Cooperative Education and Training of Managers for Development Projects

CASE HISTORY 2:

The Malia Coast
Comprehensive Health Center

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EAST-WEST CENTER
East-West Resource Systems Institute
Honolulu, Hawaii U.S.A.
THE MALIA COAST COMPREHENSIVE HEALTH CENTER

by

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ABSTRACT

Malia, a poor rural community in the State of Hawaii, had no health facility; thus in the early 1950s Malia residents asked the federal government to assist them in building and operating a health center. From 1950 to 1970, the federal government provided Malia with no assistance. The Malia community, however, organized the Malia District Comprehensive Health and Hospital Board, Inc. (Board). Composed totally of residents, the Board's purpose was to upgrade health care in Malia. Then in 1972, federal government agencies agreed to assist Malia. The Regional Medical Program, the Department of Health, Education and Welfare, and Model Cities each awarded grants to the Board to design, build and operate a neighborhood health center.

To initiate the grants, the funding agencies recognized the Board as the official policy-making organization for the proposed health center; and the Board agreed to fulfill numerous reporting and monitoring conditions for each agency. The Board then hired a project director to design the health center. When completed, the design specified plans for the construction of a primary care building, and the implementation of a community-oriented health program. The initial project director then resigned, and the Board selected a new director to implement the health program. The new director was unable to establish effective working relations with the Board and he also resigned. The Board then hired the Board president, Edward Kahele, as the new project director.

Although Kahele had the full support of the Board, he had neither the formal training nor the administrative experience to implement the health program. Consequently, he failed to accomplish key program goals. Operating and personnel policies were never finished; working agreements with hospitals and health providers were never established; the required prepaid health plan was never drawn up; and the health program was never expanded. The failure to accomplish these goals led the funding agencies to insist that Kahele be replaced with a qualified administrator. The Board, however, refused, feeling that the funding agencies were trying to gain direct control of the Center. An impasse resulted and the funding agencies cut off all operating funds. The Center was forced to close.

After the closing, the Board agreed to the funding agencies stipulations and the Center was reopened. The Board then reorganized itself and hired a new project director.

The Malia case history illustrates problems encountered by many projects. Some of these problems include conflicts between the indigenous community and the outside funding authority, organizational tension created by multiple funding sources, problems of coordination and supervision stemming from an inadequate design, and the antagonism between experts and lay policy-makers.
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The need for more effective project planning and management has only recently been identified as a critical function for all countries, in both public and private sectors. Vast resources have been channeled into development projects, but lack of viable policies coupled with poor management has resulted in a waste of valuable resources—human, financial, and natural. Attempts to accelerate economic and social growth in developing countries have often floundered because of serious problems with project planning and implementation. Costly mistakes have occurred for the same reasons in projects carried out in highly industrialized Western societies.

Much of the problem lies in traditional project management training programs, which are narrow and segmented in their point of view and fail to provide trainees with a coherent overview of the complex life of a development project. The need to replace these existing educational and training programs with a cohesive framework of studies is more than evident. We need a new program, one which considers the entire project cycle as an integrated process.

The East-West Center has recognized problems in the area of public policy implementation and project management for some years. From 1972 to 1975, the Center has worked cooperatively with a total of over 50 organizations in 15 countries on specific aspects of the overall problem, such as Project Feasibility and Evaluation, and Public Leadership. Since June 1975, the Center, in partnership with scholars and practitioners in seven countries, has developed a prototype curriculum for the education and training of project managers for all sectors of the economy and society. This new program for project managers is aimed at increasing their understanding of the integrated project cycle: the entire spectrum of a given project, ranging from planning through implementation and evaluation.

The prototype curriculum package consists of a detailed syllabus, portfolio of case studies in development projects, teacher's guide on use of the case studies, selected readings, and an annotated bibliography. The curriculum is flexible for adaptation by educational and training institutions in countries with different social and economic settings, as well as different cultural and social values.

Basic to the prototype curriculum is a series of seven case histories covering agricultural, industrial, public works, and social sectors. In recent years, case history research has become a widespread instructional tool in medical and law schools, followed by schools of business, public administration, and engineering. These case histories are innovative, however, in representing the first attempt to construct a series of case analyses within a single conceptual framework—that of the development project as an integrated whole. Participants from a number of countries conducted field research and wrote their cycle. The case studies, which included such diverse topics as a metropolitan water improvement program in Thailand, a Pacific Islands livestock development project, and a rural social development project in the Philippines, were an important feature.
of the prototype curriculum, providing relevance and practicality both to classroom discussion and the follow-up field practicum. Five of the case studies, together with an introductory chapter explaining the integrated project cycle, will be published as a textbook, Management of Development Projects: An International Case History Approach, in the spring of 1979 by Pergamon Press.

In the next two years, a second series of approximately forty new case histories will be produced under the sponsorship of the Exxon Education Foundation. The writing of the new set of studies will be supervised by an international steering committee composed of senior scholars and practitioners from Indonesia, Malaysia, the Philippines, the United States, New Zealand, and Iran. This second series of case histories differs from the first series in two respects: (1) we have adopted the term case history rather than the previously used case study, to reflect the fact that these reports describe actual field situations rather than hypothetical constructs for the classroom, and (2) the new case histories will be written in the framework of a refined integrated project planning and management cycle (IPPMC), as illustrated in the diagram at the right.

The second series will include case histories of such diverse projects as social condominiums in the Philippines, the Alaska pipeline, industrial engineering in sophisticated factory situations, an integrated water resource and agricultural development project in the Philippines, a timber complex project in Malaysia and many more. The broad scope of this series is meant to reflect our conviction that a development project is not, in the narrow sense, simply a program to upgrade a sector of a developing country but is rather a utilization of resources that provides benefits and services to the people of any country, developing or developed.

Both case history series represent the attempts of the Technology and Development Institute (merged into the Resource Systems Institute as of September, 1977) to achieve the East-West Center's goals of better relations and understanding on economic and social development problems of mutual concern to all countries, East and West, through cooperative research, study, and training activities. Special thanks are due to the authors of the case histories in both the first and second series and to their respective institutions for their fine cooperation. Grateful acknowledgment is also due to the Exxon Education Foundation for providing the grant to continue the research and development of the second series of case histories.

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September 1978
Integrated Project Planning & Management Cycle:

The Four Phases

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(1) Planning, Appraisal, & Design

(2) Selection, Approval & Activation

(3) Operation, Control & Handover

(4) Evaluation & Refinement

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Feedback Process

Two-Way Information and Authority Flow
I. PROJECT BACKGROUND

In 1946 the United States Public Health Service and the National Commission on Hospital Care issued two publications reporting that the number of hospitals serving rural areas of the United States was sorely inadequate. These reports provided the first empirical evidence that health care in rural areas of the U.S. had been neglected; and they spurred the federal government into action. Soon after the reports were made public, Congress passed the Hill-Burton Act, which greatly expanded hospital services in rural areas. Because the authority to provide health care was constitutionally reserved to each state, however, the Hill-Burton Act could not permit the federal government to directly implement or to centralize rural health services. Nevertheless, this legislation did grant money to the state governments to build and improve hospitals in those rural areas lacking health facilities.

By 1954, however, state health officials realized that it was impractical to build hospitals in small rural communities, and therefore the federal government would have to provide grants-in-aid to the states to build smaller health facilities, which could be more feasibly located in these communities. Thus, in 1954, Congress amended the Hill-Burton Act to include financing for health centers, as well as hospitals. The federal government further encouraged the development of these smaller facilities by passing legislation such as the Comprehensive Health Planning Act of 1966 and various amendments to the Public Health Service Act. In addition, health centers were supported by special federal programs and federal agencies such as Model Cities, the Office of Economic Opportunity (OEO), and the Regional Medical Program (RMP).

Despite this support and the millions of dollars spent on grants-in-aid, projects to build and operate health centers were plagued by numerous problems. Problems of coordination occurred because each health center required several grants, but each grant was provided by a different agency. Problems of overlapping jurisdiction occurred, since some funding agencies were loosely consolidated within the U. S. Department of Health, Education and Welfare (HEW), but others were under the administrative branch of the Department of Housing and Urban Development (HUD). Finally, the projects to implement health centers were hindered by numerous "on-the-ground" problems--lack of community support, difficulty in hiring medical personnel, and lack of qualified administrators.

The following case study—a description of a project to build and operate a comprehensive health center in a rural area in the state of Hawaii—focuses on the management difficulties in dealing with these problems.
Malia, a Rural Community in Transition*

Located in the central pacific basin, Hawaii is the western-most state of the United States and consists of several islands, the most populated of which is Oahu. Situated on Oahu's western shore is the Malia Coast. The Malia Coast is isolated from the rest of Oahu by the ocean to the west, the Malia mountain range to the east, and a nearly impassable jeep trail to the north. To the south lies the only road; it leads to urban Honolulu, which is about 30 miles away. Dry and rocky, the Malia Coast encompasses a land area of about 50 square miles, but the habitable land occupies a narrow corridor situated between the ocean and the mountain range. Along this seven-mile corridor are several closely grouped residential areas, whose residents identify themselves collectively as the community of Malia.

Malia has a multi-ethnic population of approximately 27,000 people. Hawaiians or part-Hawaiians make up 36 percent of the population, Caucasians 27 percent, Filipinos 14 percent, and Japanese 5 percent. This differs considerably from the rest of Hawaii where Hawaiians and part-Hawaiians compose 15 percent of the population; Caucasians, 33 percent; Japanese, 28 percent; and Filipinos, 7 percent. Malia's population is also quite youthful, with about one-half the residents 17 years of age or younger. The major problem is poverty. Compared with the rest of Oahu, Malia residents suffer from high unemployment, lack of local employment opportunities, low family income, low educational levels, substandard housing, and poor health. (Table 1 contrasts the Malia Coast with the entire island of Oahu.)

Political jurisdiction for Malia is divided between and among the United States Federal Government, the State of Hawaii Government, and the City and County of Honolulu Government. The federal government has overall authority and mandates national policies with which Malia must comply. The state government mandates state policies with which Malia must comply. And, finally, the city government directly administers Malia, providing day-to-day services such as fire and police protection. In theory then, the federal government and the state government set the broad overall policy for Malia, while the city government implements this policy through an elected City Council, as well as an elected mayor and his administration. In reality, Malia retains considerable local autonomy, partly because Malia's geographic isolation from the city government in Honolulu has forced residents to solve their problems independently, and partly because grassroots community organizations have demanded to participate in making and implementing policies for Malia.

The residents not only support but also defend this de facto autonomy. In understanding Malia's special problems and unique lifestyle,

*For reasons of personal and political sensitivity, the names of most specific places and individuals have been changed. When direct quotes are used, the pseudonyms replace the real ones. Citations that compromise true identities have been omitted. All other factual description is accurately represented.
Table 1
1970 SELECTED INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Malia</th>
<th>Oahu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families with income under $3,000 per year</td>
<td>17.0%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Median family income</td>
<td>$8,950</td>
<td>$11,554</td>
</tr>
<tr>
<td>Unemployment</td>
<td>9.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Median years of school (persons over 25)</td>
<td>11.1</td>
<td>12.3</td>
</tr>
<tr>
<td>Substandard housing units</td>
<td>42.6%</td>
<td>28.9%</td>
</tr>
<tr>
<td>People over 65 years of age receiving old age assistance</td>
<td>12.5%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Crude birth rate (per 1,000)</td>
<td>32.3</td>
<td>23.2</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>25.0</td>
<td>20.1</td>
</tr>
<tr>
<td>Premature birth rate (per 1,000 live births)</td>
<td>114.5</td>
<td>91.9</td>
</tr>
<tr>
<td>Rate of mothers without prenatal care (per 1,000 live births)</td>
<td>48.5</td>
<td>16.5</td>
</tr>
</tbody>
</table>

they feel strongly that they are best qualified to manage Malia's affairs. Consequently, residents may be divided among themselves over many issues; but when outsiders come into the community telling them how to solve their problems, they unite against them. It is not that the residents do not want outside help. They welcome outside help. But they will not tolerate outsiders managing their affairs or telling them what to do.

In recent years, however, changes have forced Malia to become less insulated. The population has grown from 3,000 in 1940, to 16,000 in 1960, to over 24,000 in 1970. The city of Honolulu has sprawled out into the suburbs, leaving Malia closer than ever to densely populated areas. Most significantly, the economic underpinnings of the area have shifted. The area's major employer was a sugar plantation, which grew sugar cane in the valleys. The plantation, however, was unproductive and unsuited for commercial expansion: it had an inadequate water supply; it was too far from the processing plants; it had insufficient land; and its soil was too rocky. Thus, in 1946 the plantation closed down. Some residents converted the most fertile plantation land into truck farms; others started small pig farms; but, for the most part, Malia residents were forced to work as laborers outside of Malia. In the early 1960s, private developers planned to build the area into a resort location and the state government decided to use Malia for a low-cost housing program. To initiate these plans, Malia's southern road was widened and linked to the network of freeways into Honolulu.

By the late 1960s then, Malia was a rural community in transition; it was undergoing major economic shifts and its traditional autonomy and isolation were decreasing. Yet, beneath these changes, there was still strong sentiment to maintain autonomy and to preserve community control over community affairs.

The Problem

A major problem facing Malia was the lack of health services. One health facility, the Plantation Medical Center, served the area. But this had closed in 1946 when the plantation was shut down. Between 1946 and 1964 Malia's medical services were limited to two physicians who worked in the area. Then, in 1964, the Kaiser Foundation Health Plan began operating a Malia clinic. However, it did not meet the residents' needs. The clinic was open only during weekdays from 8:00 a.m. to 4:30 p.m., with no emergency service at other times. It was staffed only by one full-time physician, a laboratory technician, and a nurse. Most significantly, the clinic limited its services to members of the Kaiser Prepaid Health Plan, which few residents could afford. In 1964 then, the medical needs of Malia's 20,000 residents were served essentially by two private physicians, a city and county ambulance station, and one dentist.

Clearly, the medical services available to Malia's 20,000 residents were inadequate. Moreover, a resident requiring emergency treatment or hospitalization would have to travel to Honolulu, a 45-minute drive away from Malia.
II. PLANNING, APPRAISAL, AND DESIGN

Identification: A Grassroots Initiative

As early as 1946, Malia residents identified lack of health care as a major problem and they initiated a grassroots campaign to obtain adequate health services. Residents held general community meetings, petitioned the governor, spoke to their city and state representatives, and met with state agencies. By organizing through mothers' groups, civic clubs, social clubs, welfare recipients groups, community action groups, and other community associations, they demanded that government help them obtain adequate medical services.

In response, federal, state, and city government did little. Although realizing Malia's health problem, they were strongly influenced by the American Medical Association, which opposed publicly subsidized medicine. Moreover, since Malia was a rural area and had a small population, it had little political leverage and could not make its problems salient political issues. Finally, Malia's community groups and associations dissipated their effectiveness by failing to unite in a single organization. Thus, Malia received no government support until 1966, when it was no longer politically feasible to ignore the health needs of 20,000 people.

In 1966 the Community Action Program (CAP), a federal government program that assisted poverty-designated communities to organize and solve their problems, assigned representatives to Malia. The representatives helped unify Malia's efforts by serving as a focal point through which the entire community could articulate their health care needs. They also coordinated the residents' activities through CAP committees. Representing a good working balance of residents, the CAP committees were assigned the vital task of formulating a unified health proposal for Malia.

The CAP committees began formulating the health proposal in late 1966, and were assisted by the Honolulu Council of Social Agencies and the Kaiser Foundation Research Institute, who provided outsiders' views and professional expertise. To complement the professional input, the CAP committees also held open community meetings at which residents argued their positions and articulated their health needs. Using the meetings and the professional aid for direction, the CAP committees worked arduously through 1966, and, in early 1967, completed the health proposal. Identifying as the primary project a centralized health center with a broad range of medical services, the proposal was submitted to the federal government's Office of Economic Opportunity (OEO), which granted funds for neighborhood health centers.

