CRMP's Seven-Year March Toward Medical Regionalization

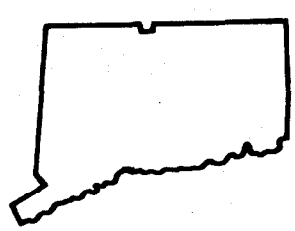
Special Grant Request for May-June, 1973

"Phase-Out" Grant Request for July 1, 1973—February 15, 1974

Connecticut Regional Medical Program

Connecticut Regional
Medical Program

272 George Street
New Haven, Conn. 06510
(203) 772-0860



CONNECTICUT REGIONAL MEDICAL PROGRAM

CRMP'S SEVEN-YEAR MARCH TOWARD MEDICAL REGIONALIZATION

SPECIAL GRANT REQUEST FOR MAY - JUNE 1973

"PHASE-OUT" GRANT REQUEST FOR JULY 1, 1973 - FEBRUARY 15, 1974

March 15, 1973

VOLUME I

SUMMARY EDITION

VOLUME II

DETAILED BUDGET REQUEST

A companion volume to the Summary Edition which contains detailed program and budget information

Connecticut Regional Medical Program
272 George Street
New Haven, Connecticut 06510

(203) 772-0860

VOLUME I

SUMMARY EDITION

CONTENTS

THE MIDDLETOWN PRESS
The home newspaper of the Southern Connecticut Valley
472 MAIN STREET MIDDLETOWN, CONN. 06457 • 347-3331

Russell G. D'Oench, Jr.
Editor

March 15, 1973

Harold Margulies, M.D.
Director
Regional Medical Programs Service
Health Services and Mental
Health Administration
Parklawn Building
5600 Fishers Lane
Rockville, Maryland

Dear Dr. Margulies:

I am writing to comment on the functioning of the Connecticut Regional Medical Program (CRMP) since my last letter of November 1, 1972; to discuss the reaction of the CRMP Advisory Board to President Nixon's budget message of January 29, 1973, which calls for a rapid phase-out of Regional Medical Programs; to describe CRMP's tentative plan of action in the circumstances; and to transmit two grant requests to "phase-out" CRMP which have been developed in the context of your instructions of February 1 and 22, 1973. One of these grant requests covers activities during May - June, 1973 and a second covers terminal activities during the July 1, 1973 - February 15, 1974 period.

With regard to the functioning of CRMP since our report of November 1, 1972, it is pertinent that the Advisory Board has met three times since that date and the Executive Committee four times. The last meeting for both bodies occurred on March 8, 1973. In addition, all members of the CRMP Executive Committee and many other members of the Board participated extensively in the two-day site visit by RMPS which was conducted on December 13-14, 1972, at the request of CRMP. Furthermore, all of the approximately 60 program elements currently being supported by CRMP submitted written progress reports on January 29, 1973, and an up-to-date evaluation of the effectiveness of those activities has been carried out. That evaluation was made by the CRMP Review and Evaluation Committee, augmented by fourteen members of the Advisory Board (including five CHP (b) Agency designees), during February 1973. The detailed approach to this evaluation is set forth in a letter of March 6, 1973 to me from Chairman Howard Levine which is contained in this Report. The full results of this month long evaluation process were presented in a preliminary form to the Advisory Board on February 27 and in a final form on March 8. They contributed heavily to the official Board decisions which are reflected in this Report.

In summary, the recent CRMP review activity confirmed the fact that the vast majority of CRMP-supported activities are making outstanding contributions to the health and welfare of the citizens of Connecticut. A few need some fresh stimulus and help from CRMP and three were recommended for termination of CRMP support on April 30. As a part of the discussion at the Advisory Board meeting of March 8 six members of the CRMP Review and Evaluation Committee--all prominent members of the Connecticut health community--made statements about the impact of CRMP on the Connecticut health scene. Their observations were considered so cogent that they are included in this report.

CRMP is convinced that Connecticut needs a continuing coalition agency of health providers and community spokesmen which has the expertise to recommend health policy and which has the capability to stimulate and help activate programs across organizational lines to meet the larger health needs of the people of the State.

CRMP is fully prepared, therefore, to continue and grow as a major constructive influence in the health affairs of Connecticut during the whole of 1973-74, through the implementation of the plan-of-action set forth in its grant request of November 1, 1972. That over-all plan was strongly reaffirmed by the recent round of CRMP review, since the modifications proposed related to details, not to the basic program. In this connection, too, CRMP was pleased to receive, on February 22, 1973, a "draft advice letter" from RMPS, stemming from the RMPS December site visit and subsequent review. Your letter gave, overall, strong endorsement to the CRMP program, offered suggestions as to priorities of program implementation, and indicated that the National Advisory Council had approved a funding level of $2,332,820 (direct costs) for 1973-74. This would be a substantial increase over the current level of funding.

Against this background, CRMP has felt dismay at President Nixon's budget message of January 29, 1973 calling, among other things, for a rapid phase out of Regional Medical Programs. Our dismay has deepened with the passing weeks as the dialogue between the National Administration and Congress on the role of the federal government in the health field has unfolded, revealing a dichotomy in points of view and an inadequate plan on the part of the Administration for meeting the health needs of the American people.

I have been instructed by the CRMP Board "to make a vigorous protest to Mr. Caspar Weinberger, Secretary of HEW, and to the Regional Medical Programs Service on the plan and on the time schedule for phasing out Regional Medical Programs." I make that protest now to RMPS and wish to stress the following points:

A. CRMP cannot judge to what degree the 56 RMPs across the United States have been ineffective, as charged by the Administration. CRMP is well aware, however, that the functions assigned to RMPs by the Administration have often been vague and have undergone repeated revision since enactment of PL 89-239 in 1965; that the funds made available to RMPs have been constantly fluctuating and

uncertain; that the problems in health care delivery which are now being addressed by RMPs are the most central and difficult health issues facing the American people; and that the leadership needed to staff and guide RMPs did not exist in 1965 but had to develop through experience. In the light of these circumstances the performance to date of many RMPs across the country has been commendable and the performance of some RMPs, including CRMP, has been outstanding.

B. In the CRMP view, the national Administration has not suggested any realistic leadership force as an alternative to Regional Medical Programs to work for top quality medical care to all citizens in an efficient way. No convening agency, other than RMP, has been proposed to bring together the various components of the health delivery system to work collectively for the ends mentioned. Perhaps the federal Administration is looking to state governments to fill the vacuum--drawing, possibly, on revenue sharing funds. If this be so, there are many uncertainties relating to the facts that legislation in this field has not been developed; that revenue sharing funds assigned to the states may not be large enough or made available for the task; that to date few states have shown any inclination to assume responsible leadership in this field; that there is a dearth of leadership in state governments to develop and guide such programs; that the tooling up phase would take several years; and that the Administration's plan of action to phase out RMPs would eliminate the only real source of expertese, forthwith, rather than preserving it as a resource on which to build a new approach.

C. CRMP is deeply concerned with the precipitous phase-out for RMPs called for in the Administration's present time schedule. CRMP has an outstanding record in stimulating new programs which have become permanent fixtures on the Connecticut scene. CRMP staff have contributed greatly to securing matching money and sources of permanent financing for many projects--as set forth in detail in the "Summary Edition" of the CRMP Progress Report of November 1, 1972. Yet many program activities have to reach a point of maturity, or "proving themselves", before sources of permanent financing are willing to invest. The short time between President Nixon's announcement of a planned phase-out of RMP support and the date of stopping funds is not sufficient for some CRMP supported activities to gain an alternate source of financing—though CRMP staff will make a valiant effort in coming weeks to be helpful in this regard. Yet the net effect of the precipitous "phase-out" may well be substantial waste of public money through the demise of some activities which are not mature enough to survive.

D. There is another reason to be concerned about the rapid phase-out plan. Most CRMP supported programs have emerged from study and planning activities in local communities which often cover a period of months, occasionally years, before the program itself gets under way. The study and planning time is used to develop local understanding of a health problem and a consensus about a solution.

When this local "base building" is done thoroughly, the launching of the program itself usually proceeds smoothly and the success of the program is reasonably assured. The precipitous curtailment of RMP which is proposed by the federal Administration means that many plans-in-the-making, some near maturity, will not be implemented. This represents, again, waste of time, emotional input and money of many people and the dashing of hopes for a resolution to long existing health problems.

In view of the total situation being discussed here, the CRMP Board recognizes three possibilities in charting current CRMP activity.

First, the Board recognizes that, despite President Nixon's present plans to phase-out RMPs, Congress may well pass legislation and authorize appropriations to continue RMPs beyond the terminal date currently set and that, for various reasons, there may be an acceptance of this continuation by the Administration. In that event, as previously stated, CRMP has a complete plan of action ready for implementation during 1973-74.

Second, the Board recognizes that President Nixon's plan for phase-out may well prevail and it has taken action to "authorize and support a full exploration of ways to continue CRMP through special funding from (a) foundations, (b) state government, (c) various federal agencies or (d) some combination thereof." After the current period of program review and decision making are complete and this report is submitted CRMP will turn to that exploration.

Third, the Board recognizes the need to comply fully with the RMPS requests of February 1 and 22 for a complete phase-out plan. This report is devoted largely to the presentation of such a plan, though, as has been true of all other CRMP Progress Reports to RMPS, it is also designed to serve the additional purpose of an official report to over 2,500 people who represent the primary constituents of CRMP throughout Connecticut.

The following pages, therefore, focus on four topics:

A. There is a presentation of "CRMP's Seven Year March Toward Medical Regionalization." This discusses the developments to date of CRMP's central thrust, which has been to create two networks of interlocking institutions and programs in Connecticut, with each of the two university health centers serving as hubs. In the CRMP view if these two systems are fully activated a high probability exists that top quality health care can be made available to all the citizens of Connecticut in an efficient way.

B. There is a presentation of CRMP's "Special Grant Request for May - June, 1973" which is designed to extend CRMP's present fiscal year ending April 30, to the end of the federal fiscal year, which terminates June 30. CRMP has been advised by RMPS that a sum of $264,157 (direct costs) is available for the May - June period.

This is substantially less than the level of funding currently available and also substantially less than the level recommended by the National Advisory Council for 1973-74--so, all CRMP supported activities are programmed for reductions, looking toward the completion of CRMP support on June 30 with very few exceptions.

(C) There is a presentation of CRMP's "Phase-Out Grant Request for July 1, 1973 - February 15, 1974" which projects a step-by-step plan for termination of all RMPS support for CRMP activities.

(D) And, as previously mentioned, there is a summary of the recent activity of the augmented CRMP Review and Evaluation Committee, along with assessments of CRMP's impact on the Connecticut health scene by six prominent citizens of Connecticut.

One program and funding situation deserves special mention here. On June 8, 1972 you notified CRMP that RMPS was giving "three year approval, in the amounts requested" to assist in the operations of the Connecticut Institute for Health Manpower Resources, Inc. Subsequently the funds to cover the three years were transferred to Connecticut. CRMP feels it made a firm commitment to that agency, that funds are on hand to cover that commitment and, thus, CRMP is making no special request for that agency in this report.

As you can tell from the above, CRMP faces a very busy schedule in the weeks ahead. We hope the federal Administration's plans to phase-out RMPS, as described in your telegram and letter, will change but we recognize that any change that occurs may not come until late spring. In the meantime CRMP staff and Board leadership will be seeking funds from a variety of sources to keep the central elements of CRMP alive and to finance many of the ongoing program elements on a permanent basis. In this connection, you will recall that prior to President Nixon's budget message of January 29 Dr. Henry Clark resigned as Director of CRMP effective May 1, 1973. At that point Mr. Edward Morrissey, Associate Director, will become Acting Director. I am pleased to report that Dr. Clark has agreed to remain with CRMP as a Senior Consultant for a three-months period beginning May 1 in order to assist in the critical transitional activities of that period.

If you have questions about any of this report, Dr. Clark, Mr. Morrissey and I will be pleased to comment.

Sincerely yours,

Russell D'Oench, Jr.
Chairman
CRMP Advisory Board

/lp

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration

GRANT APPLICATION

REGIONAL MEDICAL PROGRAM

LEAVE BLANK – FOR HSMHA USE ONLY

Project Identification Number

Administering Component	Major Program Categories	Serial Number	Year of Support	Supplement Number

Administrative Codes

HSMHA Programs	Type of Program	Type of Application	Resubmittal

Program Data

TO BE COMPLETED BY APPLICANT

1. TITLE OF PROJECT (OR PROGRAM) *(Limit to 53 spaces)*

CONNECTICUT REGIONAL MEDICAL PROGRAM

2. NAME AND ADDRESS OF APPLICANT *(Street Number, Street Name, City, County, State or Country, ZIP Code)*

Yale University
155 Whitney Avenue
New Haven, Connecticut
06510

CONG. DISTRICT
3

3. EMPLOYER'S IDENTIFICATION NUMBER

IRS #06-0646973

5. PROJECT PERIOD (TRIENNIUM)

FROM *(Mo., Day, Yr.)*	THROUGH *(Mo., Day, Yr.)*
January 1, 1972	December 31, 1974

6. BUDGET PERIOD

FROM *(Mo., Day, Yr.)*	THROUGH *(Mo. Day, Yr.)*
May 1, 1973	June 30, 1973

7. AMOUNT REQUESTED FOR

a. BUDGET PERIOD $ 330,078
(Include Indirect Costs)

4. DIRECTOR OF PROJECT *(Program or Center Director, Coordinator or Principal Investigator)*

NAME *(Last, First, Middle Initial)*

☐ Mr.
☐ Miss
☐ Mrs. CLARK, HENRY T. JR., M.D.
☐ *(Specify)*

TITLE

DIRECTOR

DEGREE	SOCIAL SECURITY NUMBER
M.D.	116-20-4129

ADDRESS *(Street Number (or Box Number), Street Name, City, State (or Country), ZIP Code)*

272 George Street
New Haven, Connecticut
06510

8. FINANCIAL MANAGEMENT OFFICIAL

NAME *(Last, First, Middle Initial)*

☐ Mr.
☐ Miss
☐ Mrs. WASSERMAN, JOEL A.
☐ *(Specify)*

TITLE

Manager, Grants & Contracts
Financial Administration

ADDRESS *(Street Number (or Box Number), Street Name, City, State (or Country), ZIP Code)*

Yale University
155 Whitney Avenue
New Haven, Connecticut
06510

OFFICE TELEPHONE *(Area Code, Tel. No., Extension)*

OFFICE TELEPHONE *(Area Code, Tel. No., Extension)*

PROJECT IDENTIFICATION NO.

