. This represents the administrative funds now disbursed to the LROs minus the project costs of the DHR regional offices. It does not calculate the costs of the services the LROs provide directly to the counties, such as health education or outreach. Additionally, the state has estimated that 35 percent of the "administrative" coordinator salaries should be considered as supporting direct services to health departments and communities.

No formal cost-effectiveness study has been done, and one state official calls the $200,000 figure an "unsophisticated, overestimated statement of savings." If $200,000 is saved, that will amount to $2,000 for each of the 100 counties.

Will this small amount of additional money for each of the counties be gained at the expense of losing quality technical assistance for the counties and effective monitoring of services? The leaders

HEW officials have raised questions about the ability of individual counties to effect a 'coordinated delivery system.'

of the Local Health Directors Association would answer no to that question. But HEW officials in Atlanta do have those reservations. They are concerned about the North Carolina program losing the expertise of the LRO coordinators.

The state has adopted the policy of trying to hire the experienced coordinators to work in the DHR regional offices. But to date, the policy has not worked. All of the six experienced workers in four LROs that have already been phased out of family planning have left the state program. At least one of them was offered a job at the DHR regional office, but she declined because she did not think the same kind of quality job could be done out of the DHR regional office.

The LRO coordinators, who have had limited access to the policy makers responsible for the change, have reservations about the ability of the four DHR regional offices and the health directors to continue the present program. They say they have worked extensively with community groups in their regions, served as catalysts for regional programs---like the vasectomy program in Region G---that individual counties could not support alone, helped health directors obtain the services of social workers to certify patients for reimbursement programs, and generally supplied the full-time supervision of family planning programs that local health directors, with their many responsibilities, cannot. Many coordinators reported instances of health directors failing to pass along information from Raleigh to their staffs. They said they follow up directly with clinical personnel to make certain that the information has been received.

The coordinators as well as Family Planning Branch and HEW officials are worried that the DHR regions and the local health directors will not be able to maintain the "coordinated delivery system" that is required by law. They are afraid that although health directors support in theory the concept of coordination of services, in practice each of the counties will be out for itself.

Instances of competition rather than cooperation have occurred in the past. When Dr. Morrow was director of the Guilford County Health Department, Guilford obtained a family planning grant directly from HEW. When the state adopted the LRO administrative structure, it instructed Region G to tap $10,000 of Guilford County's funds to finance a regional program. Both Dr. Morrow and the executive director of the Region G COG subsequently appeared before the Guilford County commissioners, Dr. Morrow to argue against the decision, the COG director to support it. The decision to divert the funds to the regional program was upheld. Becky Bowden, the family planning consultant for the regional area that includes Guilford County, explained the state's position: "I don't feel badly at all if we reduce the money in Guilford to provide services to all seven counties."

In another instance, $8,000 originally allocated to Brunswick County was taken and redistributed by the regional agency among other counties in the region. "We were penalized," said the Brunswick County health director.

An example of what coordinators think could happen under the new system is available presently in Region E, where the LRO has elected not to hire a full-time coordinator and funnels almost all responsibility to the individual health departments in the region.

Robin Foster, the part-time family planning coordinator, says her supervisors have her spend a minimum of time on family planning since the COG receives no family planning funds to pay her salary. As an observer, Ms. Foster finds that the individual health directors are too busy to allocate sufficient time to overseeing family planning programs. The result is that the "comprehensive nature of the program is being hurt." She notes, for example, that the regional advisory council for family planning does not have the wholehearted support of the local health directors, who look upon the council mainly as a group required by HEW.

Dr. Ronald Levine, assistant director for state services in the Division of Health Services, said he has some concerns about the ability of small counties to compete with the larger counties for grants. He said the Division of Health Services would try to develop an allocation procedure that will protect the smaller counties.

Ms. Margie Rose, the head of the State Family Planning Branch, described implementation of the new administrative structure as "a challenge." She said: "I will have confidence (in the new structure) if these people (the present coordinators) are maintained in the system and if we do an adequate training job."