The OEO, however, rejected the proposal, pointing out that it lacked implementation plans and that it had been criticized by the Honolulu county Medical Society because the health center's scope of services was too broad
and its cost unjustified. The Society also objected to medical facilities and services financed with public funds. Kaiser Foundation Research Institute developed a second proposal and submitted it to OEO. It was also rejected for the same reasons.

Although the CAP initiative yielded no improvement in Malia's health services, advances had been made. Malia residents had achieved organizational cohesion. For the first time, a government agency had supported Malia's drive to improve health services; and, for the first time, a health care center had been formally identified as the primary project. On the strength of this concrete progress, Malia had made itself an extremely attractive candidate for federal government development project funds.

Surely enough, in 1968, Model Cities, a federal anti-poverty program that provided "model neighborhoods" with funds to plan and operate development projects, designated Malia as a model neighborhood. At the same time, the Regional Medical Program (RMP), a federal program that gave development funds to health projects, was directed to coordinate funding with Model Cities. To receive Model Cities funds, residents would first have to organize a neighborhood planning committee, as required by Model Cities' funding provisions. The planning committee would have two purposes. First, by placing priorities on the neighborhood's development efforts, it would act as the community's policy-making body. Second, by requiring a majority of the committee to be local residents, it would guarantee resident participation in neighborhood planning.

Using the organizational structure of the old CAP committees, residents quickly organized a neighborhood committee and named it the Malia District Neighborhood Planning Committee (MDNPC). Like the grassroots organizations and the CAP committees, MDNPC was democratically organized and relied on active community participation to plan and make decisions. As a result, MDNPC meetings were well-attended and characterized by animated, often heated, debates. This guaranteed that the committee's decisions—even controversial ones—were community decisions endorsed by a majority of Malia residents. MDNPC's first decision was non-controversial. It made the improvement of health services the area's number one priority.

With the improvement of health care established as Malia's number one priority, residents organized a health task force. Composed of community leaders and residents interested in improving Malia's health services, the health task force's purpose was to formulate a comprehensive health plan for Malia and identify specific projects to carry out the plan. Chosen as the chairman was John Hama, a resident of Malia.

As task force chairman, Hama first reviewed the studies that evaluated Malia's health needs. After examining the studies, he thought that several of them would be particularly useful in formulating a comprehensive health plan for Malia. He felt that one study—a community profile study, which had been conducted by CAP staff in 1968—would be important because it not only provided baseline data on the residents' poverty, but it also documented their strong traditional ties with community, neighbors, and kin.
He believed that another study—the Conway Report, which was a hospital feasibility study sponsored by the state Department of Accounting and General Services in 1968—was useful because it provided an analysis in support of building a hospital on the Malia Coast. Finally, he felt that a third study—the Gallimore and Howard study, a community structure analysis done in 1968 by anthropologists from the University of Hawaii—would be crucial because it specified the following medical behavior of residents:

- They are almost totally crisis oriented.
- They defer medical attention.
- They have poor preventive health practices.
- They have poor personal hygiene practices.
- They conceal signs of illness.
- Men rely on relatives or friends for treatment.
- Women prefer home remedies and are likely to use traditional Hawaiian medications.
- Young couples are encouraged by parents to have families rapidly.
- An unemployed head of household usually drops health insurance.
- They do not go for medical treatment—facilities are too far away, they lack transportation, and they are threatened with wage and job loss.
- They do not keep appointments.

Formulation: Some Outside Help

The Program Concept

After organizing this information, Hama and the health task force members tried to formulate the health plan. However, since the task force was composed wholly of community residents none of whom were health professionals, Hama soon realized he needed outside professional help. He asked the state government for support. And in October 1968, John A. Burns, governor of the State of Hawaii, asked the University of Hawaii's School of Public Health to assist Hama, and it agreed. Specifically, the School of Public Health proposed to formulate a program concept of health services for Malia. The job was assigned to Dr. Roy Wilson.

In formulating the program concept, Wilson imposed three guidelines upon himself. First, because he was impressed by Malia's grassroots effort and because he advocated consumer-oriented medicine, he had to use Malia residents' participation and input in determining the major health
needs of Malia. This was obtained by working closely with Hama and the health task force and by holding weekly community meetings, chaired jointly by himself and Hama.

Second, because Malia residents objected to being further scrutinized by outsiders, Wilson had to use only the existing data and studies. The task force provided Wilson with the information they had already collected and organized.

Third, since numerous health care providers, such as the state Department of Health, were interested in helping to formulate and eventually to implement Malia's future health services, he had to incorporate their suggestions and recommendations in the program concept. This was accomplished by holding combined working sessions, during which each group took primary responsibility for devising the section of the concept that matched their expertise. For example, the Malia CAP Committees contributed extensively in determining community health needs, the state Department of Health worked on extending and coordinating state services, the Honolulu County Medical Society helped to develop physician requirements, the Regional Medical Program (RMP) documented available federal funding, and the University of Hawaii School of Medicine specified desirable medical services.

In essence then, Wilson and Hama coordinated work on the program concept, but actual formulation was the combined effort of numerous groups and agencies. Completed in March 1969, the program concept was called "Health Services for Malia: A Program Concept (hereinafter referred to as Program Concept)."

Wilson and Hama organized the Program Concept into four parts. Part one provided the health profile and health needs of Malia residents, along with general guidelines for any health projects. Part two described specific projects to cope with the health needs of residents. Part three recommended an activity sequence for implementing the projects. And part four identified the potential funding sources for the projects. The following paragraphs describe the Program Concept in more detail.

In part one, Hama and Wilson analyzed health needs within Malia's social, economic, and cultural environment, and concluded that, in order to succeed, the health program required community support. This meant that projects specified in the Program Concept would have to be staffed by residents and led by an organization clearly identified as a community entity. Additionally, because of resident discomfort with impersonal health environments, any health project would have to provide a traditional, personalized setting. This would both preserve the feeling of community and build the trust of residents. Finally, they reasoned that the community would need outside professional help; therefore, it was vital to establish close working relationships with all health agencies and health professionals. Based on this reasoning, Hama and Wilson recommended that:

- A community organization develop policies and provide guidelines for all health services.
• The community organization fully coordinate its efforts and cooperate with all professional health care providers.

• All ancillary health activities--social, welfare, and referral—be integrated into a single system.

• Services be provided rapidly and maintain the client's personal dignity.

• Community resources and manpower be trained, developed, and used whenever possible.

These recommendations, they stated, should be guiding principles for Malia's entire health program. They emphasized, in particular, the recommendation to develop a local community organization to set health policy, and the recommendation to use and train indigenous manpower.

In parts two and three, Wilson and Ha,aa proposed an overall health program consisting of three component projects. Reflecting Malia's urgent need for a general health facility, the first component would be a comprehensive health center. In addition to providing 24-hour emergency service, the center would offer clinic services, special diagnosis, medical treatment, and education and training programs.

The second component would be home care, consisting of home health care and outreach workers. To be organized soon after the health center began operations, this component would emphasize preventive medicine, hygiene in the home, and patient rehabilitation at home. This would provide residents with health care in the safety of their own homes and, at the same time, build the residents' trust in professional medical treatment. To implement home care, outreach aides--trained medical and social para-professionals—would be hired to work in the community, teaching residents proper health care, and informing them of the health center's services. The third component would be a hospital; this, however, was to be a future development. In parts two and three, then, Hama and Wilson identified a comprehensive health center as the immediate project.

In part four of the Program Concept, Hama and Wilson identified the several potential funding sources, including:

1. Model Cities. This federal government anti-poverty program had already designated Malia a model neighborhood. To receive Model Cities funds, the health task force would have to submit a specific project proposal to the Malia District Neighborhood Planning Committee (MDNPC). MDNPC would then decide whether the project fit into the neighborhood's development priorities. If it did, MDNPC would select it for funding and send the proposal to the City Council of Honolulu for approval (see Figure 1).

2. Regional Medical Program (RMP). RMP, a federal agency whose objective was to upgrade medical services, coordinated health
project funding with Model Cities. To receive RMP funds, a non-profit corporation would have to submit a specific project proposal to the Hawaii Regional Advisory Group (RAG), which was RMP's decision-making body. RAG would decide whether or not to finance the project (see Figure 1).

3. Department of Health, Education, and Welfare (HEW). Empowered by Section 314(e) of the Public Health Service Act, HEW granted funds for developing and operating neighborhood health centers and family health centers (these funds hereafter referred to as HEW-HC). To receive HEW-HC funds, the task force would have to submit a detailed project proposal to HEW's regional office in San Francisco. The regional office would then ask the state Comprehensive Health Planning (CHP) Advisory Council to comment on the proposal. The CHP Advisory Council was responsible for the state's overall health planning and issued certificates-of-need to health facilities, if the facilities met community needs. After receiving CHP comment, the HEW regional office would internally review the proposal and give it a priority (see Figure 2).

In essence, the Program Concept was an overall health master plan. It recommended general guidelines, identified health projects, established a schedule for implementing the projects, and suggested ways to fund the projects. It did not, however, detail specific project plans.

The Malia District Comprehensive Health and Hospital Board, Inc.

After reviewing the Program Concept, the health task force members decided to incorporate as a non-profit health corporation. By incorporating, they could negotiate as a legal entity and qualify to receive federal health funds. Incorporation would also give them status as a serious, permanent group, and thus give them credibility as Malia's formally sanctioned health organization. This would add immensely to their political clout. In April 1969, they incorporated as the Malia District Comprehensive Health and Hospital Board, Inc. (hereafter referred to as the Board). The Board's purpose was "to improve the health of all citizens of the Malia District."7

Organized as a residents' participatory body, the Board was composed wholly of residents; many were community leaders, but none were health professionals or experienced in establishing health organizations. The Board was informally structured, had few procedural rules, and depended on resident input. For example, any resident who attended Board meetings was an official Board member and could vote on Board issues. Board members felt strongly that formal procedures could be worked out as the need arose, and that informality was the way to conduct business in Malia.

Informal Feasibility Discussions

Hama was chosen Board president; and he decided to discuss the Program Concept's overall feasibility with various health agencies. During April
FIGURE 1. MODEL CITIES ORGANIZATIONAL CHART
(As it relates to Malia Project)
FIGURE 2. REGIONAL MEDICAL PROGRAM AND HEALTH EDUCATION AND WELFARE ORGANIZATIONAL CHART
(As it relates to Malia Project)
and May 1969, Hama and the Board held discussions with RMP, Honolulu County Medical Society, state Department of Health, and the Office of Economic Opportunity (OEO).

Briefly summarized, the discussions were as follows:

1. RMP told Hama and the Board that they totally supported the Program Concept, thought it was feasible, and would provide the technical assistance needed to complete detailed project proposals. RMP also told Hama that they could not grant money for health center construction, but could fund center operations.

2. The Honolulu County Medical Society reacted negatively to the Program Concept. They told Hama that there were too many federal agencies involved, none that could totally fund the concept; moreover, the comprehensive health center's proposed services were too complex and discouraged doctors from practicing in the area.

3. The state Department of Health pointed out to Hama and the Board that the Program Concept was not a project implementation plan. To implement the concept, Hama would first have to draw up detailed project plans.

4. The OEO similarly told Hama that detailed project plans were needed.

5. Several private health providers, Kaiser Foundation Health Plan, St. Francis Hospital, and Straub Clinic, also discussed the Program Concept with Hama. Basically, they thought the Program Concept was feasible, but only if it was implemented incrementally and in coordination with private interests.

Initial Funding

Based on these discussions, which served as preliminary and informal feasibility studies, Hama and the Board decided the Program Concept was sound, but to implement it they would have to design detailed project plans. To do this, they needed money to hire outside experts. Hama again asked state government for help and Dr. Wayne Ott of the University of Hawaii volunteered. Meeting with Hama and the Board, Ott explained that the best way to get project design funds was to write a federal grant proposal based on the Program Concept, and submit it to both HEW and Model Cities. The Board agreed on this course of action and, over the next two months, Hama and Ott completed the proposal. In it they requested money to hire a planning staff, including the project director. Because Hama insisted on community input, they also stipulated that the planning staff and project director would work closely with the Board to develop detailed plans for the construction and operation of a comprehensive health center. Finally, anticipating questions about the proposal's financial management,
Hama and Ott named the respected and well-known Research Corporation of the University of Hawaii to administer the grant.

The Board discussed the proposal, approved it, and submitted it to HEW for funding review. For four months, Hama and the Board waited in great anticipation but received no answer. Unable to restrain themselves, they wrote to their federal congressional representatives in Washington, D.C., requesting them to inquire about the proposal's status. Their representatives wrote back, saying that they would find out whether or not the Department of Health, Education and Welfare (HEW) intended to fund the proposal. Questioning HEW, the representatives discovered that the regional office in San Francisco had ranked the proposal number one for funding; however, HEW could not grant money for planning new health centers because it had already overcommitted the current year's budget. Moreover, the entire HEW health center program was being reorganized and new guidelines were being prepared for health center proposals. Thus, the representatives were told, until current commitments were honored and until the reorganization was completed, HEW would not fund the proposal.

Fortunately, during the four-month wait for HEW's decision, Hama and the Board had also submitted the grant proposal to the Malia District Neighborhood Planning Committee (MDNPC), as the first step to receiving Model Cities funds. In January 1970, the MDNPC noted that health care was Malia's top priority; and they therefore recommended that the Honolulu City Council approve the proposal. In February 1970, about a month after HEW's rejection, the city council approved the proposal. Hama and the Board were jubilant. This was the first time government had granted Malia money for a health project.

The City Council had approved $84,000 to pay for a project director, his staff, consultants' fees, travel, office equipment and supplies, and an office. They had also approved a one-year planning period, June 1970 to June 1971, during which the Board and planning staff would:

1. Develop precise project plans for implementing a Malia Coast Comprehensive Health Center (hereafter referred to as Center),
2. Try to fund the plans through all possible sources—federal, state, city, and private, and
3. Complete a proposal for an HEW-HC grant.

Selecting a Project Director

To accomplish these objectives and the fundamental objective of completing the Malia Coast Comprehensive Health Center, Hama and the Board knew they would have to hire a versatile and exceptional project director. They reasoned that the project director would have considerable responsibilities. First, he would be responsible for planning both the construction and the operation of the center; this meant he would have to coordinate the overall design. Second, if the design were funded, the project director
would be responsible for managing the project; this meant he would have to provide day-to-day project administration—negotiating, supervising, scheduling, and monitoring. Third, assuming all objectives were accomplished, the project director would be responsible for implementing the initial delivery of health services. This meant that, at least until the transition to normal administration, he would have to mediate between medical and administrative employees, file health claims, organize medical services, implement the health records and financial operations, and set policy. Hama and the Board reasoned that because of these many potential roles, the project director would have to be someone experienced in both project management and health administration.

Hama and the Board began to screen applicants. Since Model Cities grants gave preference to local residents, they first tried to recruit a Malia resident, but could find no one qualified. Then they began screening outside applicants. It took four months before they hired David Wayne. Considered the most versatile and competent candidate, Wayne was an architect with a Master's degree in Public Health. Although he had little experience as a project manager, he had both health and construction design expertise; moreover, he would be helped by the assistant director, who was a former aerospace project manager. The only drawback was that Wayne was not a resident and would not fully understand Malia's problems. The Board was not greatly concerned, however, since it set policy and would have considerable power over all project activities.

Having selected Wayne, Hama and the Board turned to two pressing business items—increasing the Board's credibility within the community and enhancing its image of professionalism. Since the Board's image would be enhanced by a more formal structure, Board membership was fixed at 12. Since its credibility would be increased by overt community participation, it was decided to hold a general community election for the 12 seats. The election would also give Board members community sanction. The Board publicized the forthcoming election by holding meetings, distributing leaflets, passing on information about the center, and asking residents to vote. In September 1970 the community elected 12 Board members—many of them the original members. Like the original Board, the new Board was composed of community leaders, none of whom were health professionals.