ASSURANCES AND CERTIFICATIONS BY APPLICANT

The following assurances and certifications are part of the project grant application and must be signed by an official duly authorized to commit and assure that the applicant will comply with the provisions of the applicable laws, regulations, and policies relating to the project.

The applicant hereby assures and certifies that he has read and will comply with the following:

Title VI–Civil Rights Act of 1964 (PL 88-352) and Part 80 of Title 45, Code of Federal Regulations, so that no person will be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the grounds of race, color, or national origin.

Patents and inventions (Current PHS Policy Statement) under which all inventions made in the course of or under any grant shall be promptly and fully reported to HEW.

Specific assurances, policies, guidelines, regulations and requirements in effect at the time the grant award is made and applicable to this project (including the making of reports as required and the maintenance of necessary records and accounts, which will be made available to the Department of HEW for audit purposes) which are contained and listed in the grant application package and made a part hereof.

GNATURES - Use Ink.	*Autographic signature of Official authorized to sign for applicant and Project Director or other person(s) authorized to sign in their behalf.*	
PPLICANT NO. 1 *(Name only)*	Yale University	
DIRECTOR OF PROJECT	*(Signature only)* Henry T. Clark Jr. Henry T. Clark, Jr., M.D.	DATE *(Mo., Day, Yr.)* March 15, 1973
OFFICIAL AUTHORIZED TO SIGN FOR APPLICANT	SIGNATURE Lewis Thomas.	DATE *(Mo., Day, Yr.)* March 15, 1973
	NAME *(First, middle initial, last)* AND TITLE ☐ MR. ☐ MRS. ☐ MISS ☐ *(Specify)* Lewis Thomas, M.D. Dean, Yale University School of Medicine	DEGREE M.D.
COMPLETE FOR RMPS ONLY	SIGNATURE OF CHAIRMAN OF ADVISORY GROUP Russell G. D'Oench, Jr.	DATE *(Mo, Day, Yr.)* March 15, 1973

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration

GRANT APPLICATION

REGIONAL MEDICAL PROGRAM

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Project Identification Number

Administering Component	Major Program Categories	Serial Number	Year of Support	Supplement Number

Administrative Codes

HSMHA Programs	Type of Program	Type of Application	Resubmittal

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155 Whitney Avenue
New Haven, Connecticut
06510

CONG. DISTRICT: 3

3. EMPLOYER'S IDENTIFICATION NUMBER

IRS #06-0646973

4. DIRECTOR OF PROJECT *(Program or Center Director, Coordinator or Principal Investigator)*

NAME *(Last, First, Middle Initial)*

☐ Mr.
☐ Miss
☐ Mrs.
☒ (Specify)

CLARK, HENRY T. JR., M.D.

TITLE

DIRECTOR

DEGREE	SOCIAL SECURITY NUMBER
M.D.	116-20-4129

ADDRESS *(Street Number (or Box Number), Street Name, City, State (or Country), ZIP Code)*

272 George Street
New Haven, Connecticut
06510

OFFICE TELEPHONE *(Area Code, Tel. No., Extension)*

5. PROJECT PERIOD (TRIENNIUM)

FROM *(Mo., Day, Yr.)*	THROUGH *(Mo., Day, Yr.)*
January 1, 1972	December 31, 1974

6. BUDGET PERIOD

FROM *(Mo., Day, Yr.)*	THROUGH *(Mo. Day, Yr.)*
July 1, 1973	February 15, 1974

7. AMOUNT REQUESTED FOR

a. BUDGET PERIOD $ 459,782
(Include Indirect Costs)

8. FINANCIAL MANAGEMENT OFFICIAL

NAME *(Last, First, Middle Initial)*

☒ Mr.
☐ Miss
☐ Mrs.
☐ (Specify)

WASSERMAN, JOEL A.

TITLE

Manager, Grants & Contracts
Financial Administration

ADDRESS *(Street Number (or Box Number), Street Name, City, State (or Country), ZIP Code)*

Yale University
155 Whitney Avenue
New Haven, Connecticut
06510

OFFICE TELEPHONE *(Area Code, Tel. No., Extension)*

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Patents and inventions (Current PHS Policy Statement) under which all inventions made in the course of or under any grant shall be promptly and fully reported to HEW.

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GNATURES - Use Ink. *Autographic signature of Official authorized to sign for applicant and Project Director or other person(s) authorized to sign in their behalf.*

PPLICANT NO. 1 *(Name only)*
Yale University

DIRECTOR OF PROJECT	*(Signature only)* Henry T. Clark Jr. Henry T. Clark, Jr., M.D.	DATE *(Mo., Day, Yr.)* March 15, 1973
OFFICIAL AUTHORIZED TO SIGN FOR APPLICANT	SIGNATURE NAME *(First, middle initial, last)* AND TITLE ☐ MR. ☐ MRS. ☐ MISS ☐ *(Specify)* Lewis Thomas, M.D. Dean, Yale University School of Medicine	DATE *(Mo., Day, Yr.)* March 15, 1973 DEGREE M.D.
COMPLETE FOR RMPS ONLY	SIGNATURE OF CHAIRMAN OF ADVISORY GROUP Russell G. D'Oench, Jr.	DATE *(Mo, Day, Yr.)* March 15, 1973

CONNECTICUT REGIONAL MEDICAL PROGRAM

272 George Street

New Haven, Connecticut 06510

Telephone: 772-0860

Henry T. Clark, Jr., M.D.
Director

March 15, 1973

CRMP'S SEVEN-YEAR MARCH TOWARD MEDICAL REGIONALIZATION

Introduction and Brief History

The basic objective of the Connecticut Regional Medical Program (CRMP) is to promote the delivery of the best possible medical care to all 3,000,000 citizens of Connecticut in the most efficient way. In order to reach that objective CRMP developed in 1968, as a first step, a clear set of program goals and a detailed plan of action to reach those goals. This "Grand Strategy" has been set forth in each of recent CRMP Annual Reports to the Regional Medical Programs Service (RMPS). It was last presented in the introduction to "The CRMP Story", a 250-page volume which was a part of the November 1, 1972 Annual Report to RMPS and was widely distributed throughout Connecticut.

It is important here, however, to present again a brief history of CRMP and a statement of its central thrust as background for special grant requests to RMPS for May-June, 1973 and for July 1, 1973- February 15, 1974. This should also be useful information for other agencies which may consider take-over of either the financing or the further promotion of activities which have been catalyzed by CRMP.

The Connecticut Regional Medical Program was activated on July 1, 1966 under the joint sponsorship of the Yale and University of Connecticut Schools of Medicine. In 1968 its program direction was delegated to the Advisory Board, which is currently composed of 48 members who are broadly representative of the public and health interests of Connecticut. Yale University remains the grantee agency.

CRMP stems from the "Heart Disease, Cancer and Stroke" legislation of 1965 (P.L. 89-239). CRMP leaders felt from the outset that the only effective approach to attacking these scourges was to address some basic problems in the organization and delivery of health care in Connecticut. e.g., proper care for residents of the inner city; proper care for the aging, especially in the 250 nursing homes of the state; better linkage between preventive and curative medicine; greater availability and better distribution of health personnel; and attention to the problems created by the high cost of health care.

The issues enumerated are matters in which no single agency or organization -- then as now -- has prime responsibility for leadership. In 1966, therefore, CRMP convened spokesmen for the whole health establishment of Connecticut and organized an 18-month study of the deficiencies in the health delivery system. CRMP provided staff support to nine task forces which involved about 200 Connecticut citizens. Research backup was provided by faculty of the School of Public Health at Yale. The plan of action which resulted was submitted to Washington on March 1, 1968 as CRMP's first "Request for an Operating Grant".

The Central Thrust

The overall strategy of this plan was relatively simple. Based on studies conducted at Yale, the state was divided into 10 health service areas in order to promote local planning and problem-solving. This division of Connecticut was adopted by CRMP, Hill-Burton, Comprehensive Health Planning, the Connecticut Hospital Planning Commission, and other key statewide health planning agencies. CRMP recognized that a local coalition of health and consumer interests in each health service area is desirable to attack various local health problems. It recognized, further, that the CHP (b) agencies, when fully developed, should help serve this purpose, and it proposed to work with and through those agencies when they were well established. CRMP expected that it would take several years to establish effective CHP (b) agencies in all 10 health service areas (several of the [b] agencies are still in an organizational stage in 1973), and felt that some interim mechanisms should be established which could work on selected local problems and which could feed into and support the (b) agency concept as that concept is fulfilled.

In order to stimulate local planning, CRMP challenged each of the 33 short-term general hospitals of Connecticut to look outward from its four walls; to work closely with neighboring general hospitals and other community health agencies and practitioners; to consider community-wide health problems in the inner city, in long-term care, in education of health personnel, in prevention, and in rising costs; and to serve as leadership forces in studying these problems and implementing programs to correct them.

Beginning in 1968, therefore, CRMP proceeded to implement its overall program goals in the following ways:

1. Through the mechanism of CRMP staff visits and small and large conferences -- and with the aid of spokesmen from other key Connecticut agencies and especially the Connecticut Hospital Association -- CRMP sought to persuade the leaders of the medical staffs, trustees and administrators of the 33 short-term, general hospitals of Connecticut to consider transforming their hospitals into true community health centers with significant local outreach activities.

2. Once there was local hospital acceptance of this idea, CRMP helped to make available faculty experts from the Yale and the University of

Connecticut Schools of Medicine to assist local communities to identify and study local problems and to plan solutions. The early consultations by individual faculty members evolved over time into the creation of the CRMP-assisted Community Studies Units at the two universities.

3. In keeping with the CRMP overall plan, too, those community hospitals which met certain criteria became eligible for affiliation with one of the two University Health Centers of Connecticut. These affiliations were designed to foster top quality educational and patient care programs at the community level in a variety of ways. They established the framework for the regional coordination (regionalization!) of many health specialty programs such as high energy radiation, open heart surgery, emergency medical services, kidney dialysis and organ transplant services, library services, blood services and many others. In addition, they presented the universities with valuable new sources with which to round out and expand their own educational and research programs.

4. One central feature of the affiliation agreements has been the joint appointment of full-time chiefs of key clinical services in the community hospital. In the CRMP view, these men should provide needed medical leadership to foster expanded programs of education in the community hospital, to oversee the quality and acope of the hospital's patient care programs, and to develop the hospital's outreach activities. They should also serve as local leaders to help plan and implement programs to coordinate many medical specialty programs on a regional basis.

5. In order to stimulate the development of the two university-community hospital affiliation networks, CRMP has devoted much of its staff time and grant funds to programs which link physicians based in the two settings. However, taking advantage of the expanding affiliation networks, CRMP has also sponsored programs which have linked nurses, pharmacists, dentists and allied health personnel in the university and community settings, looking toward expanding program activities in those fields which will improve the quality, accessibility, and efficiency of patient care for the citizens of Connecticut. In addition, CRMP is currently stimulating some community hospitals and local health departments to coordinate many of their activities toward these same ends.

The Current Stage of Implementation

In early Summary Editions of its Annual Reports to Washington, CRMP discussed program developments on each aspect of its "Grand Strategy". By 1972 this was not feasible since program activities stimulated and/or supported by CRMP had become very extensive and complex. Instead, on

November 1, 1972 CRMP published a 250-page volume -- "The CRMP Story" -- which is a compendium of 91 weekly Newsletters that present detailed program developments from May 1970 to September 1972. Some of the program developments since that time are set forth in Volume II of this March 15, 1973 report. A revised and expanded version of "The CRMP Story" is anticipated for 1974 as one product of a sabbatical year which is in prospect for the present Director of CRMP.

It is pertinent, however, to comment briefly here on the current stage of implementation of the Central Thrust of CRMP.

Since 1968 over 150 studies have been carried out by university Community Studies personnel and other CRMP-supported researchers to assist local health leaders in Connecticut to analyze local health problems and to plan action programs to overcome them; furthermore, the demand and capacity for such studies is growing. Prior to 1968, there were no affiliations between the 33 community hospitals of Connecticut and the two University Health Centers; today 29 community hospitals are affiliated and discussions are in process involving three others. In 1968 there were six full-time chiefs of clinical service in three community hospitals; in March 1973 there were 57 additional chiefs at work (30 being supported, in part, by CRMP) in 20 hospitals. Furthermore, in March 1973 there were 21 joint university-community hospital search committees seeking new chiefs, with seven of these to fill positions in hospitals which had not previously had a full-time chief. The January 1973 progress reports by the 30 CRMP-supported chiefs -- and the subsequent site visits to seven hospitals -- indicated that remarkable progress is occurring in converting community hospitals in Connecticut to true community health centers. And these same reports, plus others from regionally-oriented faculty based in the two University Health Centers, indicated that extensive joint educational, patient care and research activity is developing in many settings in the context of the affiliations. Altogether, a solid base has been built for medical regionalization in Connecticut -- and this represents a very significant accomplishment of CRMP's 1968 program objectives.