THE CHANGE in administrative structure has prompted the HEW officials who reviewed North Carolina's application for 1980 funds to recommend that the program be approved subject to "provisions." The concerns of Janice Maddox, the primary reviewer for HEW, and Sam Ray, the federal agency's chief for

North Carolina and South Carolina, were expressed in memorandums obtained by the Center.

Since there is "no uniform contract available for measurement of performance in the counties under contract," the federal reviewers wrote, North Carolina must develop county contracts that insure performance standards and continued accountability to HEW. The federal reviewers also raised questions about the future role of citizen advisory councils in the new structure and the capacity of the new system for providing all North Carolinians access to family planning services. Ray has reservations about the ability of some local health departments to handle the family planning program on their own. He suggested that the state be prepared to provide services directly if local programs were found to be inadequate.

Is there an alternative to the drastic change in administrative structure that Dr. Tilson has ordered, an alternative that would speak to local health directors' desire for more control over programs yet retain the regional coordination provided under the old system?

There is a model for an alternative in the administrative structure of the Emergency Medical Service (EMS), another program run by the Department of Human Resources. The EMS program has four supervisors, one in each of the DHR regions. But it also has 16 regional coordinators, based---as were the family planning coordinators---in the LROs. The difference is that the EMS coordinators receive their salaries directly from the state rather than from the LROs. The LROs are reimbursed for the office space and the support services they provide to the coordinators.

According to EMS spokesman Tom Harmelink, the arrangement has worked well. The coordinators, located close to the counties they serve, have been "a strength and liaison with local governments." Local governments have benefited, Harmelink said, from having state representatives who are familiar with their areas and readily available to provide assistance. The coordinators have also helped to maintain regional advisory councils.

Might it not be possible to provide direct family planning contracts to local health directors to satisfy their primary objection---having a non-health agency as an intermediary---and still maintain geographically close coordination by having state-paid coordinators in the LRO offices?

There has already been some consideration of decentralizing the new coordinator positions, that is, moving some of the new staff people out of the DHR regional offices and closer to the counties they will serve. The task force appointed by Dr. Tilson endorsed the concept of decentralization. And Dr. Levine, Dr. Tilson's assistant, said he didn't see any reason why staff members assigned to the regional offices couldn't be located closer to the counties. But will the regional offices have enough staff to permit decentralization? Mrs. Jean Lassiter, the health director in one DHR region, says she is willing to subdivide the 33 counties that make up her region, but she added that she didn't know whether that would be possible if only three persons are assigned to the regional office. Dr. Morrow is leery of alternatives that would bring the LROs back into the administrative structure. "With any LRO involvement," she says, "we would get back into the situation of non-uniformity."

Under the new administrative structure, some family planning coordinators will be located far from the counties they serve.

THE QUESTION is whether the uniformity of administration sought by Dr. Morrow will work to the benefit of North Carolina's family planning program and the people it serves. In effect, the state is abandoning a successful structure for one that conforms to its normal administrative pattern with no assurances that the change will improve the delivery of family planning services.

The state will now write uniform contracts with all of North Carolina's health departments and districts. But as the result of HEW officials' reservations about the new arrangement, particularly about the loss of the regional coordinators, the contracts will contain specific provisions designed to assure the local providers' accountability to HEW. The emphasis on carefully specified contracts may prompt local health directors to worry more about complying with the provisions than about providing quality services.

The regional coordinators were able to help local health directors both comply with the federal regulations and provide a full range of services. Located near the counties they served, they were able to monitor services and provide assistance in areas such as health education, the organization of regional advisory councils, and the acquisition of reimbursement funds.

State officials could have taken a less sweeping approach to revamping the family planning program. Dr. Koomen recommended two years ago that the state maintain the successful parts of the program and change only those parts that needed changing. Instead, the policy makers decided on a full-scale change even though they can not be sure the new system can deliver all the medical, social, and educational services that make up a comprehensive family planning program. □