The newly elected Board chose as president, Edward Kahele, a construction worker actively involved in civic affairs. Kahele would work closely with Wayne to design and implement the Center.

Design: A Complex Process

Some Ancillary Support Activities

As project director, Wayne's first action was to meet with Kahele and the Board to discuss preliminary planning criteria. From these initial meetings Wayne learned that, because the Malia Comprehensive Health Center's purpose was to serve residents and complement their needs, he would have to
work closely with residents and community organizations. He also decided that it was absolutely essential to cooperate fully with the Board and incorporate it totally in the planning process. This was partly because the grant had stipulated that he would work closely with the Board and partly because Wayne wanted to minimize the tension that was inherent between himself as the manager and the Board as the policy maker.

Following these initial meetings, Wayne organized his work schedule and set the planning staff's activities. Then, in October 1970, he met with the Board to discuss the planning strategy. At this meeting he explained that an immediate problem was the June 1971 deadline. The project was already four months behind schedule because the Board had taken so long in selecting him; and he anticipated further delays in the planning process. Wayne therefore recommended that the Board request a six-month funding extension. The Board concurred and asked Model Cities to extend the planning period to December 31, 1971. Model Cities agreed, allocating the project an additional $40,000.

With the extension approved, Wayne immediately initiated project activation tasks. Although not part of the design, these tasks would proceed simultaneously with it. This overlapping schedule would save time and would enable the project to begin immediately upon approval.

First, because the Board would have to be knowledgeable about formal health administration, Wayne initiated an informal training program to familiarize Board members with the types of health care delivery, the variety of health resources, and the federal guidelines for funding. As an integral part of the program, the Board took one educational and fact-finding trip to learn how other federally funded health centers throughout the United States organized services, set policy, and dealt with center administrators. They discovered that theoretically all health centers were intended to be financially self-supporting, but no center had yet achieved this goal. They were thus convinced that the Malia Center would need continuing outside support and they would have to plan for this.

Wayne then initiated a second activity. In October 1970, having concluded that the project would eventually receive federal construction funds, he decided to select and acquire a site for the Center. Wayne worked closely with Kahele and a special site-selection committee, and together they chose five sites and examined them with regard to: (1) zoning laws, (2) central location in Malia, (3) room for expansion, (4) ease of installing electricity and water, (5) cost, and (6) ease of acquisition. After deliberating, the committee agreed unanimously on a parcel of state-owned land at Pahuna Point. The Pahuna Point site had 14.3 acres of land, was centrally located in Malia, already had water and electricity, and was near the site of a temporary health clinic built in 1969. In addition, the acquisition cost would be negligible since state law stipulated that public facilities—such as the proposed Health Center—had principal use rights on state-owned land.

In January 1971, before they knew whether Center construction would be approved, Wayne and Kahele began acquiring the Pahuna site. The land
belonged to the Hawaiian Homes Commission (HHC)—a special state agency that provided homesteads for native Hawaiians. The Board could acquire Pahuna for one dollar if HHC agreed to exchange it for another parcel of state-owned land. To facilitate such an exchange, Wayne and Kahele met with the Executive Committee of the Hawaiian Homestead Association, which represented homesteaders. The Executive Committee was reluctant to exchange Pahuna for another site because it was an ideal housing location. The committee said, however, that it merely represented homesteaders; HHC actually controlled the land.

Over the next few months, as they continued designing the Malia Comprehensive Health Center, Wayne and Kahele met with HHC. They also met with the state Department of Land and Natural Resources (DLNR), which would be responsible for finding comparably valued exchange land. Finally, in May 1971 HHC agreed to negotiate the exchange. Beginning the negotiations, DLNR appraised Pahuna. But HHC rejected the appraisal, feeling the land value would soon rise dramatically and DLNR had not included this in their appraisal. Negotiations dragged on. Then in September 1971, Wayne and Kahele decided they could wait no longer and they requested a right of entry so that they could analyze the land for construction. HHC granted entry rights and agreed to continue negotiating; but, until an exchange was agreed to, HHC would lease—not give up rights to—Pahuna Point.

Wayne began a third activity. Because he wanted health services to start before the Center formally opened, he began developing an outreach program as envisioned in the Program Concept (refer to page 7). To begin the program, Wayne and the Board recruited residents, who would become outreach workers, employed by the health center to perform health and social services within Malia. Residents were recruited and arrangements were made with Honolulu Community College to train them.

A final support activity that Wayne initiated was a program to train residents to be aides and assistant workers at the Center. This was to be part of the ongoing training and educational program to develop local community manpower (refer to page 9). The Board sponsored the training of two laboratory assistants; other residents would be trained later.

Organizing the Design

In January 1971 while these support activities were proceeding, Wayne and Kahele organized a voluntary consulting group, the Technical Advisory Committee. Composed of representatives from public and private health care providers, such as the state Department of Health, Regional Medical Program (RMP), Hawaii Medical Service Association, and Kaiser Foundation Health Plan, the Technical Advisory Committee was created to give the Board technical advice on the design. Theoretically, the committee was also to have considerable input in all policy decisions. Kahele and the Board, however, did not get along well with the committee; they felt it was too concerned with technical professional aspects of the Center and did not adequately consider community needs. Therefore the Board largely ignored its policy recommendations. The Board did, however, ask the committee to revise the Program Concept, which the committee consented to do.
While the Program Concept was being revised, Wayne and Kahele contracted an architectural firm to prepare preliminary Center blueprints and construction specifications. They felt that these documents would coordinate the overall design by matching proposed medical services with a physical model of the Center. Wayne and Kahele hired the Honolulu firm of Noda and Sons.

In April 1971, the Technical Advisory Committee completed their revisions of the Program Concept. They modified very little, but, in part one, specified that the Board was the resident organization in charge of Center policy. Then, in May 1971, Noda and Sons completed the architectural documents. In them, they sketched a physical model of the Center, specified space requirements, designed the preliminary floor plan, and provided a phased construction budget.

Wayne and the Board reviewed the documents and realized that construction would take longer than anticipated. Wayne and Kahele therefore decided to begin delivering health services as soon as possible, in a temporary location. After the Center was built, they would transfer operations to the permanent site. To expedite this plan, Wayne made the following two decisions:

1. He divided the design into two phases: construction design and Center operations design. This would allow both design phases to proceed simultaneously, and would also prevent delays in either phase from hindering the other.

2. He decided to contract out the final construction design so that he could concentrate on designing Center operations.

An Informal Feasibility Study

Before proceeding with this strategy, Wayne and Kahele decided to informally check the feasibility of the architectural documents and the revised Program Concept. They asked the Honolulu County Medical Society to conduct a review, confident that the review would validate the Center and provide it with a professional endorsement. However, after evaluating the architectural documents, the Society commented that the Center was economically unfeasible; its physical layout was unrealistically large and complex. The Center, they felt, should initially be built to provide basic services, adding facilities for specialities and sophisticated services only when justified by client demand.

Turning to the Program Concept, the Society identified a potentially critical problem. They pointed out that part one of the Program Concept never made explicit the relationship between the Board and the health Center. Furthermore, it was impossible to establish any firm policies between the Board and the Center, since the Board conducted all business informally, without due process. In such an environment, the Society emphasized, there was too much uncertainty; the Board could make medical decisions and become directly entangled in the Center's day-to-day management. This would be intolerable.
Kahele and the Board met with Wayne to discuss the Society's review. In discussing the criticism of the architectural layout, the Board and Kahele argued that since Malia had no hospital, the Center would be a surrogate hospital, and should therefore be built to house a complete range of health services. Moreover, Malia deserved a first-class public facility with room for specialists and sophisticated services. They also pointed out that the Society, like many other professionals they dealt with, was insensitive to community needs. They were adamantly that Wayne use the architect's report. Wayne pointed out—as the Society had—that the envisioned Center would be extremely costly, and providing specialist services would be financially unviable. Wayne, however, did not press this issue since the Board felt so strongly. Instead he agreed to use the architect's report—on a funding-available basis.

In discussing the Society's review of the Program Concept, Kahele and the Board agreed to work out policies and procedures that specified the Board would make no medical decisions. They stressed, however, that the decision to develop procedures would not be dictated to them by outside professionals and that they would work on these matters as they felt the need.

Problems and Solutions

In June 1971, Wayne, although apprehensive about the Board's decision, continued with the design. He faced two immediate problems—time and money. On the one hand, Wayne knew that the December 1971 planning deadline was unrealistic; designing the Center's operations would take until March 1972. On the other hand, he knew that he needed more money, both to complete the construction design and to guarantee that health operations could be started. To cope with the time and money problems, he wrote three grant proposals. He submitted one to the Regional Medical Program (RMP). If funded, this proposal would help pay the cost for both designing Center operations and implementing them. He submitted a second proposal to Model Cities. This proposal requested a six-month planning extension, money to prepare the Pahuna site for construction, and money to hire an architect. Wayne submitted a third proposal, this one to HEW requesting Department of Health, Education and Welfare—Health Center (HEW-HC) funds. He considered this proposal the most important because, if funded, it would pay for most of the first year operating costs.

In August 1971, the HEW regional office in San Francisco returned the HEW proposal, telling Wayne that they needed detailed plans of the Center's operations. They further advised Wayne to wait before submitting these plans because they were preparing new HEW—HC guidelines. If he waited, they would help him write a new proposal.

Wayne waited for a reply on the other two proposals. While waiting, he worked with Kahele and other Board members to seek private funds. The Board contacted trusts and foundations requesting financial aid, but were unsuccessful. Nonetheless, proceeding on the assumption that the proposals would eventually be funded, they continued all design activities. They
continued organizing Center operations; and they selected Noda and Sons to draft the final construction specifications and blueprints. Noda and Sons were notified that they could start as soon as the Board received funds.

By late summer 1971, however, no agency had communicated with the Board. Thus, in August, Wayne and Kahele decided to visit the agencies in person. They first traveled to HEW's regional office in San Francisco and met with program advisor Irene Reed. They told Reed they were designing the Center but would need firm financial commitments to finish. In turn, Reed informed them that HEW's new guidelines for health centers were almost complete. Upon their completion she would personally visit Malia and help prepare an appropriate HEW-HC proposal. Wayne and Kahele thanked her and set February 1972 as the tentative date for her visit. Next, Wayne and Kahele met with Model Cities officials. They received good news; Model Cities had decided to fund their proposal. The Board would be given $52,000 for a six-month planning extension and $144,000 for architectural fees and site preparation. Although delighted with the Model Cities funds, they still knew that they needed RMP funds both to finish designing the health Center operations, and to begin delivering health services.

The RMP proposal, in the meantime, had passed preliminary screening and had been sent to the local decision-making body, the Regional Advisory Group (RAG). RAG was rigorously appraising the project, and was bothered—as the Honolulu Medical Society had been—about (1) the expense of the Center's specialist services, (2) the lay board that set Center policy, and (3) the lack of Board policies and procedures. They reached an impasse. Although recognizing the pressing need for the Malia Coast Comprehensive Health Center, RAG thought it was financially and administratively unviable.

In September 1971, RAG announced a final meeting to decide on the proposal. A national RMP representative was sent to Hawaii to evaluate the situation and offer an opinion. Before the final meeting, the national representative visited Malia and met with the Board. He was impressed by Board efforts, particularly their attempt to actively involve the community. Thus, during the final review meeting, he vigorously endorsed the project, telling RAG that the proposed Center complemented the new policy, emphasizing support for medically underserved areas. Because of this strong endorsement, RAG approved the proposal. In October, RMP awarded the Board a first-year allotment of $158,000. (There were, of course, conditions that the Board had to agree to before receiving the money; they will be discussed in the section on negotiation, page 27).8

**Completing the Design**

Wayne notified Noda and Sons to start working on construction specifications and blueprints. Since they were thoroughly familiar with the Center's working requirements, they worked rapidly and finished in December 1971. The specifications and blueprints, which served as the final construction design, specified three construction phases:
1. Phase 1 - the emergency facility,
2. Phase 2 - the primary care facility, and
3. Phase 3 - the dental and vision care facility.

Noda and Sons had carefully designed the Center. When the three phases were finished, the Center would consist of a cluster of buildings in a campus arrangement. This design would permit the emergency facility to begin operating while the others were being built.

Final design of Center operations took considerably longer, and, in fact, was not completed until after the Center began operating. Three factors contributed to the delay. First, Center operations were extremely complex; the Board had to hire outside consultants, review their work, and reconsult them if the work was unacceptable. Second, the Board and Center administrators had to fulfill a growing number of funding requirements from all agencies (these requirements will be discussed in the next section). Finally, and most significantly, the Board had previously decided to wait on developing Board policies and procedures. This meant that the rights, powers, and duties of the Board, in relationship to the Center, were undefined. Clearly the Board could set policy. But it was uncertain whether the Board could also administer the Center. Until the Board developed policies and procedures that defined their relationship to the Center's administration, the management system for health operations could not be designed.

Wayne recognized the latter problem as one that RAG and the Honolulu Medical Society had previously pointed out, and he urged the Board to develop policies, establish procedures, and clearly delineate their relationship to the Center. But the Board reiterated that their informality was appropriate and they would develop policies and procedures as needed. They emphasized moreover that this was completely a Board matter.

Over the next few months, Wayne, Kahele, and the Board completed what they could of the design. By February 1972, the design of Center operations was organized as follows:

A. Goals and objectives. The principal objective of the Board was to make adequate health care available to all residents in a setting that enhanced their dignity. The most important goals of the project director included:

1. Implementing a pre-paid health insurance plan.
2. Enrolling 4,000 residents in the plan by the first year.
3. Providing 24-hour emergency care for the Malia district.
4. Guaranteeing direct and indirect consumer participation in Center decisions and policy.

5. Providing job opportunities and training for Malia residents.

6. Developing a team concept for a family-oriented outreach program.

7. Coordinating services with other health care providers and health agencies in Malia.

B. Operating policies. The Center's formal operating policies were not drawn up for two more years. Wayne and the planning staff did, however, draft rough guidelines, which temporarily substituted for operating policy. These were divided into the following three sections:

1. Personnel. This section included employee policy such as salaries, benefits, and working hours, but it lacked position descriptions, job qualifications, and employee appeal procedures.

2. Finances. This section specified insurance needs, such as malpractice and liability; and it also identified the primary donors.

3. Operations. Although giving a general overview of Center operations, including emergency operations, diagnostic services, specialties services, transportation requirements, financial operations, and maintenance operations, this section did not comprehensively detail how the operations would actually be administered and who had authority to make final decisions (see Figure 3 for proposed operational structure).

C. Activation activities. Based on RMP funding requirements, the following activities had to be completed before operations could begin:

1. Obtain firm financial commitments to build and operate the Center.

2. Advertise, screen, interview, and select core staff.

3. Contract a consulting firm to design a system for patient records, internal communication, and fiscal management.

4. Develop policies and a management system for the Center. Since the system had to be consistent with HEW guidelines, a consulting firm would have to be contracted to...
FIGURE 3. MALIA COMPREHENSIVE HEALTH CENTER PROPOSED ORGANIZATIONAL STRUCTURE
complete this system. Their work would also include an administrative procedures manual for Center operations.

5. Prepare and implement training programs for Center employees.

6. Contract a medical group for all medical services, including physicians to work at the Center, and a medical procedures manual to set medical policy.

7. Locate a temporary facility to serve as the Center.

8. Initiate all health operations by July 1972.

Although lacking detailed administrative and implementation plans, the design provided a fairly complete description of Center operations and provided Wayne, Kahele, and the Board with a rigorous schedule of activation tasks. The immediate tasks were to submit a proposal to the Malia District Neighborhood Planning Committee (MDNPC) for Model Cities' construction funds and to submit a proposal to HEW for first year operating funds.