Attention should be called at this point to the charts which appear at the end of this statement. They depict the annual growth in the development of the two affiliation networks and in the appointment of full-time chiefs from 1968 to 1973.

Some Other Accomplishments

Several other "accomplishments" of CRMP are less tangible and less subject to measurement. However, they are no less real, and they are very important to the continuing improvement of health services to all the people of Connecticut. The following paragraphs indicate the nature of those "accomplishments".

1. From its beginnings CRMP has sought to transform community hospitals from dormitories in which skilled technical services can be rendered

to the patients of community physicians to social instruments concerned with planning and implementing programs, in conjunction with health practitioners and other health agencies, to meet the total health needs of their communities. In the CRMP view, there has been a remarkable attitudinal change in this direction in about three-fourths of the general hospitals of Connecticut, and some progress in this respect in the other one-fourth.

2. From the beginnings, also, CRMP has sought to persuade the two University Health Centers to become the central elements in an integrated health delivery system serving all the people of Connecticut and, furthermore, to expand some of their teaching and research activities into various community settings. In this undertaking CRMP had strong support from a few faculty members at each university center. However, many more faculty members were wary of the "burden" the universities would be assuming and fearful that the new relationships would produce responsibilities which would dilute the effort of the universities in their traditional roles as teaching and research centers. During the last few years the early faculty advocates of greater university involvement in the community have been joined by many colleagues who have discovered that the community setting, when properly developed, offers expanded opportunities for research and for the training of university students. Other university faculty members have either not been willing to venture into the community or remain skeptical of the benefits to their departmental activities. Overall, however, there has been a substantial attitudinal change toward greater university involvement with community elements.

3. The constructive influence of the individual full-time chief in his hospital and in his community is discussed extensively in other sections of this report. It is interesting to speculate, however, what the collective impact of the chiefs will be, in time, on the medical affairs and medical politics of Connecticut. The Connecticut State Medical Society (CSMS) has, officially, strongly opposed CRMP in its efforts to promote the establishment of the full-time chief system in the community hospitals of Connecticut. In contrast, the majority of the practicing physicians of Connecticut seem to favor the CRMP point of view, in that they have helped to implement various CRMP goals in their own communities, have voted to establish the full-time chief system in 27 hospitals and have participated in the selection of the new chiefs. These chiefs have medical competence, leadership ability and, collectively, a more liberal point of view than that represented by the Council of CSMS. Hopefully, CSMS will involve these men in its affairs and listen to their advice. In any event, CRMP has helped to create an additional source of medical leadership in Connecticut.

4. During the past three years CRMP has created a review mechanism which has proved very competent in assessing the effectiveness of the programs it has supported. Many governmental agencies and foundations have good mechanisms to judge the "promise" of a given program, through

a combination of reviewing a written grant request and of conducting site visits by peers. Few governmental agencies and foundations conduct adequate follow-up examinations, however, to determine if programs are being implemented effectively. Since early 1971 the CRMP Review and Evaluation Committee, made up of 24 distinguished members of the Connecticut health community, has reviewed progress reports from CRMP delegate agencies on at least an annual basis and has sent over 200 site teams to visit programs in operation in their local settings. This overall review has resulted in a few early terminations of CRMP program support, some changes in program direction, and a great deal of stimulus and constructive suggestions to promote more effective program development.

5. Particularly heartwarming to CRMP leadership as an "accomplishment" has been the progressive recognition, since 1966, of CRMP as a creative force on the Connecticut health scene and growing acceptance of its leadership by most local and statewide health agencies. This point is amplified by several of the panelists whose statements of March 8, 1973 are contained in this Report.

6. Perhaps the greatest "accomplishment" of CRMP has been to demonstrate that medical regionalization can work in the United States despite the limited success of past ventures in this field. Using the "carrot and stick" technique and with a great deal of dedication and hard work, a relatively small group of professional and lay leaders, functioning in the public interest, launched a program in 1966 to overcome vested interest, inertia and institutional pride and build the framework for a more effective health care system in Connecticut. Their initial successes brought new converts to help with the task. The collective results of their effort are presented in this report.

Potentials for the Next Three to Five Years

The CRMP Triennial Application which was submitted to Washington on August 1, 1971 projected program developments through 1974. Thus, the following comments, which suggest potentials for program development through 1978, are unofficial and represent only a fragmentary and topical presentation of what "might be". Yet, the examples cited build on the existing program base which CRMP has helped to establish and they are, for the most part, logical extensions of existing programs.

For the months immediately ahead, one objective should be to extend university health center affiliations to the four community hospitals that do not have them now. A corollary of this is to gradually expand the collaborative effort between the University Health Centers and each of 33 community hospitals in the fields of patient care, education of health personnel and research. The presence of two University Health Center-community hospital affiliation networks in Connecticut provides the "skeletal" framework on which to build quality, accessibility and efficiency of health care to all citizens. As collaboration between

specialty services in the university centers and their counterparts in the community goes forward, the program "substance" is added to the "skeletal" framework. The prototypes of these linkages are already developed in the fields of gastroenterology, diabetes, kidney disease, blood services, library services and newborn care. But these systems need to be more fully developed -- and systems involving many other medical specialties have hardly been started.

Another early objective should be to increase the number of full-time chiefs of service in several of the 20 community hospitals in which chiefs are currently functioning; to extend the full-time chief concept promptly to seven additional hospitals where the policy has been approved and search committees are at work; and to stimulate the adoption of the full-time chiefs program in the six remaining general hospitals which have not yet approved the policy. Working with and through the chiefs of service, CRMP should put more emphasis on peer review and the establishment of local standards of quality of care.

In this connection, too, CRMP should assist the chiefs of service and, where appropriate, the CHP (b) Agencies to study local health care problems and, in turn, assist the community hospitals or other appropriate local agencies to implement programs to overcome those problems.

In a related field, CRMP should promote the functioning of the Connecticut Institute for Health Manpower Resources and the Yale Office of Allied Health Manpower to the end that the needs for health personnel in the various health service areas will be determined and local educational consortia developed to train those personnel.

During the next three to five years CRMP should also develop greater liaison with a number of voluntary health agencies in the fields of heart disease, cancer, respiratory diseases, etc. which are well established organizations with a noble history of service in Connecticut. Greater participation in the development of medical regionalization in Connecticut would likely give new purpose to some of these agencies. And part of the costs of some local "outreach" programs could probably be provided by these agencies.

Since 1966 the Connecticut State Commissioner of Health has been intimately involved in directing CRMP affairs. Since 1968 the Commissioners of Mental Health, Welfare, and Community Affairs and the Chancellor for Higher Education have also been members of the CRMP Board. The relationships between CRMP and the several State departments have always been cordial -- but joint program activities between CRMP and those departments have been limited, with a few notable exceptions. CRMP has focused to date mostly on stimulating program developments in the voluntary sector where indeed, most of health care to citizens is given. During the next three to five years, however, CRMP should undoubtedly develop more programs in collaboration with official agencies. For example, CRMP should continue to assist in implementing a statewide program of Emergency

Medical Services, though the prime leadership should be assumed by the State Department of Health. As another example, CRMP might help to catalyze university relationships with some of the state-supported long-term-care hospitals, somewhat along the lines of the university-community hospital affiliations.

Finally, during the next three to five years CRMP should give increasing attention to the costs of health care and, particularly, to financing the basic costs of medical regionalization. A full study is needed to determine what the basic costs of medical regionalization properly are or should be, but they include at least the following: the costs of a central staff (such as the CRMP program staff) which can serve as conceptualizer, convener and catalyst for program development; the costs of two university offices to promote the workings of the affiliation networks; the costs of a research staff which can study the key regional or state-wide health problems; and the provision of some "challenge" funds with which to help launch selected demonstrations of new health programs. Some of these costs of medical regionalization may be obtained from federal grants; some may be obtained from local or national philanthropic foundations, but the basic continuing financing should undoubtedly come from the state. It should be recognized that the activities under discussion are those concerned with promoting an efficient and effective health delivery system for Connecticut. The costs of these activities would very likely be less than one half of one percent of the total annual expenditures on health services in Connecticut. The past functioning of CRMP is a partial indication of what "might be" for the future in this connection.

What Will Remain if CRMP Phases Out?

The CRMP Report of November 1, 1972 to the Regional Medical Programs Service (Volumes I and II) describes a large number of programs which CRMP stimulated and helped finance during the previous six years, which have proven their value and which have become permanently established on the Connecticut scene through alternate sources of financing.

Similarly, this present report to RMPS requests funds to continue several key activities currently being supported by CRMP for several months while permanent financing is being phased in. Included in this category are the Community Studies Unit in the two University Health Centers, the Offices of Regional Activities in the two University Health Centers and five "categorical" regional programs in the fields of gastroenterology, diabetes, kidney disease, emergency medical services and library services.

In addition, and very important, CRMP anticipates most of the university-community hospital affiliations will remain in force. Furthermore, it appears that all of the full-time chiefs currently on hand will be continued by their parent community hospitals. And hopefully, many of the attitudinal changes discussed above will continue if CRMP phases out.

What Will Be Lost if CRMP Phases Out?

If CRMP phases out, as President Nixon proposes, most of the programs projected above for the next three to five years will probably not materialize. The CRMP review mechanism which has contributed in such a major way to program performance -- and the assurance that public funds are well spent -- will cease to function. CRMP staff, who have served as conceptualizers, catalysts and consultants to many program activities, will take other positions. The common meeting ground which CRMP has provided to bring together the various parts of the health establishment of Connecticut to plan and function together in the public interest will disappear. And in the absence of the catalytic effect of CRMP some of the attitudinal changes discussed above may retrogress.

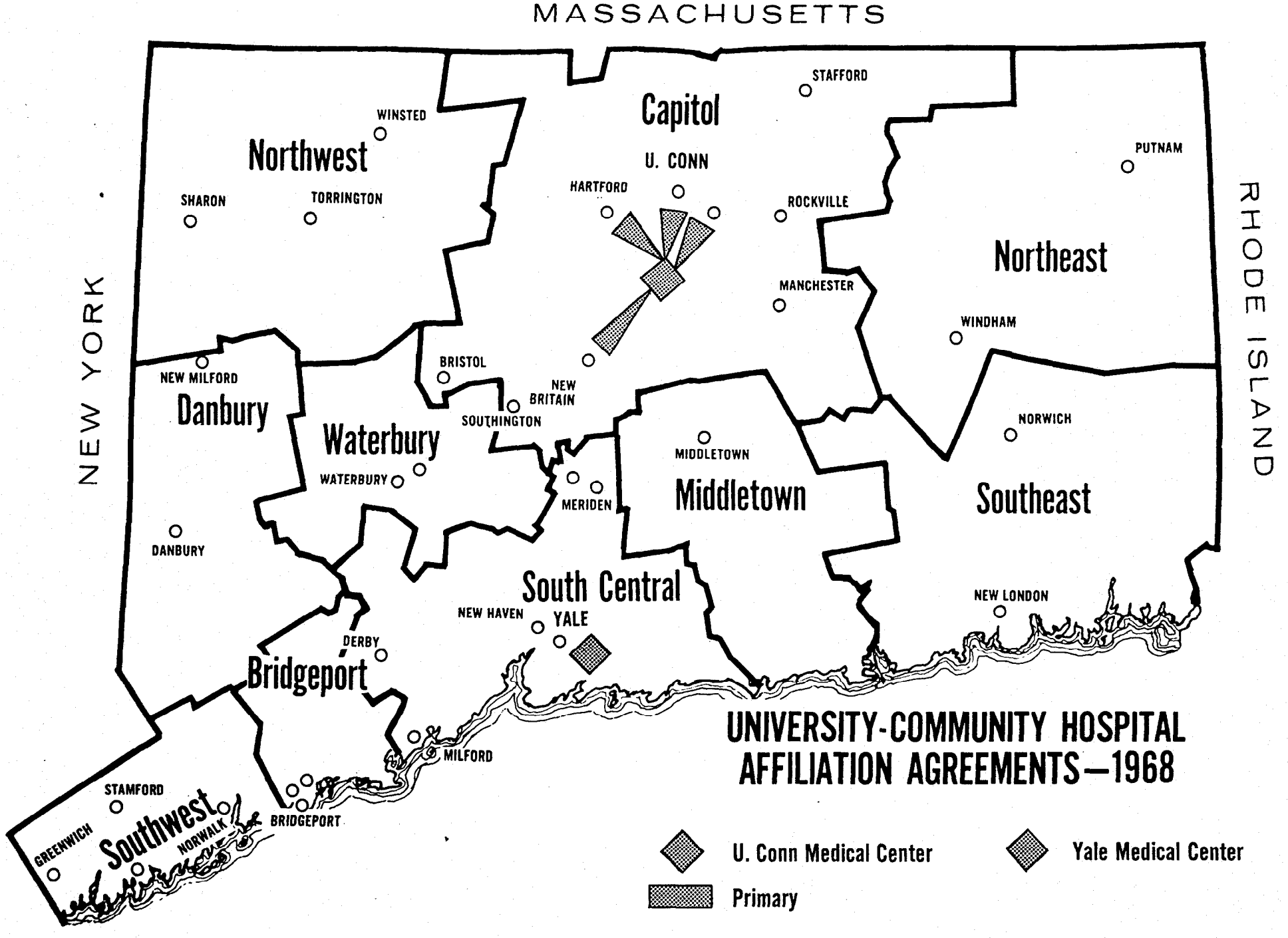
Concluding Comment

On March 8, 1973 six prominent members from the Connecticut health scene who are all members of the CRMP Review and Evaluation Committee, were in invited to present their views to the Advisory Board on the effectiveness of programs currently being sponsored by CRMP and on the impact of CRMP as a whole. Their statements appear in this Report and they amplify the above discussion.