In January 1972, Wayne and Kahele submitted a proposal to the MDNPC, requesting that the budget included in the final construction design be funded. To review the proposal, MDNPC held a public meeting. At this meeting, the Board was criticized by the Hawaiian Homestead Association (see page 17) for using homestead land and was criticized for "trying to make a name for itself." But the MDNPC finally approved the proposal and sent it to the City Council for a decision.

The HEW-HC proposal was completed in February 1972 when, as promised, Irene Reed visited Malia. In assisting Wayne, Kahele, and the Board to prepare the proposal, she explained the new guidelines and pointed out the information that was expected. She also recommended that the Board meet with the state Comprehensive Health Planning Agency (CHP) because HEW would ask them to review the proposal and CHP would have to issue the Center a certificate-of-need prior to construction. When completed, the proposal was the most comprehensive statement yet: it included the Program Concept, the architectural documents, the preliminary operating procedures, the Center design, letters supporting the Center, and studies testifying to Malia's medical need. It was submitted to HEW in late February.
III. SELECTION, APPROVAL, AND ACTIVATION

Selection: A Foregone Conclusion

Although the preliminary design of the Malia Comprehensive Health Center had been funded, money for the Center's construction and operation had not yet been decided upon. Wayne, Kahele, and the Board were confident, however, that approval would be a mere formality. They reasoned that over the past few years, the Center had gained considerable political support. Community support had grown and solidified through the grassroots campaign and the Board election; Malia's federal representatives had actively lobbied for the Center; state officials had testified in favor of building the Center; and private health care providers had written letters endorsing the Center. This support exerted considerable political pressure on federal policy makers and made the Malia Comprehensive Health Center a politically viable project.

They believed that another political factor was government credibility. So many federal agencies were enthusiastically supporting the Center and helping the Board (the Community Action Program sponsored CAP committees; Model Cities designated Malia a model neighborhood; the Regional Medical Program (RMP) notified the Board of their intent to provide development funding; and HEW helped the Board prepare a proposal for HEW-HC funds) that if the Center were not completed, the federal government would be embarrassed and lose credibility. Thus, it was politically expedient to complete the Center.

Wayne, Kahele, and the Board were also optimistic because the Center was a high priority project, fitting into local, regional, and national development plans. Locally, the Malia District Neighborhood Planning Committee (MDNPC) had ranked the Center the number one project because Malia desperately needed a public health facility and because Malia's number one development priority was to improve health care. On a regional level, HEW had ranked the Center as the number one project because it complemented plans to improve health care in rural areas. Finally, the Center fit national development plans to make health care delivery more consumer-oriented. In this respect, the non-professional resident composition of the Board and its efforts to involve the community in deciding the Center's services represented the kind of innovative health care management that the federal government wanted to encourage.

Finally, Kahele and the Board reasoned that the Center had gained so much momentum and proceeded so far, it was virtually impossible to halt its implementation. Already, proposals totaling $439,000 had been approved to plan the Center, design its operations, and prepare its site for construction. The completion of these activities had marked the passing of a half-way point and it was presumed that federal agencies would build and operate the Center.
In sum, the Board was convinced that the Center had become so urgent politically and developmentally, and had gained such momentum, it was virtually assured of selection, despite reservations about its feasibility.

In March 1972, after the state Comprehensive Health Planning Agency (CHP) endorsed the Center and issued it a certificate-of-need, HEW approved HEW-HC funds. These funds would be released in June 1972. In July 1972, Model Cities announced the Center's selection for $759,000 of construction funds, which would finance all construction for the first phase—the emergency unit. Added to the Regional Medical Program (RMP) selection in October 1971 (see page 20), these two selections meant that the first phase of the Malia Comprehensive Health Center was close to becoming a reality.

**Negotiation and Approval: Some Unanswered Questions**

Despite selecting the Center, Model Cities, RMP, and HEW were still concerned about its feasibility. No formal feasibility study had been conducted; in its absence, the Board had solicited comments from professional health agencies (refer to pages 13, 18, and 20). Generally the health agencies had expressed doubts about the Center's financial and administrative viability. Specifically, they had questioned the competence of the Board and expressed concern about the Board's lack of policies and procedures. Model Cities, RMP, and HEW now wanted assurance that the Board would deal with these problems.

To receive this assurance, Model Cities insisted on several conditions. First, they stipulated that a staff member from the City Demonstration Agency (CDA) monitor project activities and act as the liaison between Model Cities and the Board. CDA was the city agency that administered and monitored Honolulu's Model Cities' grants. Second, Model Cities stipulated that the Research Corporation of the University of Hawaii (RCUH) monitor the project's management and finances. Since RCUH was already doing this, the Board readily agreed to the condition. Third, Model Cities required the Board to undergo an annual external review. This review would help the Board improve the project and inform them of any deficiencies. Finally, since Model Cities stressed neighborhood planning and participation, the Board had to report regularly to the MDNPC and attend open public meetings to discuss Center activities and progress. The Board also had to give preference in hiring to qualified residents—a condition which the Board had already instituted. The Board did not negotiate any of these conditions; they simply accepted them as requirements for receiving Model Cities' funds.

RMP had selected the Center for funding in October 1971, after the Regional Advisory Group (RAG) had approved it with reservations. Reflecting RAG's concern, RMP issued the following burdensome funding requirements:

1. **Review.** RMP made it clear that the health Center could be funded for a maximum of three years, but each year the
Center would be strictly reviewed before new funds were approved. The Planning, Evaluation, and Implementation Committee (PIE), which was RMP's on-site evaluator, would conduct the reviews.

2. **Liaison.** A professional RMP staff member would be the Board's liaison with RMP; the Board would have to cooperate fully with him.

3. **Reporting.** The Board had to provide monthly forecasts of expenditures and also submit monthly progress reports. The forecasts and progress reports would be evaluated by the RMP staff and then sent to RAG. The RMP liaison would also discuss the evaluation with the Board.

4. **Expenditures.** The Board had to consult with and receive RMP's approval before hiring consultants, traveling out of state, purchasing equipment over $100, and hiring employees with a salary over $10,000.

5. **Monitoring.** The Board had to cooperate fully with RMP's monitoring body, the Planning, Implementation, and Evaluation Committee (PIE). PIE would conduct site evaluations and send the results to RAG.

Because these conditions were required for RMP funding, the Board agreed to comply. In determining their first year allotment, however, they negotiated for a sum of $119,625, which was considerably less than the $158,000 they initially requested.

In June 1972, HEW similarly insisted on certain conditions before approving funds for the Center. They stipulated three routine conditions. First, the Board had to cooperate fully with HEW liaison personnel, who would occasionally monitor the project and make recommendations. Second, the Board would have to undergo an annual Comprehensive Health Planning Agency (CHP) review. In this process, the CHP Review Committee would evaluate project progress and then report to the CHP Advisory Council. The Council would then endorse or reject the Center and send their decision to HEW. Third, and most important, the Board had to develop a prepaid health plan, enrolling as many residents in it as possible. Because the development of a prepaid health plan demonstrated fiscal responsibility, the Board had to fulfill this stipulation promptly.

Because HEW was greatly concerned about the Board's administrative competence, it also stipulated special conditions. In the funding agreement, HEW stated that the Board had to:

Submit by February 1, 1973, a Board of Directors Procedure and Policy Manual which delineates role and duties of Board members, officers and functions of standing committees, including methods of operation.
of each committee if such functions affect health
center activities and services.13

HEW further required the Board to agree to fulfill eight special
conditions of administration. These eight conditions were best summed up
by the following two statements:

Submit by February 1, 1973, an Administrative/Personnel
Policy and Procedure Manual governing operations of the
health center, including detailed job description of
duties, functions, lines of authority and responsibility,
qualifications and salary ranges of each salaried position
within the center.

Submit by February 1, 1973: Evidence of mechanisms
for evaluation of personnel during probationary and
permanent status; and reassessment of personnel
allocations for most effective, efficient program
operation; and evidence that salary level is commen-
surate with duties, qualifications and positions
elsewhere on Oahu.14

Again, the Board did not negotiate these conditions, but simply agreed to
them. They did, however, negotiate for the first year allotment and
compromised with HEW on a figure of $307,207.

Activation and Organization: Potential Problems

Activating Center Construction

Because they had been convinced that the Malia Comprehensive Health
Center would be completely funded, Wayne and Kahele had decided to begin
construction before receiving overall approval. By immediately beginning
visible activity, they hoped to give the Center credibility within the
community. Thus, in December 1971, prior to their completing the oper-
ations design, they invited contractors to bid on preparing the Pahuna
site for construction. Seventeen contractors submitted bids, but all bids
were too high, so Wayne and Kahele revised their specifications and asked
the contractors to submit new bids. After the second round of bids, the
lowest bid was accepted. The selected contractor first prepared an
environmental impact statement and then began to grade the site.

Crucial Decisions

Then, in January 1972, with the site preparation proceeding smoothly,
Wayne made a crucial decision. He decided to resign, effective when the
Center opened in its temporary location. Wayne had felt, all along, that
he would only be interested in designing and activating the project. He
did not want to get involved in implementing Center operations because he
was unenthusiastic about administration. He therefore submitted his resignation to Kahele and the Board on very friendly terms.

The Board accepted the resignation and decided to hire one person, both to assume Wayne's duties as project director and to become the Center's permanent administrator when all health operations were implemented. To complement the project director's dual appointment, they also decided to hire a project team which would implement Center operations at the temporary location, and then become the permanent core staff.

In February, Kahele and the Board recruited applicants through advertisements, and interviewed them; in March, they hired the administrative project team consisting of: (1) an assistant administrator, who was Wayne's current assistant administrator, (2) an information specialist, and (3) a community health specialist. The project's medical staff, including resident outreach workers and trainees, would be hired after administrative preparations had been completed. They also hired the new project director, Ray Johnson. Johnson, a retired army officer, had considerable experience as an army health administrator, but he was not a resident. This was to create some friction, as the Board had wanted the permanent administrator to be a resident.

An Ominous Review

After the administrative project staff was hired, Model Cities decided to conduct a review of the project. Kahele and the Board determined that this review would be particularly significant. It would be the first formal evaluation of the project and would therefore be closely scrutinized by all funding agencies. Moreover, as the first comprehensive analysis of the project, it would systematically evaluate all past and proposed activities, pointing out deficiencies, and indicating potential long-term problems. While the review would be desirable from the standpoint of remediying weaknesses, it would be undesirable if it encouraged other funding agencies to stipulate additional monitoring conditions. Since a negative evaluation would have serious implications for the Center's future, Kahele and the Board were quite anxious.

As could be predicted from the previous informal evaluations, the review focused on the administration of the project, and the Board's overall competence. In evaluating the administration, the review pointed out that certain key tasks had not yet been accomplished, particularly a formal feasibility study. As stated in the review:

Project staff are proposing to begin construction of a center within a few months, prior to completion of all the detailed planning called for in the first-year work program. While not all such tasks need be completed before construction begins, it is recommended that, at the very least, the project complete a detailed analysis of the feasibility of at least those estimates which affect building specifications. These include the specific
services proposed, staffing and equipment required for each service and space required for the staff and equipment. To confirm these estimates will require a careful determination of the need, potential use and ability to pay for the various levels of services proposed for the Center.\textsuperscript{15}

Although basic oversights by the administration were serious problems in themselves, they were part of a larger question: Was the Board competent to administer the Center and to set its policy? The review never stated the question quite so bluntly, but it clearly implied the question by emphasizing that the Board should solicit professional advice and acquire professional members. For example, one section of the review stated:

The development of a viable, ongoing resident health organization capable of planning and possibly administering health services on the Malia Coast should be viewed as an objective in itself. To accomplish this . . . Agency and professional involvement should be strengthened. The Technical Advisory Council should be more closely involved in future developments with more use made of the expertise of its members . . . Project staff should facilitate more direct resident-professional interaction . . . Members of the resident board should be exposed directly to more agency and professional views, and vice-versa.\textsuperscript{16}

From the Board's perspective, it was not so much a question of avoiding professional input as it was a question of retaining community control of the Center.

Retaining community control had, of course been a long-standing objective. It had been stressed from the Center's inception by residents who felt that they understood Malia's unique environment and therefore were most competent to set Center policy. It had been emphasized as the first guiding principle in the Program Concept; and it had been underscored when the Board had been criticized by the Honolulu County Medical Society for planning too many specialized medical services, but remained firm in retaining them all. Thus, given the intense feeling about retaining community control, the Board viewed direct professional involvement as an encroachment on their autonomy.

The report recognized the Board's concern, but also noted that direct professional input was necessary, both to provide the Board with technical information about the health services, and to provide it with information on how to administer them. In analyzing this situation, the review ominously forecast, "at some time soon, the key conflicts concerning . . . lay or professional control must be resolved."\textsuperscript{17}

The Board discussed the review, dismissed it as an outsider's overstatement, and decided to continue with the activation tasks that were scheduled in the design (see pages 22-24).
Completing Activation Tasks

Several crucial tasks had to be completed before the Center could be opened; but Johnson, the new project director, was still becoming oriented to his job and could not oversee the operations. Rather than wait for Johnson to "catch up," however, Kahele and the Board decided to supervise the activation tasks and let Johnson help them when he was prepared.

The first task was to work on an integrated system of billing, patient records, and internal communication. Kahele contracted a private information systems firm, Control Data Corporation, to develop alternative systems, test them, and complete a final report of the findings. From these findings, Kahele and the Board would select a system for the Center. Control Data submitted the report in March 1972; and Kahele directed the community health specialist to review the report with physicians and information specialists. From these reviews, Kahele learned that the report was deficient in integrating internal communication, so he returned the report to Control Data and made them correct the deficiency. In May 1972, Control Data provided Kahele and the Board with a supplementary report, from which a system for the Center was selected.

In June 1972, Kahele began working on management procedures for the Center. He hired a special consultant to write an administrative procedures manual for Center operations. However, the consultant could not complete the manual because the Board's role in managing the Center was uncertain. Nonetheless, he did complete a preliminary document, which Kahele approved.

By June 1972, Johnson had become sufficiently oriented to the project to provide leadership in completing the activation tasks; and he particularly wanted to help select the rest of the project team. However, Kahele and the Board had no confidence in his leadership and they still viewed him as an outsider, so they asked him to complete the monitoring forms, the progress reports, and the supplemental RMP funding request. Somewhat alienated from the activities, Johnson proceeded with the paperwork and completed the second year RMP budget request. Kahele and the Board, in the meantime, directed the project's activation.

In late June, Kahele began obtaining the project medical staff. To obtain a physician, he negotiated with Family Medicine of Hawaii, a medical group, which contracted physicians to work in rural areas. Some problems were encountered in negotiations because there was so much scepticism about the Center's administration. Nonetheless, Family Medicine finally agreed to find a physician because of the urgent necessity to implement health services. For a one year period, July 1972 to June 1973, Family Medicine agreed to provide one full time physician, referral for special services, and hospital referral. For the first six months, consulting services would also be provided. Family Medicine, however, could not guarantee to continue its services after the first year; and it could not develop the Center's medical procedures manual.
Following the negotiations, Family Medicine contracted David Alexander to be the full-time physician at the Center; Kahele and the Board, with the help of other health agencies, signed agreements with two specialist physicians, who would work at the Center, on a fee-for-service basis. To fill out the rest of the medical project team, Kahele hired one registered nurse, two medical aides, and one outreach worker. Unlike Alexander, who had a contract with Family Medicine, these personnel would become Center employees, directly accountable to the project director. The project administrative and medical staffs were now complete; and one task remained.

In July 1972, the Board decided to use a deserted laundromat for the temporary Center. Although not the most attractive or prestigious building, it was centrally located in Malia, had considerable open space, and would be relatively inexpensive to renovate. Renovations were begun in August and completed in October 1972. Health services were ready to begin.

Organization: Potential and Practical Authority

Because the project was both an experiment in resident-consumer control of health services and a professional medical center, two organizational structures with different lines of authority evolved. The first was the practical structure. In this structure, which was the day-to-day reality, the Board autonomously set Center policy, exercised considerable discretionary power over the project, and even directly administered project activities. These powers were vested in Kahele, as Board president. And, in fact, Kahele used these powers to act as the unofficial project director, accompanying Johnson to all meetings, taking part in negotiations, and sometimes directing the project staff. In the practical structure, then, Kahele and the Board exercised total discretionary power over the project and their duties conflicted with the project director's.

Superimposed upon the practical structure was the potential structure. In this structure, the Department of Health, Education and Welfare (HEW), Model Cities, and the Regional Medical Program (RMP) had final authority over the Board, based on their power to withdraw funding if the Board did not comply with their conditions and pass their reviews. Although these federal agencies were constitutionally restricted from exercising direct control over the health project, their authority was deceptively real. The numerous funding conditions were a form of indirect control that made the Board accountable to the agencies. Furthermore, the required reviews were open-ended and could evaluate any Board activity. If some Board activity was evaluated unsatisfactory, the agencies could mandate new conditions. This potentially gave the agencies direct authority over the Board.

By the time the project was to be implemented, the Board and funding agencies reached an uneasy accommodation. The Board agreed to fulfill the funding conditions, particularly developing policies that defined their power over the Center. To insure the funding agencies of satisfactory progress, the Board also agreed to report regularly to RMP and HEW liaison staff, who, in turn, would advise the Board whenever progress was unsatisfactory. Finally, the Board agreed to undergo annual review by the
Comprehensive Health Planning (CHP) Review Committee and the Planning Implementation and Evaluation Committee (PIE), which were RMP's review staff. Within this monitoring system, the Board retained direct control over the project, with direct authority over the project director and all Center staff (see Figure 4 for potential and practical structure). They would retain this authority as long as they made satisfactory progress.

It is significant to note that, at this point, the Board was still composed totally of lay persons, and their professional advisor—the Technical Advisory Committee had not participated in designing Center operations. Thus, from an organizational standpoint, the Board had no direct professional input.
FIGURE 4. POTENTIAL AND PRACTICAL ORGANIZATIONAL STRUCTURE
    OF THE MALIA PROJECT

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IV. OPERATION, CONTROL, AND HANDOVER

Implementation: The Problems Become Critical

Loose Ends but Immediate Progress

In October 1972 construction on the first phase of the Health Center, the emergency unit, was proceeding smoothly; and Johnson, Kahele, and the Board could do little to oversee the construction besides monitor progress. Thus, with the construction of the new emergency facility scheduled for completion in October 1973, they turned their full attention to the temporary facility and decided to begin health operations immediately. They acknowledged that opening the Center so soon was a calculated risk. Administration would be difficult because they had completed neither a medical procedures manual nor an administrative procedures manual. Moreover, Johnson, confused by Kahele's authority in the project, suspected that conflicts of authority would increase until the Board completed its own policies and procedures. Most significantly, they all acknowledged that the pressures of opening the Center might make it impossible to finish these tasks. But, if they were not completed, the Center would eventually fail. The lack of clearly defined procedures would create insurmountable administrative problems, and the lack of formal policies would jeopardize continued funding. By implementing the project immediately, then, the Board risked failure.

Nonetheless, the Board determined the risk was acceptable. Already, the Center was months behind schedule, and the community was growing increasingly skeptical. If the Board delayed the opening any longer, the Center's credibility might be irreparably damaged. Moreover, since the contract with Family Medicine had begun in July, the Board had to make available a facility for Dr. Alexander to practice in, or he would go elsewhere. Underlying these two factors was the Board's attitude that since the Center was merely a work place for doctors to treat patients, it was vital to hire doctors, but unimportant to complete formal Center policies and procedures. Family Medicine recognized this underlying attitude and later commented that it had "stressed the importance of developing workable programs and systems prior to the opening. . . . The Board of Directors and staff, however, appeared to be interested only in securing additional physicians to work at the clinic."18

Despite initial apprehension, the Center was opened successfully. The delivery of health services began smoothly, with medical operations functioning autonomously, much like a small private practice. Doctor Alexander, who had been hired by Family Medicine in August, served as the Center's only full-time salaried physician. He treated patients, and directly supervised the medical team—one nurse, two medical aides, and an outreach worker. Additionally, he coordinated the schedules of the two specialists, who worked at the Center on a fee-for-service basis. Since the medical roles were well-defined, little direction was necessary.
With medical operations requiring little administrative direction, Johnson succeeded in completing several key tasks. He organized his staff, the assistant administrator, secretary, information specialist, and community health specialist and assigned them specific tasks under his direct guidance. With the help of the information specialist, he successfully set up the system of billing and patient records. Since the system was necessary to the effective functioning of medical operations, the project team was extremely gratified to see it working efficiently after the first two weeks. Johnson and his assistant next performed a trend analysis. Indicating a steady rate of about 40 patients per day, the trend analysis allowed Johnson to set Center hours and plan for expanded operations. During the month, no administrative problems arose, and it seemed that the initial apprehension was groundless.

Johnson, Kahele, and the Board met in November and decided to set aside detailed planning for the second and third phases of construction. They reasoned that consolidating Center operations would demonstrate the viability of the present management and thus strengthen their construction grant proposals. Moreover, based on the smooth beginning, they believed it would take only a few months to accomplish the implementation goals specified in the design. After these were completed, they could begin construction planning in earnest. Kahele and Johnson thus specified the following priority of objectives:

1. By December 1972, complete the provisions for the prepaid health insurance plan and by January 1973, begin marketing it.

2. By February 1973, execute formal agreements with other agencies and health care professionals in order to (a) guarantee continuing service for the Center, and (b) provide 24-hour emergency service.

3. By February 1973, complete and submit the annual continuation budget request to HEW. This, of course, would be the first step in obtaining HEW-HC funds for 1974.

Each objective was crucial. Successful completion of the prepaid health plan was a primary criterion for HEW funding; formal agreements with doctors and other health care providers would guarantee that the Center could offer more health services; and, the HEW request would ensure enough money to continue operations.

Significantly, however, this new schedule of objectives now overshadowed the completion of administrative policies and procedures.

A Tumultuous Period

By late November 1972, the Board had become so intent on completing the new schedule of objectives that it seldom conferred with the liaison personnel. The liaison personnel had never really been in a position to advise the Board, but now they could only report on Center progress and
maintain indirect communication between the Board and the funding agencies. In essence, Kahele and the Board controlled the Center independently. The intensity of working on the objectives also prevented the completion of policies and procedures. Ironically, the lack of policies and procedures began to hamper work on the objectives.

In December 1972, with the Center settling into a routine operating pattern, Johnson decided that his immediate tasks were to guarantee continuing medical services and to provide 24-hour emergency service. He thus began negotiating with Family Medicine for (1) an extension of Doctor Alexander's contract, which expired in June 1973, and (2) for two full-time physicians, who would agree to be on call 24 hours a day. Negotiations were a failure. No policies or procedures clearly delineated the project director's or the Board's authority, so Kahele assumed executive prerogative as Board president and oversaw all negotiations. He made Johnson report regularly to him and, whenever he objected to an offer that Johnson made to Family Medicine, he would make Johnson retract the offer and propose a new one. Johnson felt his work was undercut and his ability to negotiate was compromised. He could make no offer in good faith. Family Medicine, already disturbed about the Center's management, viewed the situation as further proof that the Center's administration was intolerable. In a terse letter to the Board, they terminated negotiations, saying:

Family Medicine has continued its contract with Malia Coast Comprehensive Health Center (MCCHC) to provide physician services until July of 1973. At that time, no physician services will be provided to MCCHC by Family Medicine.

Family Medicine is intensely interested in the provision of high quality medical care in a rural setting. The current disorganized, uncontrolled state at the clinic makes the chances of this outcome occurring very remote and the provision of any type of care quite slim.

Federal and state governments have spent considerable sums of tax money on the creation of a small portion of the MCCHC which will not meet the needs of the community. Family Medicine recognizes that there is precedent for similar expenditures on the mainland but we certainly have hoped and worked to prevent this type of waste in an area of great need in rural Hawaii.19

Johnson next worked on the second objective, the prepaid health insurance plan. He had to guarantee the plan's health services by formally contracting other health care providers. For example, because many Malia residents received medicaid and other federal government assistance, Johnson had to negotiate with the state Department of Social Services, which administered medicaid assistance on the state level. Johnson also had to negotiate with the Hawaii Medical Service Association, the only company capable of financing, administering, marketing, and monitoring a
prepaid health plan. Finally, Johnson had to negotiate with specialists, such as psychiatrists and pediatricians, to get them to offer their services at the Center.

In negotiating with all the health providers, Johnson was closely supervised by Kahele, who emphasized that the Board would have to approve any plan and oversee its implementation. Inordinate delays occurred; Johnson would reach an informal agreement with a provider, have it rejected by Kahele, and then have to renegotiate the settlement. Since so many negotiations were involved, it was impossible to complete the prepaid insurance plan.

Johnson accomplished one of the objectives; in February 1973 he finished the HEW continuation budget request. Included in the requisition were the new schedule of objectives, a prospectus of future activities, the budget for 1973-74, and the Center progress report. In March, he sent these documents to the HEW regional office in San Francisco and to the Comprehensive Health Planning Agency (CHP) in Honolulu. CHP responded promptly, informing the Board that it supported the new budget request. HEW replied in late March, telling the Board that it was still reviewing the progress report.

Despite successfully obtaining CHP's endorsement for continuing funds, Johnson still viewed his situation as intolerable. He was totally frustrated in his relations with Kahele and uncertain of his role or authority in the project. Moreover, he realized that although the uncertainty was created by the lack of policies and procedures, there was an underlying factor of resident control. Kahele and the Board, as representatives of the community, were determined to retain control of the Center. Since Johnson was still considered an outsider, he would be closely supervised by Kahele. Beyond him personally, however, Johnson realized that Kahele and the Board were uncompromising; they were unwilling to give up any aspect of control to outside health agencies or outside health care providers. Johnson knew, for instance, that Kahele did not really want to contract physicians through Family Medicine; he wanted to contract physicians directly, so that the physicians would be accountable only to the Center. Given this situation, Johnson felt he could no longer negotiate for vitally needed health services.

Seeing no alternative, Johnson resigned, charging that he was ineffective as project director, given the constant interference of Kahele and the Board. Furthermore, there was personal animosity between himself and Kahele.

Realizing the need for decisive action, the Board promptly accepted Johnson's resignation and appointed Kahele as the acting project director. Board members then deliberated about offering Kahele the dual appointment as project director and permanent Center administrator. They considered several factors. On the negative side was the possible charge of conflict of interest, as Kahele was also Board president. Moreover there would be questions of Kahele's competence since he had no formal training or experience in health administration. But on the positive side, Board members
knew from personal experience that Kahele was a strong leader. He was also a resident and thus understood Malia's needs. His understanding and leadership would be essential since the project had failed to meet major deadlines. At a meeting with Kahele absent, the Board decided to offer him the dual appointment. But before officially appointing him project director/Center administrator, they had to get Regional Medical Program (RMP) approval, as required in the funding conditions.

**Impending Crisis**

In early April, while the Board waited for RMP to approve Kahele as permanent director, HEW returned the continuation budget request saying that the Board would have to submit a supplemental report. HEW wanted more information about the new project director, and about progress on the major objectives. HEW also asked the CHP Advisory Council to review the supplemental report.

Kahele and the Board submitted the supplemental report to HEW and CHP on April 17. On April 19, the CHP Review Committee completed their review and, after several days of discussion, told the Board they were dissatisfied. In a letter dated April 25th, the CHP Advisory Council noted that the Board had neither contracted physicians past June, nor established working relationships with other health care providers. But their greatest concern was Kahele. In somewhat veiled terms, the letter said:

Some doubt was expressed by the Review Committee regarding minimum qualifications of the administrative staff positions of the health center. The questions raised whether personnel with such qualifications were capable of carrying out the involved difficult duties of running a complex health facility. For example, the minimum qualifications for the administrator position are optional allowing for so many substitutions that an individual totally without experience in the health field could qualify.20

The letter concluded by explaining that unless the Board was able to deliver health services and to institute the prepaid health plan by September 30, 1973, the CHP Agency would automatically withdraw its endorsement of the Center. A withdrawal of endorsement was tantamount to cutting off Department of Health, Education and Welfare-Health Center (HEW-HC) funds.

A few days after the Board received CHP's letter, HEW's regional Family Health Center Coordinator came to Malia to discuss HEW's concerns and see if some amicable, but satisfactory arrangements could be worked out. Meeting with the Board, the coordinator discussed the failure to complete the prepaid insurance plan and the failure to contract physicians. He emphasized that these failures were merely symptoms caused by the underlying problems of the lack of a qualified director and the lack of professional Board members. In a lengthy letter to the Board, dated April 30, 1973, the coordinator summarized his positions on the two underlying problems. Concerning the director he wrote:
Much discussion revolved about the Board's action in offering the position of Project Director to Mr. Kahele. Mr. Kahele stated that he had not yet decided whether or not to accept the position. While we have the greatest respect for Mr. Kahele's current accomplishments, we do not believe that he has the training and experience that we believe would be required in the future administration of a complex health care program.

Concerning the Board's professional expansion, he noted:

We believe an expanded Board, representative of additional community interests, would ultimately improve the center's ability to market the plan and improve confidence in the program by other affected members of the community. Other agency representatives expressed concern over the limited opportunities for participation.

After completing substantive discussions, the coordinator told the Board he was going to continue Department of Health, Education and Welfare-Health Center (HEW-HC) funding through September 1973, provided that the Board:

1. Recruit and hire a qualified project director, acceptable to HEW.
2. Recruit three physicians, with one as the Medical Director.
3. Complete the prepaid health plan and complete a marketing strategy.
4. Develop policies and procedures to expand Board participation to include other representatives of affected health interests.

The coordinator then told the Board that an HEW team would visit the Center in August to follow up on these new conditions. At that time, the team would evaluate progress; and, if sufficient, it would approve 1974 HEW-HC funding. Since HEW-HC funding for 1973 would cease in September, the coordinator strongly recommended that the Board mail him a progress report prior to August.

A few days after being notified that their HEW funding might be cut off in September, the Board received an ominous letter from the Regional Advisory Group (RAG). Now alerted to the problems at the Center, RAG informed the Board that it had serious reservations about continuing Regional Medical Program (RMP) funding after December 1973. RAG cited the same concerns that HEW had articulated: lack of policies and procedures, lack of center physicians, lack of a prepaid health plan, and lack of a competent project director. RAG also informed the Board that their review committee, the Planning Implementation and Evaluation Committee (PIE) would conduct an on-site evaluation to assess these concerns. Based on the results of the evaluation, RAG would decide whether or not to continue RMP funding for 1974.
The Crisis

In June 1973, with the cut-off of operating funds now imminent, Kahele and the Board met to devise a plan that would not only satisfy the funding agencies, but would also allow Kahele to remain as permanent Center administrator. It was decided that Kahele would first meet with the Comprehensive Health Planning (CHP) chairman to see if CHP would extend the September 30 deadline for withdrawing its formal endorsement of the Center. Extending the CHP endorsement would be the first step in getting HEW to reconsider Kahele.