At its March 8, 1973 meeting the CRMP Advisory Board voted to protest to HEW Secretary Caspar Weinberger the Administration's present plans to phase-out federal support for Regional Medical Programs. The Advisory Board voted further to take steps to encourage Congress to continue Regional Medical Programs. The Board also voted to explore possible alternate sources of financing for continuing CRMP, including state government, foundations and federal agencies. CRMP staff is at work on all this but will need the help of Board members, individually and collectively, in the weeks ahead.

Henry T. Clark Jr.

Henry T. Clark, Jr., M.D.
Director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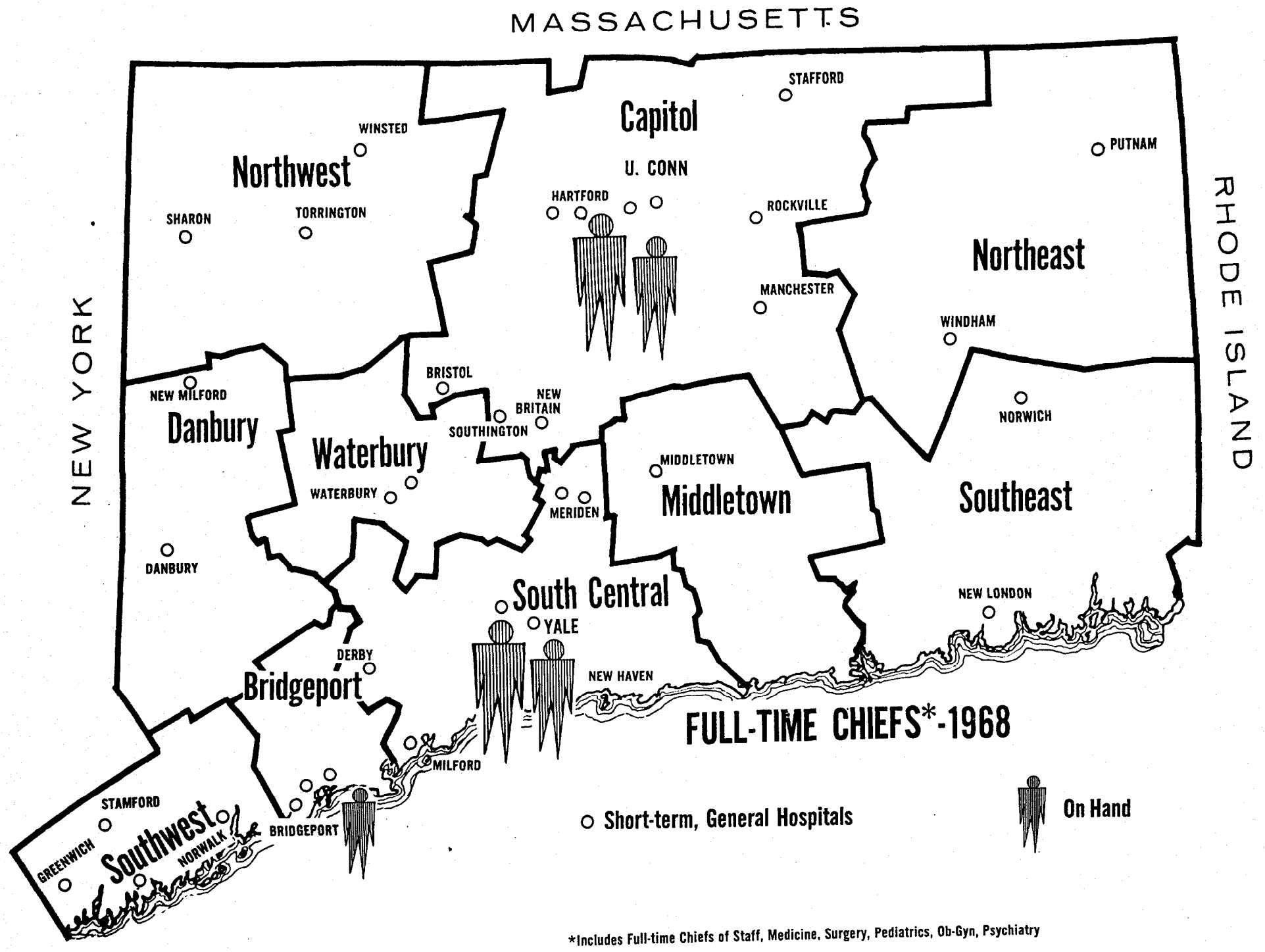

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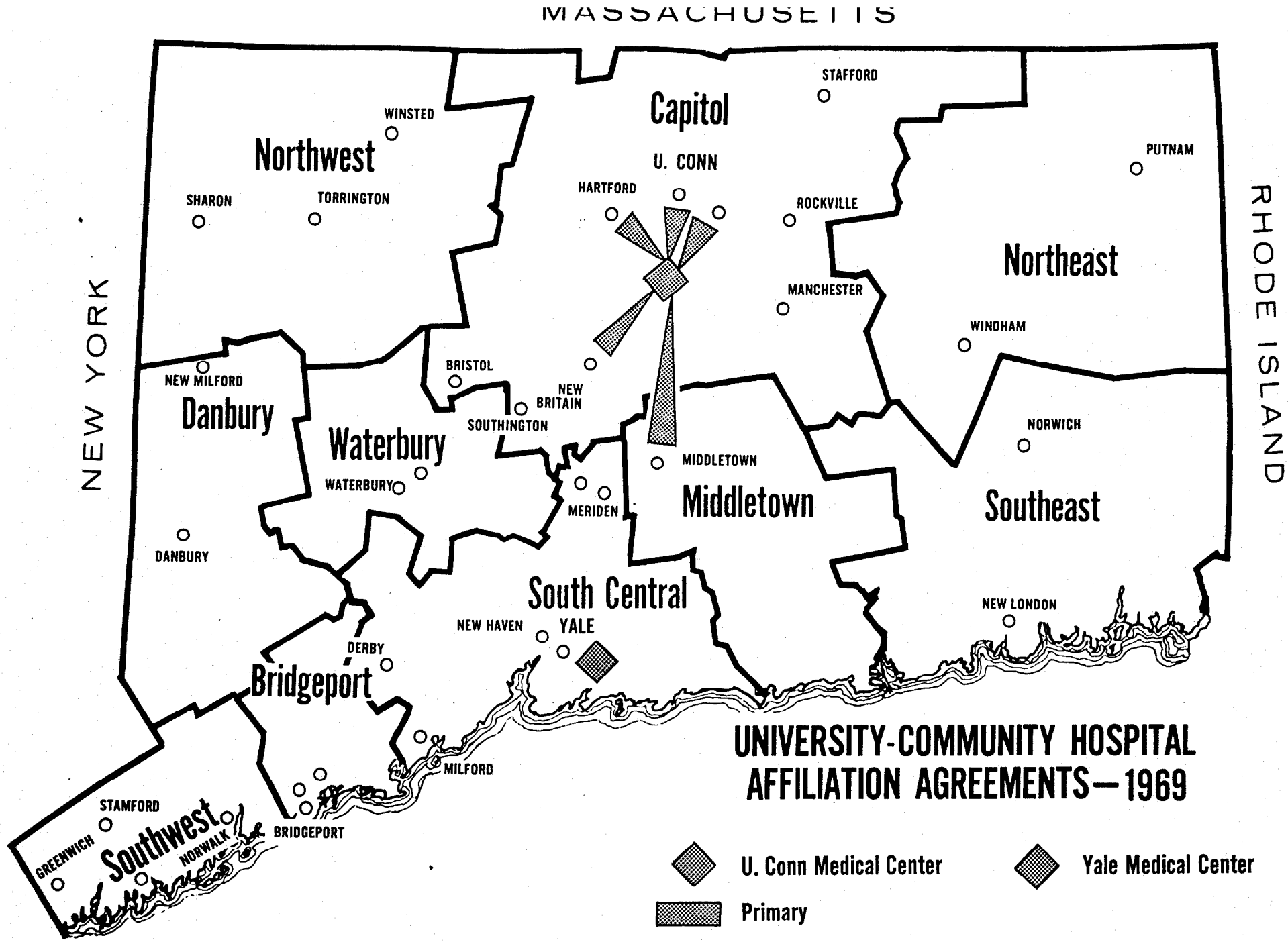
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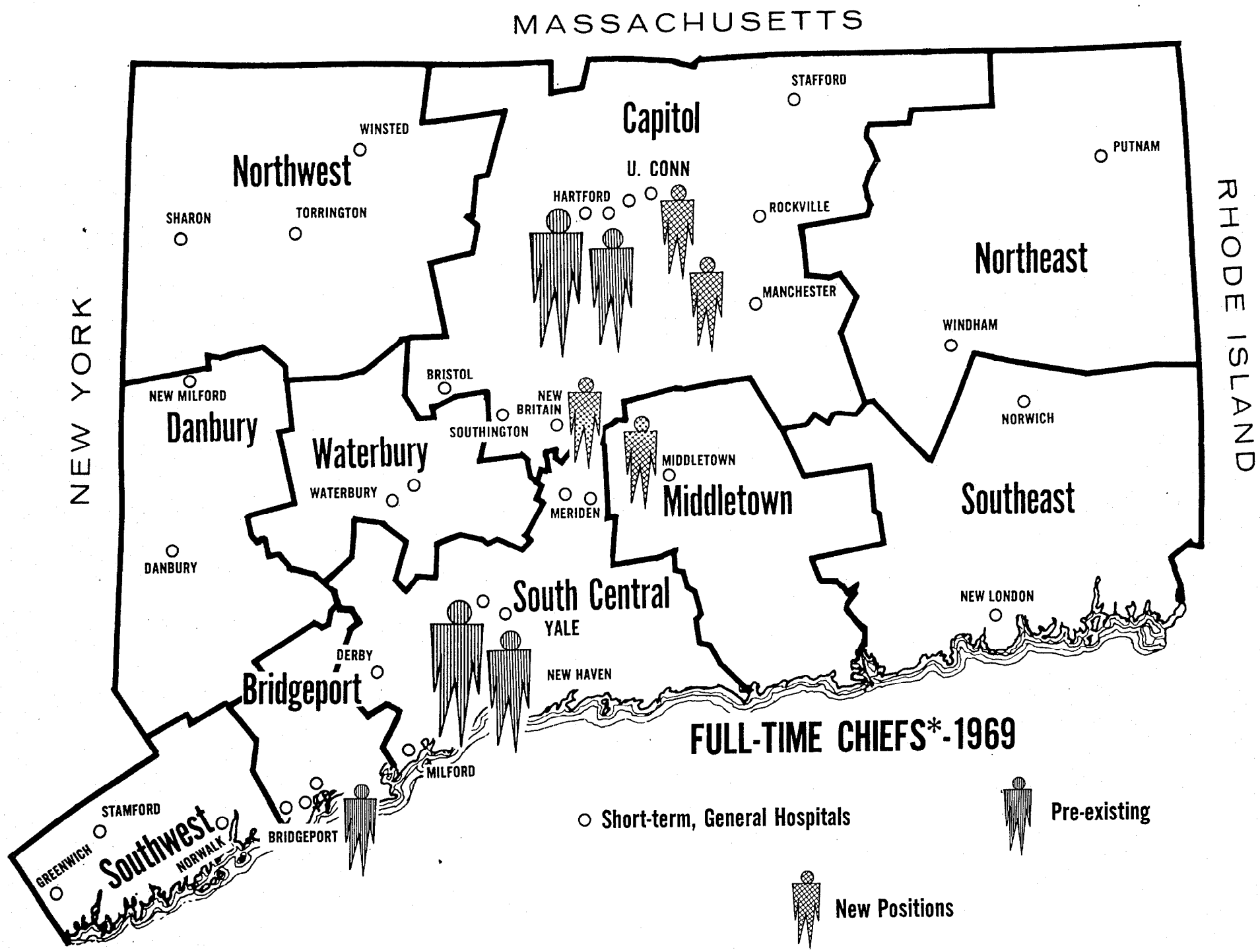