The meeting began cordially, with Kahele pointing out that the September deadline made it difficult for him to recruit physicians, because it created uncertainty about financing. He also pointed out that there were so many conditions from so many different agencies that the deadline was unrealistic. In reply, the CHP chairman stated that Kahele was in a conflict of interest since he was both Board president and Center administrator; it would be appropriate for him to step down as administrator and hire an experienced person. The CHP chairman also expressed the opinion that the Board had to expand to include some outside health representatives. The discussion became very heated and slowly degenerated into a shouting match. Nothing was resolved, and ill-feeling was created.

Later in June, the national RMP office informed the Board that Kahele was unacceptable as Center administrator because due process had not been followed in selecting him. Still resolved to appoint Kahele, however, the Board organized an Administrator Screening Committee consisting of six Board members. The committee advertised the position, interviewed four applicants, and unanimously selected Kahele. RMP, upon being informed that due process had been followed, had to approve Kahele since its stated objection to Kahele's selection had only been lack of due process. Bolstered by RMP's reluctant approval, the Board defied CHP and HEW, and formally appointed Kahele as project director/permanent Center administrator; Kahele then stepped down as Board president to avoid further charges of a conflict of interest.

While Center operations were being implemented from January - July 1973, construction on the permanent facility had proceeded on schedule. Thus, during July and August, Kahele spent much time planning the move to the permanent site. He decided to move all Center operations into the new emergency unit when it was completed in October. Although the emergency unit was inadequate for primary care, it was an improvement over the temporary facility's cramped quarters. The new emergency facility could be partitioned into offices, physician consulting areas, and examining rooms; this would serve until the Board secured funds to build the rest of the Center.

During July and August Kahele also spent much time dealing with personnel matters; he hired para-medics, laboratory technicians, and medical aides for the Center, mediated between Center employees, assigned responsibilities, and tried to recruit physicians. Recruiting physicians
was especially time consuming. Normally, CHP and other health agencies helped to recruit physicians willing to work in rural areas. But Kahele was reluctant to communicate with the health agencies, and thus he took several months simply identifying physicians who would negotiate with him. When he contacted such physicians, few were willing to work at a Center whose policies and procedures were so informal, whose funding was so uncertain, and whose relationships with all agencies were so poor. Recruiting thus constituted much of Kahele's job. Kahele spent the rest of his time meeting with the staff and the Board, publicizing the Malia Comprehensive Health Center within Malia, and maintaining good community relations. He assigned all technical administrative matters, including the writing of monitoring reports and progress statements, to the assistant administrator.

During this time, Kahele seldom communicated with the funding agencies. He made all decisions independently and operated the Center as a self-contained, autonomous unit, accountable only to the Board.

Consequently, three of the four HEW funding conditions—selection of a new Center administrator, development of the prepaid health plan, and completion of policies and procedures—were ignored. By late August, however, these conditions could no longer be ignored.

On August 29, an evaluation team from HEW's regional office visited Malia to assess the progress that the Board had made on these conditions. The HEW team found that it could not evaluate the progress because the Board had not prepared a progress report prior to the team's arrival. The team demanded to know why Kahele and the Board had not completed the report. Infuriated, Kahele and the Board replied that, with the site team suddenly appearing in Malia and demanding a report, it seemed that the regional office wanted to take over the project. Moreover, when the Family Health Center coordinator had stipulated the funding conditions in April, he had "strongly recommended"—not mandated—that the Board submit a progress report. The site team replied that they were only interested in guaranteeing high quality health care for Malia, and to do this, they had to have the progress report, so now they were mandating it. The team then stressed the need for direct communication with the regional office and gave the Board until mid-September to submit the report.

At the Center, the uncertainty of funding, compounded with the move to the permanent facility, made it impossible to adequately coordinate and supervise all activities. Although medical operations proceeded without interruption, Kahele had to spend most of his time working on the progress report, meeting with the Board and concerned employees, and planning the move. He did not have time to attend to many administrative duties, such as working out budget expenditure plans, planning medical support programs and ensuring the fiscal stability of the Center. He did, however, accomplish the key objective of hiring two physicians; they would become salaried Center employees, accountable to him directly. He also assigned to the assistant administrator the top priority task of working on the HEW progress report. The assistant completed the report, and submitted it to HEW on September 18.
Upon receiving the report, the regional office told the Board it would complete its evaluation on October 12 and then decide whether to continue the Center's funding. The Board was concerned about the timing, because HEW funding automatically ended on September 30th. However, Regional Medical Program (RMP) funds, which were approved through December 1973, were sufficient to continue Center operations. During October, the Center was moved successfully to the permanent facility, but many of the planned services and programs had to be postponed because HEW funding had ended.

Then on November 5, HEW formally notified the Board that progress on the April 1973 conditions was unacceptable. If the Board wanted continued funding, it would have to:

1. Immediately write a position description for the Center administrator and then, through a nationwide search, recruit and hire an administrator acceptable to HEW.

2. Submit Board bylaws in one month, which provide for regular elections of new Board members, and which ultimately provided for the seating of 40% professional and agency representatives.

3. Complete a Board Policies and Procedures Manual, which delineates the role and duties of Board members and officers and the functions and methods of operation of standing committees.23

If the Board accepted the conditions, HEW would approve Center funding retroactive to September 30. The Board had ten days to agree to the conditions.

Seeing the conditions as outside intrusion and a direct encroachment on their authority, the Board called their federal representatives in Washington, and angrily detailed the actions of the regional office of HEW. The Board emphasized that the regional office wanted to take over the Center and, to this end, had instigated a conspiracy against the Board. After all, they argued, the Board's troubles had begun in April 1972 when HEW notified CHP, RAG, and AMP that it considered Center administration unsatisfactory. The Board then asked their representatives to help in retaining Kahele and preserving HEW funding.

The Board also responded to HEW. In a letter dated November 15, it analyzed each condition for unreasonableness. Then a compromise was offered: the Board would fulfill all original grant conditions, if HEW withdrew all subsequent ones. HEW rejected the compromise and gave the Board until December 7 to send them a written notice stating that the Board intended to comply with the latest conditions.

The Board decided to defy the ultimatum; it would retain Kahele unless funding was terminated from all sources. Kahele himself vowed to keep the Center open and, if necessary, to use force to keep the Center operating. In mid-November, their resolve was aided by notification that RMP funding for 1974 was approved, provided that the Regional Advisory
Group (RAG) send written notice to the national office of RMP stating that "it clearly understands the problems encountered by the 'Malia' District Comprehensive Health and Hospital Board and can ensure that RMP funds and program staff activities will be used in a coordinated manner to strengthen the capability of the Malia Area to effectively manage programs locally."24 The notification also requested a clarification of all funding arrangements from all sources. Although the RAG letter constituted a very serious obstacle to renewing RMP funds, the Center was solvent for the immediate future.

Then, on November 26th, the Board's problems were confounded when Dr. Alexander, the Center's original physician resigned, saying that the administration of the Center had become too chaotic and Kahele had become overbearing. Alexander had been with the Center since its opening in October 1972; and he was upset because the medical training programs and special medical services had been postponed indefinitely. He initially assumed that the failure to implement these programs and services reflected normal and expected delays, but now, given the problems with the funding agencies, he viewed the entire situation as an administrative disaster, unlikely to improve. To call attention to the situation, he submitted his resignation not to Kahele, but directly to the Board. Upon receiving Alexander's resignation, the Board realized that Center administration (or lack thereof) was now directly hindering the delivery of medical services; the Board therefore decided to reconsider the HEW ultimatum. Separate meetings with Alexander and Kahele were scheduled for December 3rd.

Five days before the meetings, the Board received a petition signed by most of the Center employees stating that the Board's decision to meet separately with Kahele and Alexander reflected a lack of confidence in Kahele, and unless the Board supported Kahele they would all resign. Unlike Alexander, most Center staff had been hired by Kahele, and therefore had a sense of personal loyalty to him. Moreover, most staff were residents or sympathetic to resident needs. They thus felt that Kahele, as the resident most closely involved in the Center from its inception, was the person best able to serve the needs of other residents. They reasoned that although he was having difficulty in dealing with the funding agencies, when this was worked out, he would be the ideal person to administer the Center. The Board also received a letter from the two recently hired physicians stating their confidence in Kahele's leadership.

Given the employee support for Kahele, the Board decided it would defy the HEW ultimatum by retaining him as Center administrator. But it would meet separately with Kahele and Alexander to avoid a public confrontation. The HEW deadline passed without response from the Board. Then, on December 10, with HEW funding terminated, the Regional Medical Program (RMP) informed the Board that it was going to terminate funds on December 31 unless RAG provided the national RMP office with written assurance that it understood the Center's problems. RMP reminded the Board that this was the stipulation attached to the continuation funding agreement in November. The Board held an emergency meeting later in the day and discussed their
options. There was heated debate, resulting in the resignation of one Board member. But they concluded that the only alternative was to close the Center and terminate Kahele as administrator.

On December 11, the Board informed Kahele of their decision, and directed him to cease operations on December 21. On December 17, the Board held a strategy session and then by secret ballot decided to accept all HEW conditions.

Reorganization and Completion

By the time the Board decided to accept HEW conditions on December 17, 1973, no funds were left to operate the Center. But, an obscure emergency clause in the Model Cities grant stated that if for any reason medical services at the Center ceased, the building and equipment would revert to the control of the City and County of Honolulu. Thus, on December 19, upon being informed that the Center was closing at 4:00 p.m. on Friday, December 21, the mayor of Honolulu organized a temporary project team, consisting of physicians and technical personnel from the City and County Physician's Office, as well as administrators and finance personnel from the City Office of Human Resources. The team would use the weekend to organize and then reopen the Center on December 24th. At an informal meeting with the Board, the mayor announced that the city would temporarily assume all Center responsibilities; he would return authority to the Board once federal funding was resumed and the Board was reorganized.

Over the weekend, the temporary project team met and selected Daniel Ohana, the Director of the Office of Human Resources, as the temporary Center administrator. Ohana decided that the personnel from the City Physician's Office would provide continuous medical coverage and the personnel from the Office of Human Resources would both administer the Center and help the Board reorganize.

After reopening the Center on December 24th, the temporary project team met with the Board. Ohana told the Board that his major objective was to give the Board administrative, legal, financial, and policy assistance in the reorganization. He then assured the Board that financial and patient record systems were still operative and thus the Center's medical services could continue uninterrupted. Finally, he told the Board that the team would: (1) conduct an audit of past Center administration, (2) complete professional position descriptions for the Center administrator, finance director, medical director, and marketing supervisor, and (3) send a representative to meet with HEW's regional office. The Board told Ohana that it was ready to fully cooperate, and Ohana suggested that the Board form a personnel committee to recommend what personnel to rehire. The Board agreed to form the committee and also organized a finance committee to investigate the possibilities of resuming federal funding.
On December 28, a general meeting was held to discuss the strategy for the next few weeks. The temporary project team told the Board that a quick review of the administration revealed glaring financial problems. The Center owed $15,000 in back taxes, which had been withheld from employee wages but never paid to the federal government; the former administration had written an overdraft check for $7,400; and the only source of income was from direct patient fees. Over $47,000 was owed to the Center by patients, but, since there were no auditable records, the money might be lost. Ohana then reported that HEW had been contacted and it had assured him that interim funding would be granted to the Center under the authority of the Office of Human Resources. Irene Reed would visit the Center in late January to evaluate the reorganization and to confirm the funding.

The Board's personnel committee then reported and suggested that 16 core medical employees be rehired to relieve the temporary personnel from the City and County Physician's Office. Hiring the top administrators would have to wait. Ohana approved this plan and told the Board that the City would pay the salaries. Finally, the Board's finance committee reported that it had requested RAG to write the letter of assurance to the RMP national office as stipulated in November.

On December 31, the Board met with the RMP liaison to request continuation funding. They noted that core staff changes were being made, and that Center administration was presently being performed by qualified professionals from the Office of Human Resources. They further noted that the position description for the permanent Center administrator had been written to conform to professional standards, that RAG had been requested to write the letter of assurance, and that professionals would be added to the Board: lawyers, doctors, health, and finance professionals.

On January 3, RAG held an inter-agency meeting to determine how the agencies could help the Board. At the meeting the agencies were informed of the swift progress that had been made and were assured that Center administration was in competent hands. The agencies then agreed to assist the Board; the Comprehensive Health Planning (CHP) chairman, whom Kahele had initially confronted in a sharp exchange, volunteered to help write Board bylaws; various health care providers agreed to cooperate in developing the prepaid health plan; and RMP assigned a special liaison consultant to work closely with the Board. Finally, the agencies determined that the Board's immediate need was money, so RAG agreed to write the letter of assurance and send it to the national office of RMP. The letter, completed on August 17, was summed up in the first paragraph:

On January 10, 1974, the Regional Advisory Group (RAG) reviewed Project #30, Malia Coast Comprehensive Health Center, and approved funding for the three month period of January 1 - March 31, 1974. ... The approval, however, is contingent upon: 1) RMP funds be used only for administrative costs and not for health services costs that are subject to reimbursement through service charges, and 2) the RAG receive detailed monthly reports on the progress of the project.
On January 24, Irene Reed, the program director from HEW, visited Malia and was impressed by the rapid progress and the cooperative effort between the Board and all health agencies. She subsequently approved interim funding for the Center, from February 1 to July 31. The conditions imposed on the Board were the same imposed on them in the November 5, 1973 ultimatum: hiring a competent administrator, completing Board bylaws, and completing policies and procedures (refer to page 43). The funding would be overseen by the Office of Human Resources, but the Board would be closely involved in all policy decisions. On the same day, the national office of RMP notified the Board that they had received RAG's letter of assurance and therefore would release funds retroactive to January 1. These funds would continue until March 31, when the Board would be reviewed.

During February, control of the Center slowly reverted back to the Board, and at the end of the month, the Board selected an interim Center administrator. The interim administrator was expected to routinely manage the Center and perform a "holding action" until the Board completed the HEW conditions and hired the permanent Center administrator. Thus, for the next five months, the following tasks were accomplished:

1. Selecting a permanent Center administrator - The Board submitted the position description written by the project team to HEW, and it was approved. Then, with the help of professionals from the Regional Medical Program (RMP), the Board and interim project director prepared screening criteria, interview guidelines, and rating sheets—all of which would standardize their selection process. They then advertised the position in Honolulu and New York newspapers, and received 64 applications. Twelve applicants met the minimum screening requirements and two, who were both non-residents of Malia, were chosen as final candidates. The Board interviewed both, found one acceptable, and offered him the position. He declined, however, because the salary was unacceptable. The Board began the entire process again, and out of 50 applicants, selected Donald Dell, who was experienced in health planning and health administration. He was approved by HEW and became the permanent Center administrator in June 1974.

2. Completing Board bylaws - Board bylaws were completed in June 1974 by a committee composed of two lawyers, several Board members, and several health professionals. One of the lawyers also helped satisfy HEW's requirement of obtaining professional Board members by becoming a member himself. The committee structured the Board as a legal corporation conforming to HEW conditions. The bylaws were also revised to delineate the membership of the corporation and to provide for the regular election of 12 Board members from the general membership. Three Board directors would be appointed by cooperating health agencies.

3. Completing a Board Policies and Procedures Manual - Completing the manual was such a complex task, that the Board needed the assistance of MEDICUS, a national firm that assisted family health centers in correcting their administrative problems. MEDICUS consultants gave the Board a model of recommended policies in February 1973, and the Board appointed a committee to work on the manual. MEDICUS consultants then returned in April, reviewed the committee's draft and recommended that the Board hire a
consultant to complete the final draft. The Board hired a consultant, who finished the final draft in May. When completed, the final draft provided comprehensive organizational policies and procedures for the Board, and delineated standing committees and their relationship to Center administration. The manual also made it clear that the Board was the general policy-making body of the Center; but once policy was made, it would be implemented and administered by Center management. The Board would have to work out in practice their actual relationship with the Center administrator, but the parameters between policy-making and administration were clear.