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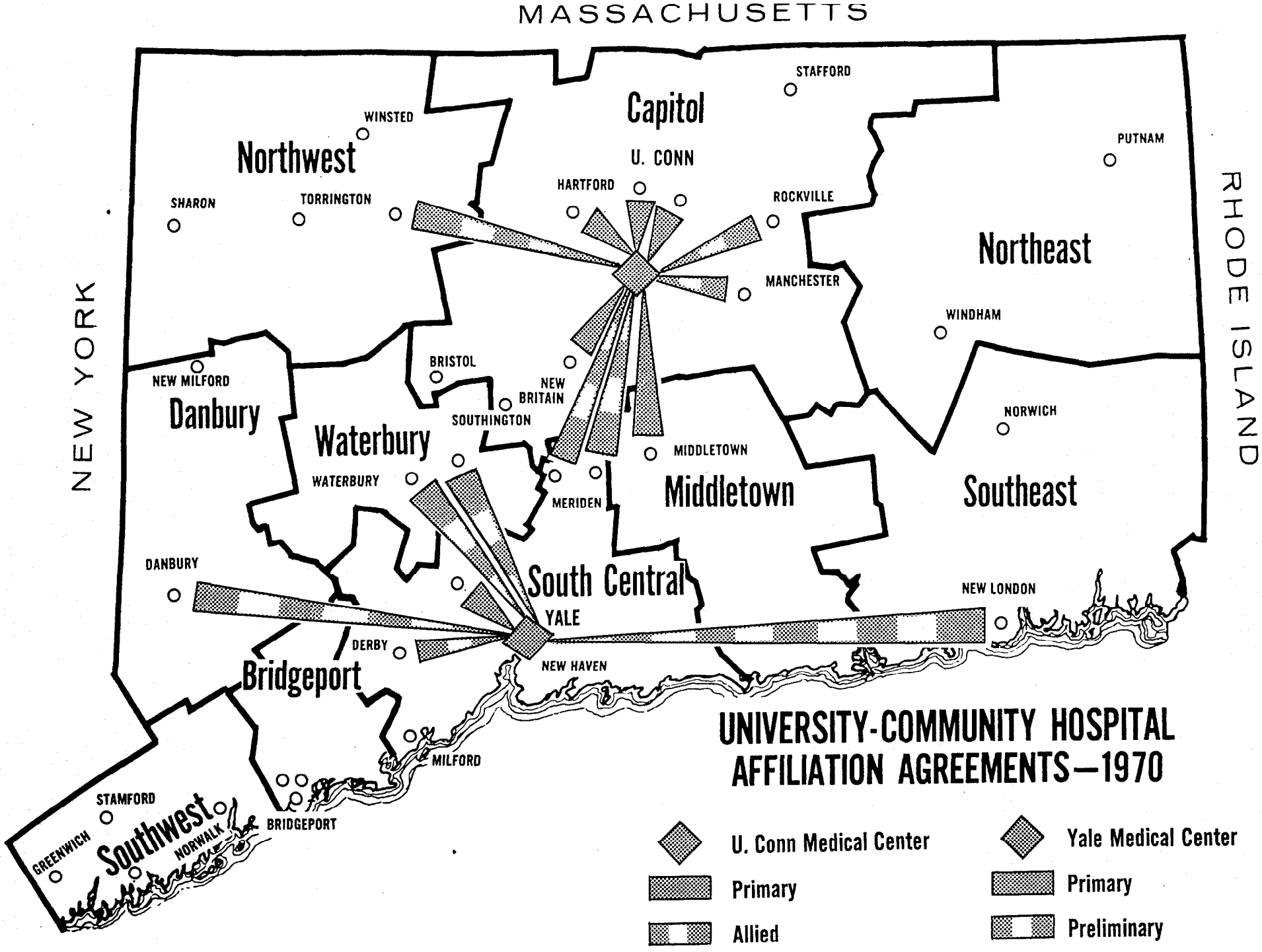
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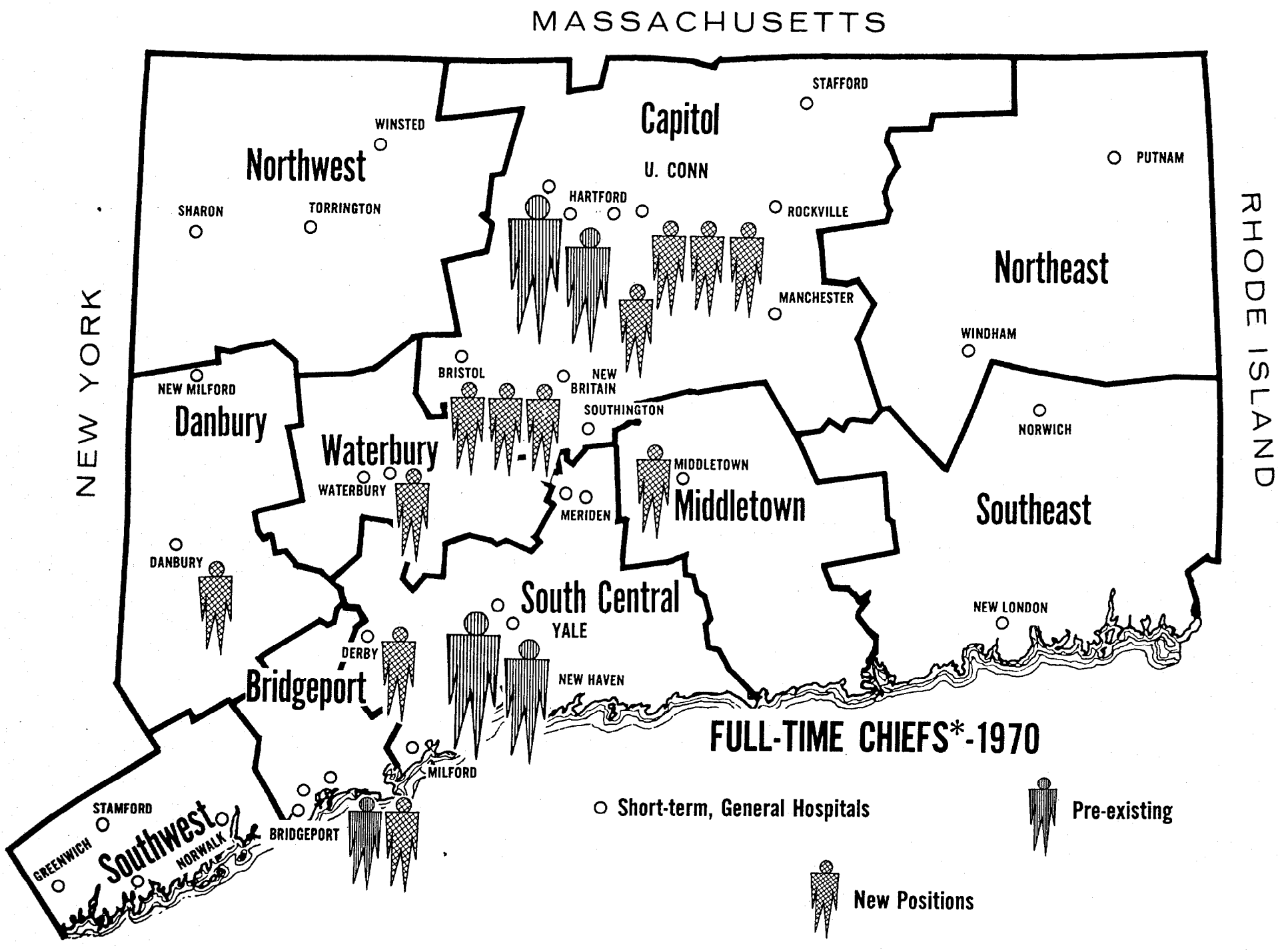

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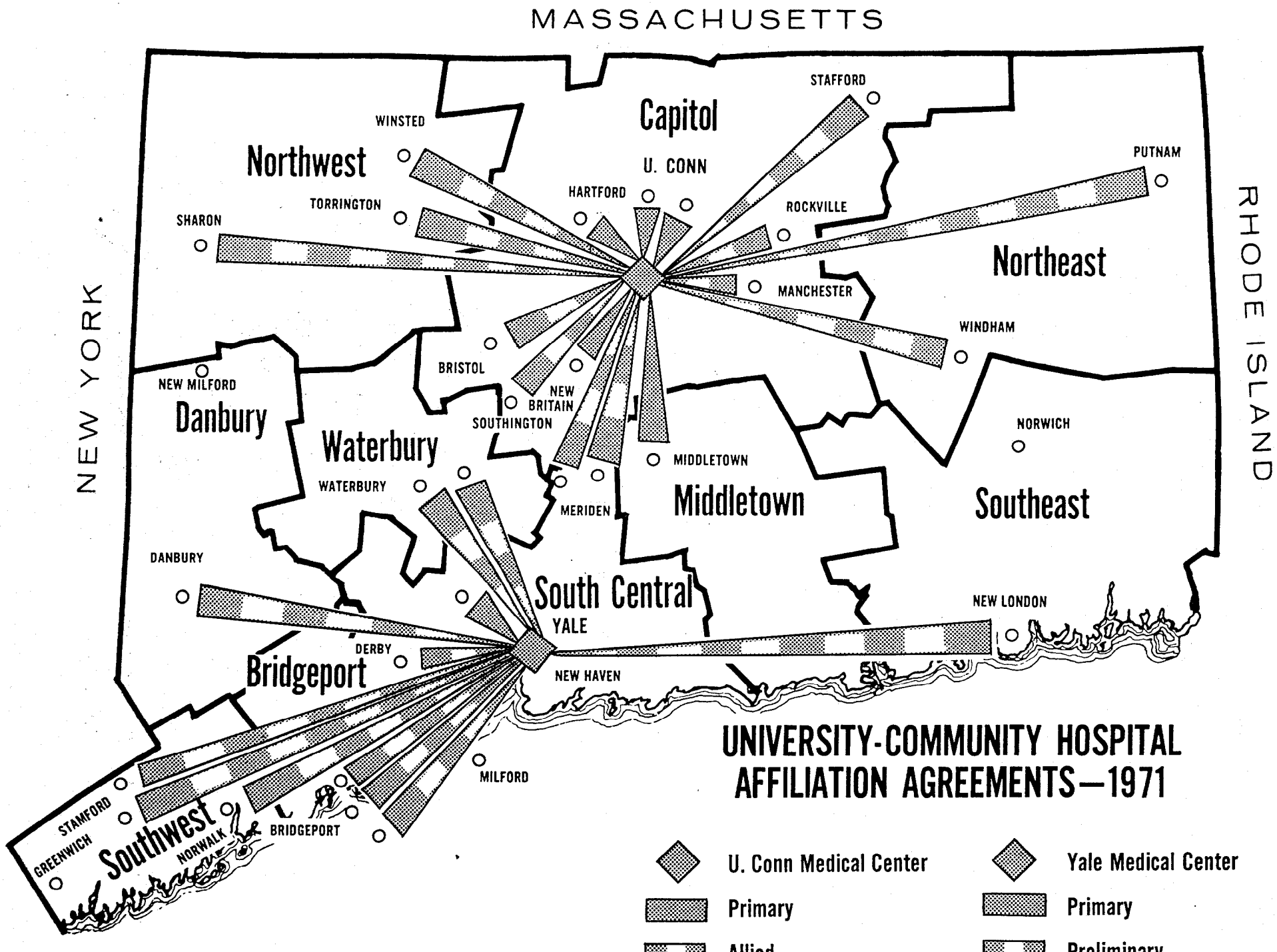
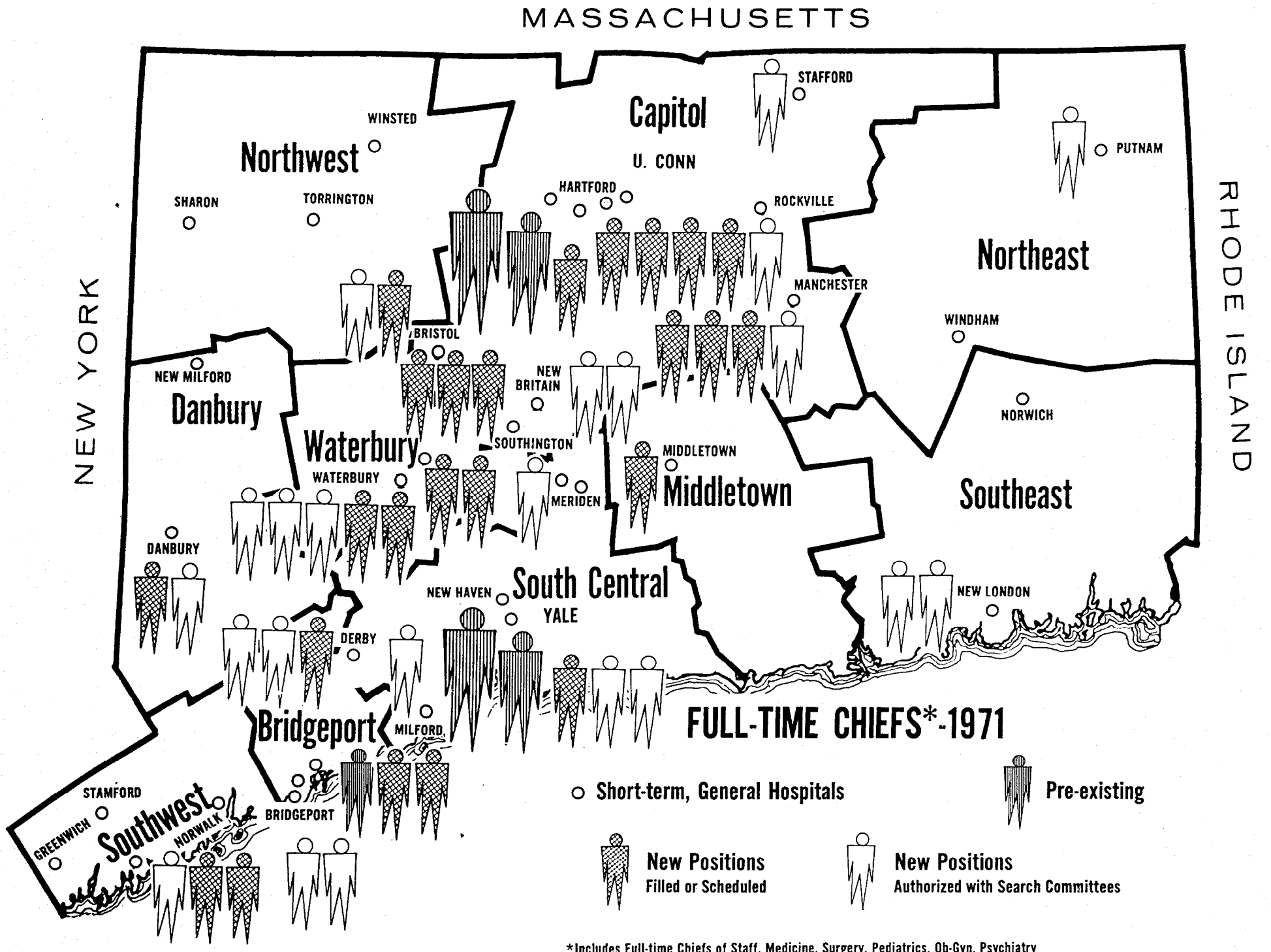


CONNECTICUT REGIONAL MEDICAL PROGRAM



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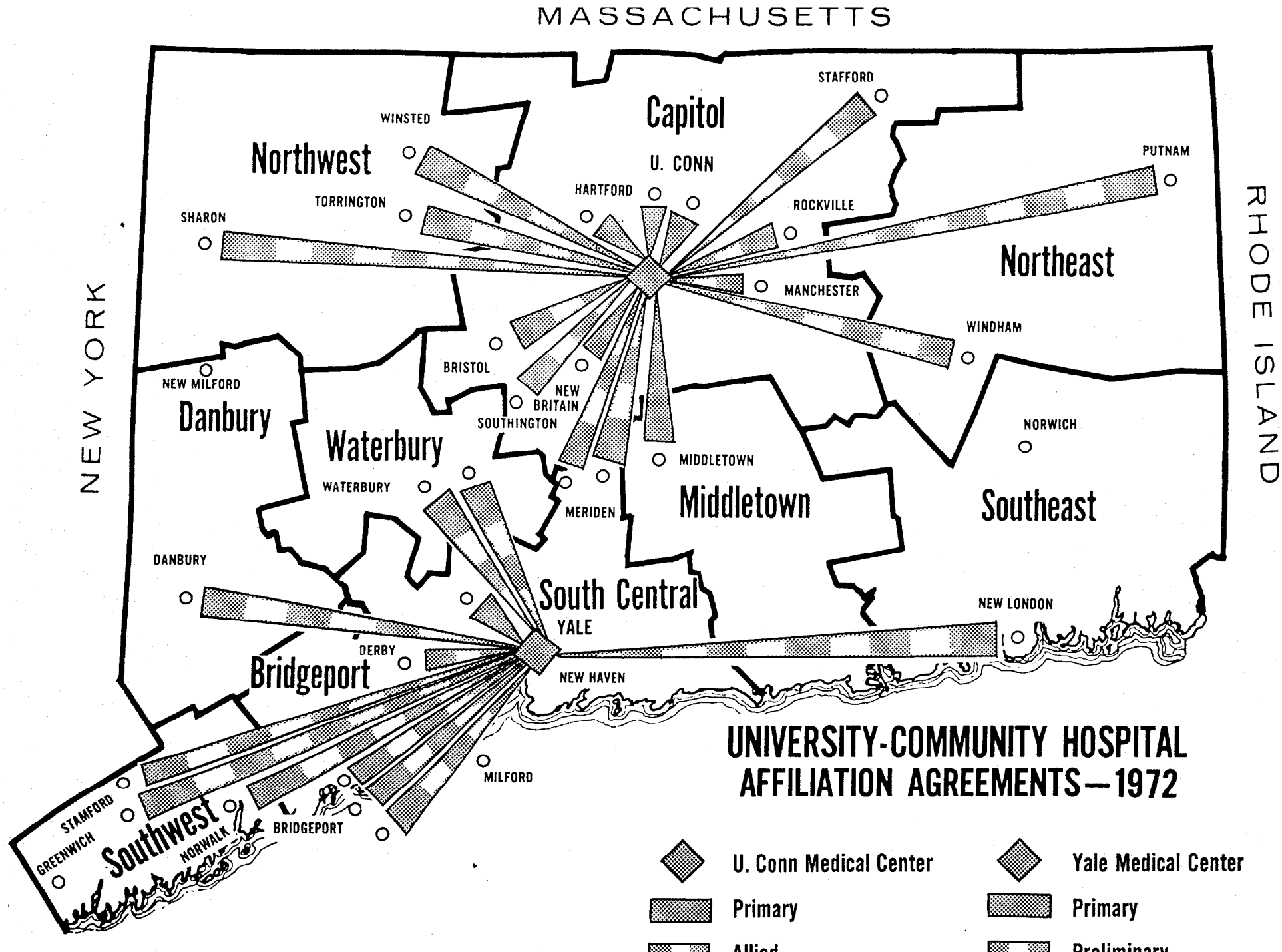
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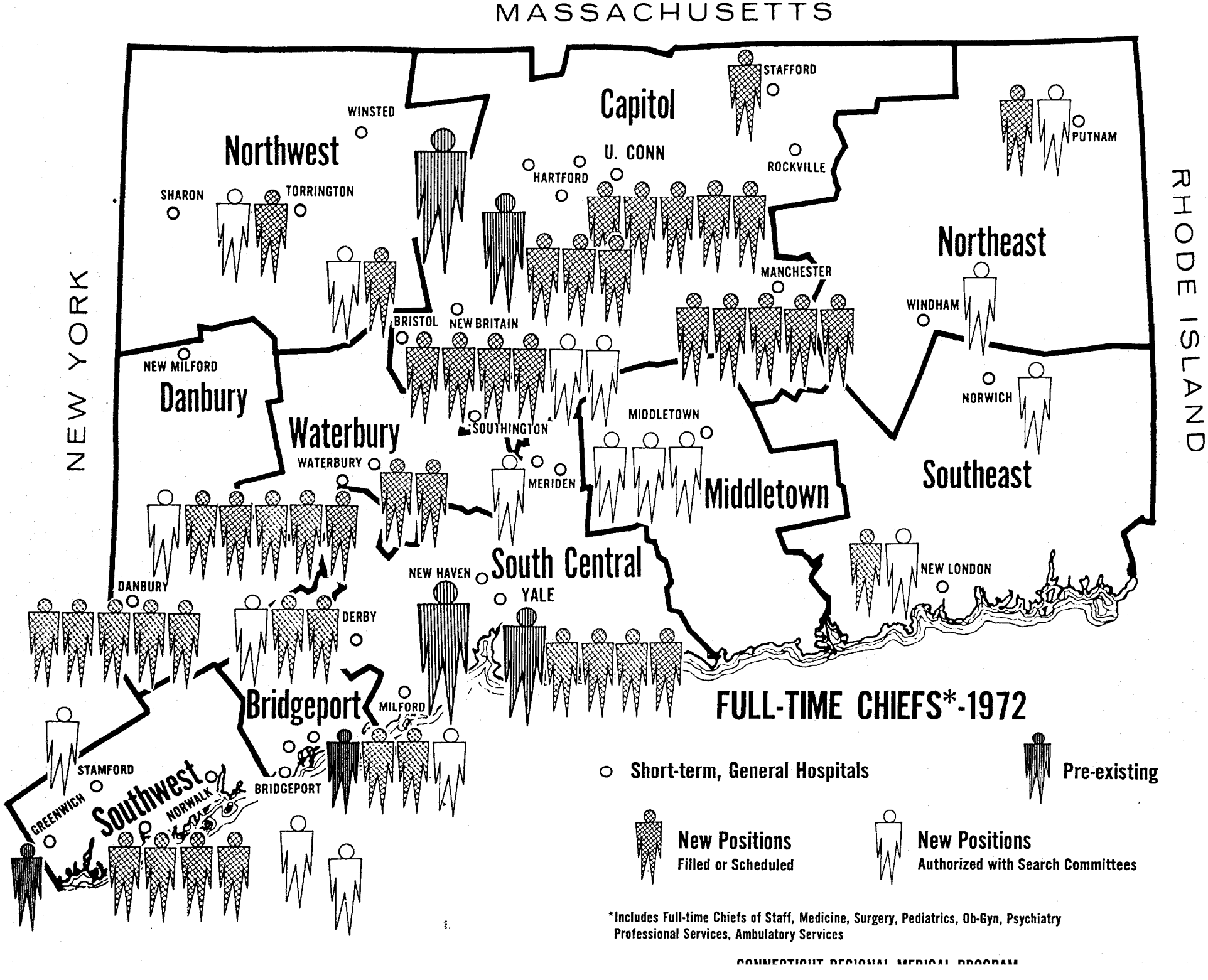
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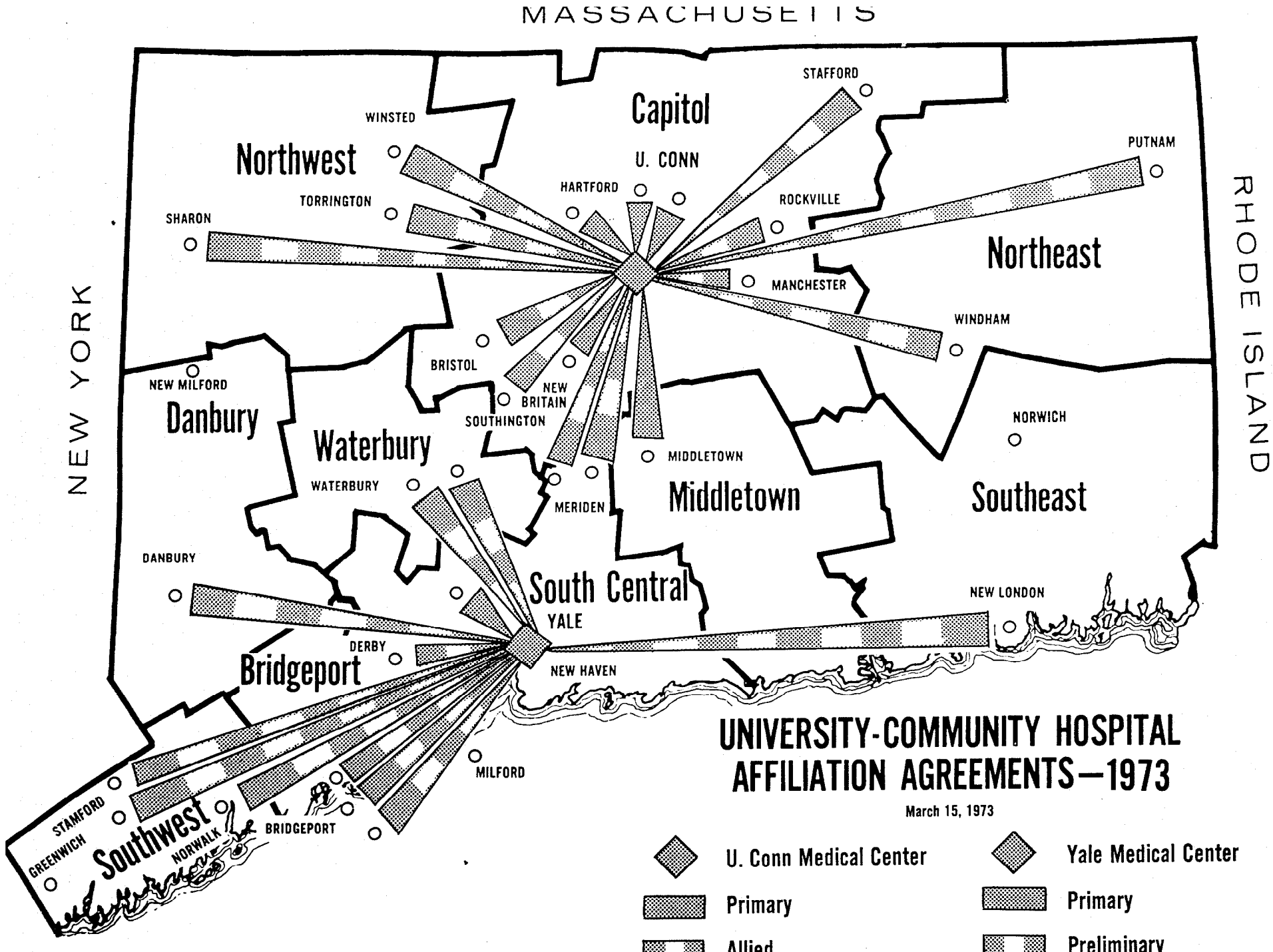
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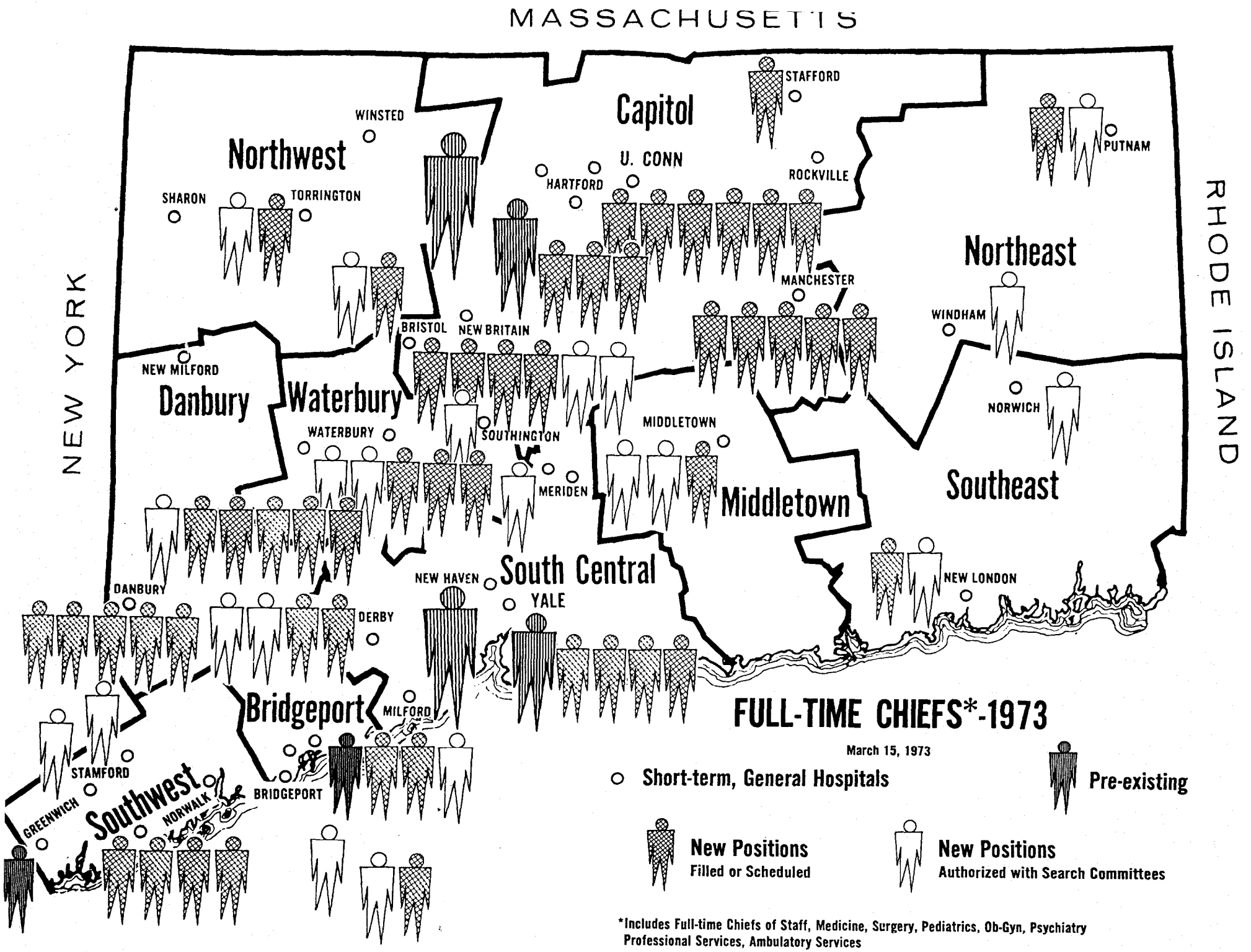
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Henry T. Clark, Jr., M.D.
Director