While the Board was working on these tasks, medical operations at the Center proceeded smoothly, and the medical staff felt that they received adequate administrative support. The actual medical operations were facilitated by the new clarity in administrative authority. The interim project director, though working closely with the Board, performed all administrative functions. He coordinated all activities and prepared the Center for support systems, such as outreach, pharmacy, X ray, and lab analysis. Implementation, however, would have to wait until the permanent administration began.

The only real problem was the lack of space at the emergency unit. The emergency unit was supposed to have housed all health operations temporarily, but it had become the major facility because the previous administrative problems had prevented funding agencies from approving construction of the primary care unit. It would still take two years to complete all arrangements for the new unit. Until then, the cramped quarters in the emergency unit would be barely tolerable. This, however, was an unavoidable situation.

In June 1974, the permanent Center administrator, Donald Dell, officially assumed his position: he first completed the 1975 HEW budget request and then submitted it to the Comprehensive Health Planning Agency (CHP) and HEW. CHP approved the request after meeting with the Board. Staff members from the HEW regional office decided to visit the Center to see how it was functioning and asked CHP to organize a special meeting of Honolulu agency representatives, health care providers, and the Board. At the meeting, the agencies testified that their working relationships with the Board had improved and cooperation was mutually beneficial to themselves and the Center. The Board articulated the problems they had in completing the prepaid health plan, but also knowledgeably outlined a strategy to overcome these problems. Their working relationships with the agencies also made it easier for them to complete the plan. After hearing this testimony, HEW approved 1975 funds for the Center.

With this approval, the Board was again in charge of Center policy, but now functioned with explicit procedures, had a definite structure, and possessed no administrative authority over Center operations. Although many administrative issues still confronted the Center, these would have to be resolved by the new administrator, Dell. The Board was no longer responsible for the day-to-day issues, as it had been in the past. The transition to normal administration was complete.
V. EVALUATION AND REFINEMENT

Evaluation and Follow-up

Since all funding agencies intended that the Malia Coast Comprehensive Health Center be an ongoing organization, they continually monitored Center activities, but did not evaluate the Center as a project with a definable lifespan. This section represents the first step in evaluating the life cycle of the project, and also recounts the ways the permanent administrator used to surmount these problems to keep the Center operational.

The Time Frame of the Project

The project formally spanned five years--from March 1969, when the Program Concept was formulated, to June 1974, when the Center was transferred to permanent administration. From beginning to end, the project failed to meet major deadlines (refer to Table 2). No project phase was finished on schedule; and cumulative time overruns so exceeded the deadlines that the Board decided to open the Center before completing the prerequisite activation tasks. This decision eventually culminated in the temporary shutdown and reorganization of the Center. As a result, the Center was handed over to normal administration about a year late, without the specific goals and objectives having been executed.

To analyze the dramatic events of December 1973 and the inability to complete the goals and objectives the project must be viewed in total perspective.

Formulation: The Birth of the Health Center's Problems

By virtue of being both a community facility intended to serve residents and a professional clinic expected to conform to national medical standards, the health Center inherently created tension between residents and health professionals. The residents demanded that the Center be managed in accordance with local needs; health professionals demanded that the Center be managed in accordance with national guidelines. The basic philosophy of the health Center then--a facility intended to serve the community and, at the same time, to stand above it--established the potential for conflict over control.

Exacerbating this inherent tension was the intense feeling of "community" within Malia, which made residents antagonistic toward outsiders who tried to exercise authority over Malia's affairs. This sense of community was especially applicable to the health Center because residents had actively participated in identifying and gaining support for it through their grass-roots initiatives and through the CAP and Model Cities efforts. Residents looked upon the health Center as their project. Thus, before the project began, residents were committed to resident control.
Table 2

THE TIME FRAME OF THE PROJECT

<table>
<thead>
<tr>
<th>Project Phase</th>
<th>Starting Date</th>
<th>Scheduled Completion Date</th>
<th>Actual Completion Date</th>
<th>Time Overrun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formulation</td>
<td>-</td>
<td>-</td>
<td>March 1969 (Program concept formulated)</td>
<td></td>
</tr>
<tr>
<td>Design</td>
<td>June 1970</td>
<td>June 1971</td>
<td>June 1974</td>
<td>4 years</td>
</tr>
<tr>
<td>Activation</td>
<td>January 1972</td>
<td>July 1972</td>
<td>June 1974</td>
<td>2 years</td>
</tr>
<tr>
<td>Implementation</td>
<td>July 1972</td>
<td>July 1973</td>
<td>(Not completed until 3 years after handover to permanent administration)</td>
<td>3 years 5 months</td>
</tr>
<tr>
<td>Total lifespan as a project</td>
<td>March 1969 (Program concept formulated)</td>
<td>July 1973</td>
<td>June 1974 (Date of handover to permanent administration)</td>
<td>1 year</td>
</tr>
</tbody>
</table>
Another problem inherent in the establishment of the health Center was the complexity of multiple funding. The Center had to obtain funding from numerous sources. This meant that numerous conditions would be imposed upon the project; and inevitably some of the conditions would create conflicting priorities. For example, conflicts occurred because a Model Cities condition gave top priority to hiring Malia residents, but an HEW condition required highly qualified professional administrators to implement the Center. Although these two conditions were not necessarily contradictory, the lack of professional health administrators in Malia, combined with the residents' feelings toward outsiders, made the priority conflict inevitable.

During formulation, these problems were recognized, and, in fact, the Program Concept recommended that the Center be implemented through a cooperative effort among community organizations, professional health providers, and all funding agencies. The Program Concept, however, did not foresee the intensity of resident feeling nor did it accurately assess the great difficulties inherent in multiple funding. Thus, although these problems were discussed, their deep-rootedness and their critical long-term implications were never emphasized as the fundamental obstacles to project success.

Design: The Time to Develop Mechanisms to Resolve Problems

The major flaw of the design--stemming partly from the formulation's lack of emphasis on the inherent problems of the health Center--was inadequacy. Three major areas of the design were inadequate. First, the Board and project director never anticipated the complexity of multiple funding and thus never devised detailed administrative provisions for complying with the numerous funding conditions, for clarifying the funding agencies' overlapping jurisdiction, for rescheduling the time delays in receiving approval, or for handling the large amount of negotiation.

Second, the Board and project director did not anticipate the complexity of operating the health Center. They prepared no detailed plans for conducting statistical research, for coordinating the integrated system of health delivery, or for establishing the requirements of special training programs. Most important, they developed no administrative procedures. Personnel qualifications and duties were unspecified; formal methods for resolving impasses were non-existent; and the functional relationship between the Board and Center administrator was unresolved.

Third, the Board and project team omitted the major objective of developing a community organization capable of guiding the policy of the Center. Subsequently the Board omitted goals, such as the establishment of a rigorous training program to give the Board basic competency in setting health policy, or the preparation of ongoing programs to raise the Board's awareness of complex health issues.

A major factor causing the design's inadequacies was the Board's desire to ensure resident control of the Center. Since the Board represented residents, it could ensure resident control by maximizing its
own authority over the Center and by preventing outsiders from having any input in Center policy decisions. Consequently, the failure to complete detailed plans for multiple funding and the failure to plan for the technical problems of implementation reflected the Board's inability to do all the planning—and its refusal to let outside experts help. After all, allowing outsiders to help would give them an opportunity to gain control of the Center.

The design's lack of policies and procedures reflected the Board's insistence on conducting business as a resident organization, which meant conducting business informally, without established procedures. The reluctance to develop procedures also reflected the Board's attempt to maximize its control of the Center in so far as formal procedures would delineate the Board's authority and thereby limit its discretionary power over the Center. Finally, the Board could not make the development of its competence an objective because this would raise doubts about the Board's ability to guide the Center. Since such doubts would jeopardize the Board's authority, the Board was unwilling to acknowledge that expertise in health planning and administration was necessary to establish Center policy.

Another major factor in the design's inadequacies was Wayne's inability to provide strong project leadership. Although Wayne recognized the problems of the design, he did not actually confront the Board. He urged the Board to correct the design inadequacies—especially the lack of policies and procedures—but he was not forceful. He did not fully assert himself and thus could not use the full range of his expertise to arrive at some amicable compromises with the Board. Moreover, he was unable to convince the Board that cooperation with outside professionals was essential.

Again, it must be emphasized that the full impact of resident control had never been fully addressed during formulation; thus, in the absence of forceful leadership, the Board could not foresee the problems that absolute resident control would entail.

Selection and Approval: Another Chance to Scrutinize the Problems

The selection and approval stage of the project introduced the complexities of multiple funding and thus highlighted some of the omissions of the design. The numerous funding conditions from HEW, Model Cities, and Regional Medical Program (RMP) created considerable confusion and led to conflicting priorities, which the Board neither planned for nor possessed the expertise to resolve. In addition, the deadlines that the Board and project team had initially set had to be postponed since the funding negotiations took much longer than anticipated. These problems, however, should really have been worked out during the design stage.

A major deficiency during selection was the failure of the funding agencies to insist upon an overall feasibility study. Although informal assessments cast serious doubts on the Board's competence and the Center's feasibility, no formal assessment was conducted. Nonetheless, the project was selected partly because of the urgency to build the Center and partly
because the funding agencies assumed that numerous funding conditions would remedy any problems.

**Activation and Organization: A Last Chance for Correction**

 Activation afforded the Board and Johnson a last chance to correct any deficiencies in the design and to complete all detailed planning. After beginning implementation, basic deficiencies and oversights could be corrected only at high costs and with long delays.

 During activation, the Board and Johnson never corrected the design's inadequacies. In particular, Center administrative policies were never drawn up. Without the formal policies and procedures, the project could not be effectively organized since: 1) no dependable mechanisms for resolving impasses existed; 2) no operational continuity and clarity could be established; 3) no clear-cut assignment of responsibilities could be made; and 4) no clear authority for project decisions could be determined.

 The project's organizational structure reflected this confused situation. In lieu of explicit policies or procedures, the project was organized with overlapping internal jurisdiction. The project director administered the Center. But the Board, retaining conflicting interests, both administered the Center and established Center policy.

 Organizational structure external to project operations similarly lacked clear definition. The Board was accountable to three different funding agencies, but made no attempt to clarify and coordinate the overall relationships between and among itself and the agencies. Because the federal structure was exceedingly complex with offices on national, state, and local levels, the interrelationships of all agencies and the Board had to be clearly determined in order to secure and coordinate the necessary support from all offices.

 Unfortunately, rather than spend additional time to clear up the organizational confusion and to complete all planning, Kahele, Johnson, and the Board decided to implement the project. And this decision resulted in a project that was insufficiently prepared for implementation.

 It is significant to note that the organizational confusion and the lack of policies and procedures stemmed from the basic underlying issues of resident control. Thus, while the decision to begin implementation was prematurely timed, it was also a way to avoid the fundamental conflict of resident versus professional control. In this respect, Johnson and the Board failed to realize that the conflict could not be avoided indefinitely--only postponed until implementation.

**Implementation: The Consequences of Unresolved Problems**

 During implementation, the issues that had been created earlier became critical problems. Work on project activities came to a virtual
standstill because the lack of administrative procedures caused uncertainty in carrying out routine tasks. The Board and Kahele were in constant dispute with the project director because of the confusing organizational structure. Multiple funding not only bogged down the project in a morass of red tape, but also made it difficult for the Board to determine which funding agency—if any—had primary authority. The Board and Kahele's desire to retain control of the Center prevented them from cooperating with health professionals, as well as made them intransigent in dealing with the funding agencies. Moreover, the desire of the Board to retain control made them extremely defensive, and isolated them from anyone who questioned their decisions. Finally, Kahele's lack of expertise, which the Board never considered to be vital, prevented him from carrying out the Center's goals and objectives.

From this perspective, the dramatic events of December 1973—although directly related to Johnson's lack of forceful leadership and Kahele's lack of competence—reflected the consequences of problems that were never resolved throughout the project's life cycle. It is useful to relate all these problems to specific project activities. Thus, as the final step in evaluation, the degree of success in achieving the specific goals and objectives are analyzed and followed up. (Refer to the design for the Center beginning on page 32.)

Evaluation, Analysis, and Follow-up of Goals and Objectives

1. Implementing a prepaid health plan. During the course of the project, a prepaid health plan was never implemented, let alone designed. Three crucial administrative failures were responsible. First, the Board had never completed an administrative procedures manual that delineated who possessed what project authority or responsibility. Therefore, Kahele, as Board president assumed responsibility for all project activities; and he constantly interfered in Johnson's dealings with outside health providers. This interference prevented Johnson from reaching cooperative working agreements in offering the plan's services.

Second, after Johnson resigned, the Board appointed a project director who lacked the expertise to draw up the plan. Although adequate data was available, Kahele was unable to define the precise services required for the plan or to estimate its cost.

Third, Kahele was unable to negotiate with health care providers for their services in offering the plan. Health care providers were willing to participate in the plan, but only if they could be guaranteed of the administrative integrity of the Center. The providers felt that administrative integrity could be achieved if the Board hired a more professional project staff, as well as developed policies and procedures. The Board and Kahele, however, were unwilling to compromise on or even discuss these issues. Given their inflexibility, there could be no negotiation.

In December 1976, long after the transition to normal administration, Donald Dell, the permanent Center administrator, implemented the prepaid
health plan. In developing the plan, he discovered a major substantive obstacle. The prepaid health plan depended upon large businesses or commercial enterprises that would provide a base clientele. Malia, however, had no large employers, and therefore no target population. Instead, Malia had a large population of medicard and other medical assistance recipients, who would be the plan's primary users. Consequently, marketing and guaranteeing the financial viability of the plan would be extremely difficult.

Upon realizing the problem, the permanent Center administrator contacted HEW and made arrangements for HEW funding to be awarded under a category of health center funding, which did not require the implementation of a prepaid health plan. Having eliminated the funding deadline for developing a plan, the Center administrator was able to cooperate with the Hawaii Medical Service Association and formulate a workable plan.

Significantly, administrative problems had prevented Kahele and the Board from even discovering the substantive issues. Once the administrative problems were resolved, the Center administrator was able to work on the real obstacles and complete the plan.

2. Enrolling 4,000 residents in the plan by the first year. During the course of the project, administrative problems prevented the completion of the prepaid health plan; consequently it could not be marketed. When the plan was finally drawn up in December 1976, it was competently evaluated and a new marketing goal was set: By the end of the fiscal year (October 1977), enroll in the plan 200 residents.

The new goal of only 200 clients, although realistic, was a far cry from the ambitious goal of 4,000 clients. However, the reason for initially setting such a high marketing figure was to achieve the Center's financial self-sufficiency. And the Center did become increasingly self-supporting from patient revenue. As indicated in Table 3, the Center expected to generate 65 percent of its own financial needs by 1978.

3. Providing 24-hour emergency care. Kahele and the Board were unable to implement around-the-clock emergency service because they could not recruit enough physicians to work at the Center. Normally, health facilities recruited physicians through an informal statewide network of health agencies, which provided the names of doctors who were interested in beginning a practice or in relocating. The Comprehensive Health Planning Agency (CHP) was especially helpful in passing on information, since it was in contact with health facilities throughout the state. Kahele and the Board, however, were never interested in cooperating with the outside agencies. They refused to cooperate because this would "open the door" for outsiders to gain influence over the Center. Moreover, Kahele was untactful and even abrasive in his dealings with the CHP chairman; he therefore had a deplorable relationship with CHP. As a result, Kahele seldom communicated with any of the health agencies and did not receive enough information to recruit a complete staff of doctors.
Table 3
CENTER OPERATING COST

<table>
<thead>
<tr>
<th>Date</th>
<th>Operating Cost</th>
<th>Percent Federal Support</th>
<th>Other</th>
<th>Percent Center-Generated Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973</td>
<td>-</td>
<td>Cannot be determined because books unauditable</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1974-1975</td>
<td>$408,064</td>
<td>85%</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>1975-1976</td>
<td>$1,017,507</td>
<td>44%</td>
<td>33%</td>
<td>23%</td>
</tr>
<tr>
<td>1976-1977</td>
<td>$1,179,301</td>
<td>50%</td>
<td>6%</td>
<td>44%</td>
</tr>
<tr>
<td>1977-1978</td>
<td>$1,384,717</td>
<td>35%</td>
<td>0%</td>
<td>65%</td>
</tr>
<tr>
<td>(Projected)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Center Records

Following the transition to normal administration, the permanent Center administrator coordinated efforts with outside agencies and was able to recruit physicians. Additionally, he hired an experienced medical director who helped develop the support requirements and the schedule necessary to offer 24-hour emergency service. Nonetheless, the service was not implemented until November 1975—more than two years past the deadline.