SPECIAL GRANT REQUEST FOR MAY-JUNE 1973

March 15, 1973

Introduction

This statement and the following summary budget data have been prepared in response to Dr. Harold Margulies' telegram of February 1, 1973 in which he discussed the impact of President Nixon's budget proposals to Congress for Fiscal '74 on Regional Medical Programs and asked for a detailed plan to phase out the activities of the Connecticut Regional Medical Program (CRMP). Dr. Margulies indicated that the CRMP plan was to be submitted by March 15, 1973 in two parts: Part one to cover the phase out of most program activities by June 30; part two to continue activities meeting certain criteria after June 30 "but in no event beyond February 15, 1974". This statement covers part one; a following statement covers part two.

This statement has also been prepared in the context of (a) advice from Ms. Eileen Faatz, the CRMP liaison officer on the RMPS staff, of February 12; (b) instructions relating to plans for phasing out RMPS which are contained in a letter of February 22 from Dr. Margulies; and (c) program and policy position of the CRMP Advisory Board which are presented in the statement by Chairman D'Oench that transmits this report.

It is pertinent that under RMPS direction CRMP functions on a fiscal year which ends on April 30. The first question CRMP faced on receipt of Dr. Margulies' telegram of February 1, 1973 was whether funds assigned by CRMP to its delegate agencies for the current fiscal year should be reduced in some across-the-board or selective manner. The decision was to continue all of these programs at current levels through April 30, 1973 with funds on hand for the following reasons: (a) all programs needed and deserved at least three more months to work toward fulfilling their program goals and thus demonstrate their full potentials; (b) all programs needed and deserved at least three more months to begin to explore alternate sources of funding based on this demonstrated performance; and (c) all programs needed time to honor commitments to personnel in terms of vacation, due notice, etc.

With that decision made, the next question became how to develop and implement a reasonable set of program priorities and budgets, in the circumstances, for May-June 1973, recognizing that June 30 is the end of the federal fiscal year and is also the federal target date for completion of all regular RMP activities.

CRMP obtained assistance in this sphere on February 12 when Ms. Eileen Faatz telephoned to indicate that $264,152 (direct costs) was available to CRMP during May-June to cover phase-out activities. CRMP was further aided in late February when Dr. Margulies' letter of February 22 arrived giving more detailed guidance on preparing phase-out plans.

In planning these programs and budget requests for May-June 1973 and for the July 1973-February 1974 period CRMP was favored by one fortunate coincidence. In December 1972 CRMP requested progress reports from delegate agencies covering all CRMP-supported programs, with a submission date of January 29, 1973. Furthermore, CRMP had projected a complete review of each CRMP-supported program based on these progress reports and augmented by site visits during February and early March 1973. Indeed the CRMP Review and Evaluation Committee was in session on February 1 to launch this activity when Dr. Margulies' telegram arrived. The contemplated review went forward in a modified form (aided by 14 Board members) and it is reported in other sections of this report.

The fact that this activity was put in motion in December has meant that an orderly process could be followed in developing this report.

In making judgments on funding levels for various CRMP program elements for May-June 1973 the CRMP Board was quite conscious that the anticipated $264,152 was substantially less than the 1972-1973 level of grants from RMPS and also sharply below the level recommended by the National Advisory Council for 1973-74. The Board was anxious to give all programs which were judged to be proceeding in an effective way toward their program objectives as much support as possible for as long as possible -- (a) so that they could demonstrate their potential value to their communities, (b) so that as a consequence they could develop alternate sources of financial support and (c) so that they could make appropriate plans to continue or, otherwise, find placements for existing staff. In this total regard, the Board recognizes President Nixon's current emphasis on economy in federal government. CRMP feels, however, that supporting selected worthy activities in the field of human service for a few weeks to the point of viability is a greater economy than terminating these activities abruptly and thereby wasting previously invested public funds. We believe President Nixon would consider this reasonable. The Board was also conscious that CRMP has an excellent record of obtaining matching money and "take over" support for its projects (as reflected in the November 1, 1972 Summary Report to RMPS) and it can continue to perform well in this regard if given reasonable time.

In order to develop a budget for May-June 1973 based on $264,152, the CRMP Board adopted a set of 10 criteria which included but went beyond those set forth by RMPS. In applying those criteria, support for three on-going programs is scheduled to be terminated April 30; four programs which were to be activated May 1 have been notified there will be no RMPS support; and all other programs are recommended for a reduced level of support, looking toward termination of RMPS grant assistance on June 30, except for the special activities described in the "Part Two Request" which follows.

A summary of the CRMP Special Grant Request for May-June 1973 is presented in the attached table. The details of this request are presented in Volume II.

March 15, 1973

CONNECTICUT REGIONAL MEDICAL PROGRAM[1]

ADVISORY BOARD REQUEST TO RMPS FOR MAY - JUNE 1973

Program	1972-73 Operating Budget[2]	1973-74 Budget Request From 11/1/72 Report	1973-74 Advisory Board Decisions March 8, 1973	MAY-JUNE 1973 ADVISORY BOARD REQUEST MARCH 15, 1973
RESEARCH AND EVALUATION				
Community Studies Personnel, Yale University School of Medicine	42,537	42,509	42,509	7,085
Community Studies Personnel, University of Connecticut School of Medicine	38,500	38,709	42,846	6,416
Health Service Area Planning Assistance	48,398	75,000	75,000	7,500
Joint Publication Series	5,000	------	------	------
Regional Blood Bank Survey and Supporting Services Program, UConn.	36,115	------	------	------
Connecticut Ambulatory Care Study	(25,000)[3]	------	------	------
HEALTH SERVICE AREA PROGRAM ASSISTANCE				
Community Health Services, Inc.	38,130	21,170	21,170	3,510
Association of Community Health Service Agencies, Inc.	11,250	10,000	10,000	1,666
Shared Hospital Services Demonstration, Connecticut Hospital Association	10,000	15,000	15,000	833[4]
Home Care Coordinator, Hospital of St. Raphael	12,000	9,000	9,000	750[4]

Program	1972-73 Operating Budget[2]	1973-74 Budget Request From 11/1/72 Report	1973-74 Advisory Board Decisions March 8, 1973	MAY-JUNE 1973 ADVISORY BOARD REQUEST MARCH 15, 1973
Regional Hospice Development Program, Yale-New Haven Hospital	22,080	18,989	18,989	3,165
Southcentral Connecticut Continuing Care Demonstration Program, Yale-New Haven Hospital	65,000	------	------	------
The Connecticut Stroke Program, Gaylord Hospital	30,000	------	------	------
Personal Health Services Planning Assistance, Southcentral Connecticut CHP, Inc.	22,000	22,000	------	------
Neighborhood Health Services, Hartford Citizens Health Action Council	33,750	------	------	------
UNIVERSITY-COMMUNITY HOSPITAL PARTNERSHIPS				
Community Hospital Based Regional Faculty	435,000	600,000	600,000	75,000
University of Connecticut				
University Based Regional Faculty, UConn. School of Medicine	150,353	196,744	196,744	25,000
University Based Regional Faculty, UConn. School of Nursing	10,871	12,400	12,400	1,812
Regional Renal Diagnostic Program	24,029	25,094	12,500	2,083
Yale University				
University Based Regional Faculty, Yale School of Medicine	135,000	249,687	249,687	22,500
University Based Regional Faculty, Yale School of Nursing	25,000	27,300	27,300	2,083[4]

Program	1972-73 Operating Budget [2]	1973-74 Budget Request From 11/1/72 Report	1973-74 Advisory Board Decisions March 8, 1973	MAY-JUNE 1973 ADVISORY BOARD REQUEST MARCH 15, 1973
Yale Affiliated Gastroenterology Program	45,554	42,000	42,000	7,000
Yale-Connecticut Diabetes Teaching and Consultation Program	29,055	24,150	29,076	4,025
Connecticut Kidney Disease Program	133,533	137,965	118,642	18,261
Regional Renal Diagnostic Program	23,192	19,700	19,700	3,250
CLINICAL SERVICES				
Connecticut Regional Drug Information Service, Yale-New Haven Hospital	30,000	30,000	30,000	5,000
HEALTH PROFESSION EDUCATION				
Connecticut Network for Medical Communications, UConn. Health Center	16,000	14,000	16,000	2,333
Allied Health Manpower Office, Yale-New Haven Medical Center	28,104	55,000	55,000	4,684
Regional Library Services, Yale Medical Library	10,083	7,333	7,333	1,222
Regional Library Services, UConn. Health Center	10,083	7,333	7,333	1,222
Regional Library Services, CRMP Consultation and Training	12,164	------	------	------
Manpower Information Forecasting and Development System, Yale School of Medicine	58,840	------	------	------

Program	1972-73 Operating Budget [2]	1973-74 Budget Request From 11/1/72 Report	1973-74 Advisory Board Decisions March 8, 1973	MAY-JUNE 1973 ADVISORY BOARD REQUEST MARCH 15, 1973
PROGRAM STAFF, CONNECTICUT REGIONAL MEDICAL PROGRAM	368,823	477,737	477,737	57,752
PROGRAMS IN SPECIAL CATEGORIES				
Statewide Emergency Medical Services	19,000	208,250	115,940	(3,351)[5]
Developmental Component	------	154,000	154,000	------
Regional Health Education Program, Yale	74,510	85,108	------	------
New Britain Child Health Program	------	80,000	80,000	------
Northern Connecticut Regional New Born Service	------	31,000	31,000	------
		T O T A L		$264,152

FOOTNOTES:

1. All budget figures presented in this table are direct costs only.
2. All 16 months fiscal year budgets have been converted to 12 months to obtain a proper basis for comparison.
3. Included in Health Service Area Planning Assistance.
4. Support terminates May 31, 1973.
5. Included in Program Staff, CRMP.

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Henry T. Clark, Jr., M.D.
Director

March 15, 1973

"PHASE-OUT" GRANT REQUEST FOR JULY 1, 1973 - FEBRUARY 15, 1974

Introduction

This request has been developed in the context of the previous discussion but, more specifically, in response to points (2) and (3) in Dr. Margulies' telegram of February 1, 1973, which are as follows:

> "2. Request continued support for only those activities requiring RMPS funds that will produce a predictable result justifying the federal investment, or
> "3. Request continued support for those essential activities where a mechanism has been established to continue without interruption support of the activity from other resources."

In the discussion of "CRMP's Seven-Year March Toward Medical Regionalization" the central thrust of CRMP was presented in some detail. That report reviewed the creation and functioning of the Community Studies Programs at both Yale and the University of Connecticut. Faculty members from these two programs are available, on request, to study local health problems and to chart action programs to overcome them. Furthermore, these same faculty members have recently begun to evaluate the impact of various CRMP-sponsored programs on the Connecticut health scene. The report on "CRMP's Seven-Year March..." also discussed the workings of the Offices of Regional Activities at both Yale and the University of Connecticut in developing and building content into the two university-community hospital affiliation networks. Furthermore, it discussed the expanding roles of community hospitals as leadership forces to improve health care for all citizens of their communities, and the roles as change agents being played by the growing numbers of full-time chiefs of service in those hospitals. And "CRMP's Seven-Year March..." described examples of regionalization of specialty services, e.g., gastroenterology, diabetes, kidney disease, emergency medical services, and library support programs which, in the aggregate, are designed to foster top quality medical care to all 3,000,000 citizens of Connecticut in an efficient way.