4. Guaranteeing clientele participation in Center policy decisions. During the course of the project, the Board failed to involve clientele in Center policy decisions. Only one Board election was held, that in 1970; and residents were able to directly address the Board only during the rare public hearings, which were held to satisfy the Board’s funding requirements. As the project progressed, the Board became increasingly insulated and felt it could not relinquish control of the Center until operations were proceeding routinely. The Board, moreover, began to grow inflexible and defensive about its decisions, particularly its decision to unquestioningly support Kahele. Thus, although the Board initially intended to involve residents in Center decisions, it slowly isolated itself as the Center’s sole policy-making body.

As a routine matter, the project director should have held regular community meetings at which residents had open access to Board members. This relatively simple task seemed a prerequisite both to ensure community support and to achieve the goal of resident participation. Unfortunately the project director failed, from the outset of the project, to open
regular channels of communication between the Board and residents. This made it difficult, if not impossible, for the Board to obtain clientele participation once implementation began.

After the transition to permanent administration, the Board realized that its isolation was a major deficiency, and it attempted to involve residents in Center policy decisions. To stimulate clientele participation in the Center, Board members developed an information brochure, which they distributed to the community. Board members also held informal talks with community organizations to discuss the changes at the Center; and they initiated a membership drive. Finally, in June 1975, an open membership meeting was held, at which the new Board members were elected. At this point, the Board scheduled regular membership meetings and elections.

5. Providing jobs and training for residents. The Board and Kahele intended that the Center become a major employer of residents; and they therefore spent considerable time and energy initiating training programs. In 1972 they sponsored training for outreach workers, laboratory assistants, and medical aides at Kapiolani Community College. Kahele, however, was unable to provide jobs at the Center because he could not get outside health care providers to cooperate with him in expanding Center services. Without this expansion, he could not justify hiring the new trainees. When he did begin to expand services in late 1973, his disagreements with the funding agencies made Center income too uncertain to employ them.

In addition to disappointing the residents’ hopes for employment, Kahele and the Board also failed to institutionalize ongoing training programs to increase the basic technical skills of the staff. The same problems that hindered employing the trainees also hindered initiating the follow-up programs. The constant threat of losing funds prevented the scheduling of any programs; the lack of cooperation with outside health care providers made it difficult to arrange regular trainings; and the numerous funding conditions made Kahele too busy to plan training activities.

After the transition to normal administration, the permanent administration clarified all funding arrangements with HEW and made continuous funding certain. He was also completely open and willing to work with outside health professionals and was thus able to secure their support. As a result, he was able to establish ongoing training programs in cooperation with the University of Hawaii's School of Medicine and School of Public Health, and the Duke University School of Medicine. Finally, his obtaining the cooperation of health care providers and his ensuring the receipt of HEW funding enabled him to effectively expand medical services. By 1977, the Center employed 51 persons; most were residents who had graduated from the training programs.

Significantly, the accomplishment of a few routine administrative tasks—securing the cooperation of health agencies, opening effective channels of communication with the funding agencies, and clarifying all funding arrangements—would have made this goal achievable during the course of the project.
6. Expanding the Outreach Program. Approximately 12 residents had been trained as outreach workers in 1972, but Kahele could employ only two until he consolidated the administration of the Center's on-site health operations. Since the administration of the main services was never solidified until the project's end, the outreach program was not expanded.

After consolidating the operations, the permanent Center administrator was able to spend time on the outreach program. He budgeted funds for outreach workers and hired them. Then, he coordinated their efforts internally, as well as coordinated their efforts externally with community groups and other health providers. This resulted in cooperative outreach efforts, such as the Early and Periodic Screening, Diagnosis, and Treatment, which was a program sponsored in conjunction with the state's Department of Health to promote preventive health care, and the Special Olympics Program, sponsored together with the City and County of Honolulu to promote physical activities for handicapped youths.

7. Coordinating services with outside health care providers. The key goal for the achievement of Center success was the coordination of efforts with key health groups and health care providers, such as the Comprehensive Health Planning Agency, the Regional Advisory Group, the state Department of Health, and the Hawaii Medical Service Association. Two components were necessary to coordinate services with these groups: 1) the willingness to cooperate with them and 2) the willingness to be flexible. Cooperation was necessary simply to be able to work with them. And flexibility was necessary to reach agreements. In this context, the whole essence of reaching an agreement is to compromise so that a mutually beneficial exchange can be worked out. In the case of the Center, however, Kahele and the Board were unwilling to cooperate or compromise because the health agencies and health care providers posed a threat to the Board's dominance of Center policy. Moreover, as the project progressed, Kahele and the Board become increasingly rigid; and their inflexibility made it impossible to reach agreements on coordinating services.

In contrast, the permanent Center administrator was flexible, less threatened, and even anxious to cooperate with the health care providers. Thus, after the transition to normal administration, he was able to work out agreements to coordinate services with the key groups. Additionally, the working relationships that he established with these groups helped him to secure the help of specialists, such as a psychologist, an internist, a cardiologist, and a urologist.

The overall objective of the project was to make adequate medical care available to all residents. During most of the course of the project, administrative problems, such as the inability to recruit physicians and the unwillingness to cooperate with support groups, interfered with the availability of medical services and actually led to the temporary closing of the Center. Moreover, the administrative problems detracted from the overall quality of medical services by disrupting support from allied health care providers and by preventing the expansion of services. Nonetheless, primary medical care was provided throughout most of the project's
life cycle; over 5,000 patient visits were made to the Center before the transition to normal administration.

In the immediate period after the transfer to permanent administration, no professional evaluations nor patient opinion surveys of the adequacy of medical care were conducted. However, the number of patients using the Center does provide an indirect indicator of adequacy. If medical care were adequate—from the clients' viewpoint—then the clients would return, and would pass on by word of mouth their satisfaction. Thus, if medical care at the Center were adequate, one would expect the numbers of return patients to steadily increase, and the numbers of new patients to progressively increase. In Table 4, this trend was apparent for the first three years, 1974-1977.

Table 4
GROWTH OF PATIENT UTILIZATION
(monthly average)

<table>
<thead>
<tr>
<th>Year</th>
<th>New Patients</th>
<th>Return Patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1974-1975</td>
<td>143</td>
<td>706</td>
<td>849</td>
</tr>
<tr>
<td>1975-1976</td>
<td>201</td>
<td>1,050</td>
<td>1,251</td>
</tr>
<tr>
<td>1976-1977</td>
<td>300</td>
<td>1,380</td>
<td>1,680</td>
</tr>
</tbody>
</table>

One indicator of the availability of medical care is the proportion of residents that used the Center. By the end of 1977, a total of 45,000 patient visits were made to the Center. This represented about 12,000 residents or about 40 percent of the Malia population; thus from the standpoint of numbers the Center was extremely successful.

But the availability of medical services for residents cannot be evaluated solely in terms of numbers. The accessibility of the Center's medical services must also be scrutinized. And, from an economic perspective, the Board has progressed in making medical services accessible to all residents. The prepaid health plan was made available to residents; and a sliding fee-scale, which charged clients according to their income, was instituted. The Board also expanded the Center's outreach program by increasing the time that workers spent in the community and by working on a system of transportation for clients who had no means to get to the Center.

Nonetheless, there is still much that can be done to increase the quality and availability of the Center's medical services. And, from this perspective, the project's initial objective has become the continuing objective of the Center.
Some Policy Implications

Although the case history has raised many health-related issues, the problems in implementing the Center were created not by substantive health issues, but by basic managerial oversights that could have hindered any project. These oversights can be generalized as the following four policy issues for project management:

First, project management must be comprehensive. The project manager must be familiar with the project in its entirety. Although he cannot be an expert in every aspect of the project, he must be a generalist. He must know enough of the technical detail of all project tasks to make knowledgeable decisions, such as when and how to use temporary experts. And he must know enough of the administrative aspects of the project to deal effectively with personnel, organization, and support groups. This necessitates that the project manager be familiar with every project phase.

In addition, the project manager must completely prepare the project for implementation. Comprehensiveness means completeness. Not everything can be foreseen, but those activities and circumstances that can be foreseen must be completely planned in advance. In addition, some procedures must be worked out to resolve special contingencies.

Second, project management must be integrative. During the course of the project many different groups perform different tasks, and it appears that the groups and tasks are independent. But all groups and tasks are interrelated. It is the job of the project manager to bring together, to coordinate, and to fit together the work of all these groups, in a manner that assures a coherent and a unified project. To accomplish this, the project manager must open channels of communication between and among himself and each group. This means he will have to willingly cooperate with the designers, the funding agencies, technical specialists, and all other groups involved in the project. Although this cooperation may be difficult to obtain, integration is vital to the project.

Third, project management must be flexible. The project manager will face many situations in which he must make trade offs. Often he must compromise and negotiate in order to ensure the completion of the project's most important goals. Unless he is flexible, he will be unable to arrive at any satisfactory resolution of the necessary compromises.

In addition, the project manager will face many unforeseen obstacles. To deal effectively with these obstacles he must be willing to adjust to changing situations. Although, as much as possible, he must adhere to the plans and schedule, sometimes it is counterproductive to do so. Thus, the project manager must be willing to adjust his plans. In this respect, planning is continuous; and project managers cannot become intransigent or fixed in their positions.

Fourth, project management demands leadership. The project manager must deal with a broad range of issues: the needs of the many support groups, the demands of the funding agencies, the sudden unforeseeable
obstacles, and the changing situations. All of these issues, and many more, become critical during implementation. And the project manager must make crucial decisions. Moreover, he must convince others to cooperate in carrying out these decisions. This requires strong and steadfast leadership. Thus, the project manager cannot provide bureaucratic skills alone—he must also provide the necessary leadership that is crucial to the project's success.
FOOTNOTES


4 M. Myers, A Community Profile Study on Oahu CAP Target Areas, Community Action Program, Honolulu, 1968.

5 Ralph H. Conway, Hospital Consultant and Associates, Work Program for a New Hospital for the Leeward Area, Oahu, State of Hawaii Department of Accounting and General Services, Honolulu, 1968.


7 From the Articles of Incorporation of the Board.

8 All documents to the Regional Medical Program are on file, as required by federal statutes requiring public disclosure. Because the specific references compromise identity, however, only the general information of date and organization will be included in the following footnotes.

9 From the federal applications from the Board to the Department of Health, Education, and Welfare, requesting Federal Funds.


11 From the Model Cities grant proposal agreements, July, 1972.

12 From the Regional Medical Program grant agreements, October, 1971.


14 Ibid.

15 From the Model Cities liaison agency, the City Demonstration Agency, March, 1972.
16 Ibid.
17 Ibid.
19 Ibid.
20 Letter from the Comprehensive Health Planning Council to the Board, April, 1973.
21 Letter from the Family Health Center Coordinator--San Francisco to the Board, April, 1973.
22 Ibid.
24 Continuation award agreement from Regional Medical Program to the Board, November, 1973.
GLOSSARY OF SIGNIFICANT ORGANIZATIONS

Community Action Program (CAP). A federal government community development program under the administrative branch of the Department of Housing and Urban Development (HUD).

Comprehensive Health Planning (CHP) Advisory Council. The Hawaii organization that officially advises the CHP Agency on all health matters.

Comprehensive Health Planning (CHP) Agency. The agency responsible for overall health planning in the State of Hawaii.

Comprehensive Health Planning (CHP) Review Committee. The committee that conducts the investigations for the CHP Advisory Committee's recommendations and decisions.

Department of Health, Education and Welfare (HEW). The federal government department responsible for the health, education and welfare of all individuals in the United States.

Department of Housing and Urban Development (HUD). The federal government department responsible for the welfare of metropolitan development in the United States.

Hawaii Medical Service Association. The only company in Hawaii that offers state-wide prepaid health insurance.

Honolulu County Medical Society. A non-profit professional society for doctors in Honolulu.

Malia District Comprehensive Health and Hospital Board, Incorporated (Board). The non-profit corporation of Malia residents established to improve health care in Malia.

Malia District Neighborhood Planning Committee (MDNPC). The resident planning organization, required under Model Cities grants, to review Malia's proposals to Model Cities.

Model Cities. The special federal program that provides grants to poverty-designated neighborhoods for development projects. Model Cities is under the administrative branch of HEW.

Office of Economic Opportunity (OEO). The federal government's anti-poverty program. It is under the administrative branch of HUD.

Office of Human Resources. The City and County of Honolulu office that administers Model Cities grants.

Planning, Evaluation, and Implementation Committee (PIE). The committee that conducts on-site investigations of the grants that RMP makes.
Regional Medical Program (RMP). The federal government office that awards grants to upgrade the quality of medical care. RMP is under the administrative branch of HEW.

Regional Advisory Group (RAG). The decision-making body of each state RMP.
SUGGESTED DISCUSSION QUESTIONS

THE MALIA COAST COMPREHENSIVE HEALTH CENTER

1. How was the project identified? How did the way in which the project was identified affect its formulation? What factors must a project manager consider when a project is identified through grass roots initiative?

2. During the formulation of the project, were all goals and objectives clearly stated? What were the goals and objectives? Did the formulators make assumptions that were evident to the project's designers?

3. If you were in Wayne's place, how would you have dealt with the Board's insistence on using the architectural documents and the Program Concept? Would you have insisted on any conditions? If so, how would you have forced the issues?

4. What factors were important in gaining the funding approval for the Center? How did these factors affect the project's subsequent implementation?

5. What are the differences between a project that has been identified, formulated, and designed through a centralized process and one that has gone through a decentralized process? What are the implications for the project manager?

6. If you were in Johnson's place—a newcomer to a project which had been going on for some time—how would you have dealt with the Board? Would you have insisted on taking a more active role in the project? How?

7. If you were Kahele, how would you have responded to the funding agencies? Discuss or list possible techniques of negotiation.
THE EAST-WEST CENTER—officially known as the Center for Cultural and Technical Interchange Between East and West—is a national educational institution established in Hawaii by the U.S. Congress in 1960 to promote better relations and understanding between the United States and the nations of Asia and the Pacific through cooperative study, training, and research. The Center is administered by a public, nonprofit corporation whose international Board of Governors consists of distinguished scholars, business leaders, and public servants.

Each year more than 1,500 men and women from many nations and cultures participate in Center programs that seek cooperative solutions to problems of mutual consequence to East and West. Working with the Center's multidisciplinary and multicultural staff, participants include visiting scholars and researchers; leaders and professionals from the academic, government, and business communities; and graduate degree students, most of whom are enrolled at the University of Hawaii. For each Center participant from the United States, two participants are sought from the Asian and Pacific area.

Center programs are conducted by institutes addressing problems of communication, culture learning, environment and policy, population, and resource systems. A limited number of "open" grants are available to degree scholars and research fellows whose academic interests are not encompassed by institute programs.

The U.S. Congress provides basic funding for Center programs and a variety of awards to participants. Because of the cooperative nature of Center programs, financial support and cost-sharing are also provided by Asian and Pacific governments, regional agencies, private enterprise and foundations. The Center is on land adjacent to and provided by the University of Hawaii.