CRMP staff believe that about three more years of RMPS support is needed to carry the system of medical regionalization under development in Connecticut to that point of maturity at which its overall viability is assured. A fully established demonstration of medical regionalization in Connecticut would have major national and international value in promoting better delivery of

health services to large population groups in many settings. The National Administration's present schedule for phasing out RMPS support eliminates some of the time needed for the optimum development of the Connecticut demonstration. Yet most of the key elements are in place in Connecticut and some of these probably can be carried to the point of permanent viability in the next few months. The institutional commitments are strong in this regard and CRMP's record of finding matching and take-over support for the activities it has sponsored, as set forth in detail in the Summary Statement of the November 1, 1972 Report to RMPS, is very convincing.

In this general context--and particularly in the context of points "2" and "3" in Dr. Margulies' telegram of February 1, 1973,--a brief comment is presented below on the programs for which RMPS support is requested for the July 1, 1973-February 15, 1974 period. The budget request for each program is shown in the table which follows this statement.

Community Studies Personnel,
Yale University School of Medicine
and
Community Studies Personnel,
University of Connecticut School of Medicine

Among the studies currently under way in these two CRMP-supported programs are the following. At Yale, community studies personnel are studying: (a) the organization of hospital-related pediatric services in Connecticut; (b) the potentials for establishing a regional health department in Darien, Connecticut; (c) criteria for determining the need for a nursing home in a given community; and (d) the desirable future direction of Connecticut's public chronic disease hospitals. At the University of Connecticut, community studies personnel are examining: (a) the impact and significance of full-time chiefs of service in community hospitals; (b) the potentials for merging the New Britain Health Department with the New Britain Hospital; (c) problems involved in rendering Emergency Medical Services at Bristol Hospitals; (d) the possibilities for establishing a District Health Department in the Farmington Valley; (e) the potentials for establishing a primary care demonstration in Windham County; and (f) the organization and delivery of services to the elderly through Hartford Neighborhood Senior Centers.

All of these studies are being carried out for agencies capable of utilizing and/or implementing them. All should be complete--or at a point where they can be completed--by the time when CRMP's support is scheduled to terminate on January 31, 1974.

The Community Studies Units at Yale and UConn have proven their value to leading Connecticut health institutions and agencies. Their continuation after January 31, 1974 appears certain through some combination of university support, grant support, and fees for services rendered.

Office of Regional Activities
University of Connecticut School of Medicine
and
Office of Regional Activities
Yale University School of Medicine

The UConn Office of Regional Activities has played a major role in developing affiliation agreements between the University of Connecticut School of Medicine and seventeen community hospitals. The Yale office has helped stimulate affiliations between the Yale School of Medicine and twelve community hospitals. Within the context of those affiliations both offices have worked to fill many full-time chiefs of service positions in community hospitals, to develop and expand more effective programs of education for medical students, interns and residents, and to promote regionalization of many specialty services. CRMP support for the university-based regional faculty and for the full-time chiefs of service in community hospitals is scheduled to end on June 30, 1973. It is essential, therefore, to keep in operation the two university offices of regional activities in order to provide stimulus and administrative support for the two university-community hospital affiliation networks. It seems clear that both of these two offices will be continued by the universities beyond January 31, 1974, when CRMP support is scheduled to end.

Yale-Affiliated Gastroenterology Program
Yale-Connecticut Diabetes Teaching and Consultation Program
Connecticut Kidney Disease Program
Emergency Medical Services
Regional Library Services, Yale Medical Library
Regional Library Services, UConn Health Center

These are specialized, regionalized programs which have been discussed fully in previous reports and are discussed in some detail in Volume II of this report. Each is moving steadily toward full program development and toward financial self-sufficiency which will make it independent of CRMP assistance. In each case modest RMPS support is sought to maintain a few central elements of each program until early 1974. The needed "take-over" money will come from voluntary sources in the cases of the gastroenterology and diabetes programs, from federal grants in the case of the kidney program, from the State and perhaps a philanthropic foundation in the case of Emergency Medical Services, and from a combination of fee-for-services and the National Library of Medicine in the cases of the two parts of the library program. A period of time is needed in each case to finalize and phase in this "take-over" funding.

Program Staff

As RMPS has noted repeatedly during recent years, CRMP has functioned with one of the smallest program staffs of any of the 56 RMPs. Nevertheless, that staff has helped make it possible for CRMP to bring to partial fruition a very complex and ambitious program of medical regionalization in Connecticut.

The broader aspects of that accomplishment are set forth in this volume; the details are given in Volume II of this Report and in the November 1, 1972 edition of The CRMP Story.

The continuation of most members of the CRMP Program Staff through December 31, 1973, with RMPS support, is necessary to solidify the gains made in Connecticut through CRMP influence, to work for take-over funds for on-going CRMP activities not mentioned above, to promote the implementation of studies currently being concluded, to help prepare final reports to RMPS and elsewhere, and to work for a continuing presence for RMP in Connecticut independent of RMPS financing.

More detailed comments on each of the above programs are presented in Volume II of this report. In Volume II, also, there is a letter from the chief administrative officer of each agency for which funds are being requested during the July 1, 1973-February 15, 1974 period.

A budget summary table follows. More detailed budgets are presented in Volume II.

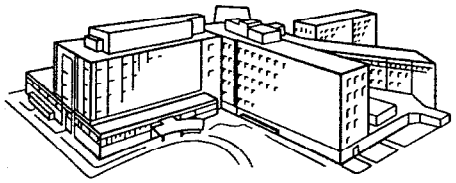
CONNECTICUT REGIONAL MEDICAL PROGRAM

March 15, 1973 Budget Request
to
Regional Medical Programs Service
for the
July 1, 1973 - February 15, 1974 Period

Component	Direct Costs	Indirect Costs	Total Costs
RESEARCH AND EVALUATION			
Community Studies Personnel, Yale University School of Medicine	24,797	11,563	36,360
Community Studies Personnel, University of Connecticut School of Medicine	22,580	8,369	30,949
UNIVERSITY-COMMUNITY HOSPITAL PARTNERSHIPS			
Office of Regional Activities, University of Connecticut School of Medicine	30,000	13,122	43,122
Office of Regional Activities, Yale University School of Medicine	33,177	19,006	52,183
Yale Affiliated Gastroenterology Program, Yale University School of Medicine	12,500	6,350	18,850
Yale-Conn Diabetes Teaching & Consulting Program, Yale University School of Medicine	13,000	7,779	20,779
Connecticut Kidney Disease Program, Yale-New Haven Medical Center	16,000	5,832	21,832
CLINICAL SERVICES			
Emergency Medical Services, Connecticut State Department of Health	35,500	4,375	39,875
HEALTH PROFESSION EDUCATION			
Regional Library Services, Yale Medical Library	6,111	3,780	9,891
Regional Library Services, University of Connecticut Health Center Library	6,111	2,655	8,766
PROGRAM STAFF-CONNECTICUT REGIONAL MEDICAL PROGRAM	137,430	39,745	177,175
TOTALS	$337,206	$122,576	$459,782

CMC:c

3-13-73



NEW BRITAIN GENERAL HOSPITAL

BLISS B. CLARK, M.D.
EXECUTIVE DIRECTOR

NEW BRITAIN, CONNECTICUT 06050 · (203) 224-5011

March 6, 1973

Mr. Russell G. D'Oench, Jr.
Chairman, CRMP Advisory Board
The Middletown Press
Middletown, Connecticut

Dear Mr. D'Oench:

I am writing to report on the recent activities of the CRMP Review and Evaluation Committee which have culminated in (a) program and budget recommendations for May-June, 1973 and (b) program and budget recommendations for July 1, 1973 - February 15, 1974. These sets of recommendations were developed in the context of instructions from the Regional Medical Programs Service (RMPS) dated February 1 and 22, which asked that CRMP develop a plan of action to phase out its operations. Furthermore, the Committee understood RMPS set a limit of $264,157 (direct costs) in available funds for the May - June, 1973 period.

In discharging its current responsibilities, the full Review and Evaluation Committee met four times -- on December 5, 1972 and on February 1, February 17 and March 1, 1973. In addition, there were several meetings of sub-committees and twelve site visits. I am pleased to report, too, that the work of the Review and Evaluation Committee was augmented at various levels during this round of review by the participation of 14 members of the CRMP Advisory Board.

At its December 5, 1972 meeting the R and E Committee adopted a plan to request written progress reports from all CRMP-supported programs, due January 29, 1973 and it made tentative plans to conduct site visits to each program during February - March, 1973.

At its February 1, 1973 meeting the Committee received copies of the agency reports which had been requested; discussed President Nixon's budget message for FY 74 which proposed a phase out of RMP; considered the contents of a telegram from Dr. Margulies which came during the course of the meeting and gave some instructions for phase out; and adopted a modified plan for

the current round of review which called for most of the review to be carried out by three panels on the written reports, with site visits to be carried out only in special situations.

At its February 17, 1973 meeting, the Committee took preliminary action on the recommendations by the panels on most of the delegate agency reports but agreed on the need for 12 site visits.

At its March 1, 1973 meeting the Committee considered the 12 site visit reports; developed program and budget recommendations for the May-June request to RMPS; developed program and budget recommendations for the July 1, 1973 - February 15, 1974 request to RMPS; developed recommendations on several programs with special situations; and developed recommendations on several policy matters concerning the future functioning of CRMP.

I am attaching a copy of the minutes of the R and E meeting of March 1, 1973 which gives the details of the Committee's recommendations for (a) the special grant request for May-June, 1973 and (b) the "phase-out" grant request for July 1, 1973 - February 15, 1974. I am writing a separate letter to summarize the Committee's recommendations on policy matters.

I will be pleased to amplify this letter and to respond to questions at the meetings of the CRMP Executive Committee and Advisory Board which are set for March 8, 1973. I expect to have the assistance of several members of the Review and Evaluation Committee on those occasions. Specifically, I have asked the chairmen of the three panels--John Barone, Ph.D., Ray Duff, M.D. and John Glasgow, Ph.D.--to give an assessment of CRMP programs reviewed by their respective panels. I have also asked Joseph Smith, M.D., Willis Underwood and Paul Doolan, M.D. to comment, in that order, on the impact of CRMP on the medical practitioners of Connecticut, on the thirty-three community hospitals and on the two University Health Centers.

I would like to mention, in closing, that the members of the Review and Evaluation Committee have again functioned with high purpose and strong dedication during the recent review cycle and that it received outstanding staff support in conducting its work.

Sincerely yours,

Howard Levine

Howard Levine, M.D.
Chairman
CRMP Review and Evaluation Committee

OFFICE OF THE PROVOST

FAIRFIELD UNIVERSITY

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March 8, 1973

UNIVERSITY MEDICAL CENTER REGIONAL ACTIVITIES
REVIEW AND EVALUATION COMMITTEE
CONNECTICUT REGIONAL MEDICAL PROGRAM

INTRODUCTION

The Panel on University Medical Center Regional Activities assumed a responsibility for the review and evaluation of eighteen (18) university administered regional programs. In eight hours of committee work, supplemented by three two-hour site visits, the panel was able to complete its assignment. Augmenting the regular R & E committee members in both program review through committee work and site visits were members of the CRMP Advisory Board, principally the CHP (b) agency designated members. The framework adopted by the panel for review of programs included a judgment as to the program's clarity of objectives, progress in achieving program goals, contribution to the overall mission of CRMP and developing prospects for alternate financial support beyond the period of CRMP pump-priming.

PROGRAM ASSESSMENT AND OVERVIEW COMMENTS

The central thrust of CRMP, e.g., creation of a university-affiliated hospital system, is successfully illustrated by the organization and range of university regional activities in research, education and patient care. The template of this arrangement, two university spheres of influence - northern half relating to UConn and southern half relating to Yale, offers a practical and manageable orbit permitting intensity of university-community interaction. The flexibility of this arrangement is evidenced by a range of Yale administered state-wide patient care/clinical programs which utilize Yale-New Haven Medical Center's enriched clinical base and which in time permitted entry of the UConn Health Center after its clinical base was well established.

Regional activities which illustrate the larger framework include:

Community Studies Units

The Department of Epidemiology and Public Health, operating within a tradition of public service, has greatly expanded its research and planning service through CRMP support and stimulus. Where CRMP has identified the problem, located the regional client and created the opportunity for study, Yale has supplied faculty and graduate students. Institutions, communities and CHP (b) agencies have been beneficiaries of this service and the future promise of help is equally great. One would hope that community hospital-based chiefs of service would increasingly turn to this resource for help in local problem-solving thus adding further substance to their university affiliation. The UConn Community Studies unit, a more recent development, shows equally high promise in assisting northern Connecticut communities. Particularly encouraging is the unit's emphasis on helping affiliated hospitals sort out answers in

primary and ambulatory care, specialty care organization, hospital-health department relationships, and the role-impact of full-time chiefs of service. Joint participation by both units in an appropriate statewide study is one of the directions future planning should take.

University-Based Regional Medical Faculty

University faculty engaged in outreach, particularly with affiliated hospitals, is a cornerstone of CRMP's program emphasis. The awareness and interactions which have resulted from this thrust have been difficult to report because of the range and breadth of their activities. It is clear that this is an essential component of an integrated health and educational system. Moreover, a whole style of medical care leadership has been developed which has taken firm root in the universities and the community hospitals, even if some university clinical departments and some smaller hospitals have not fully participated. The necessity for a stimulating and integrating force, such as the two university Offices of Regional Activities, will also remain, both to build upon accomplishments to date and to offer the community hospitals a university-based "ombudsman" for future program development.

University-Based Regional Nursing Faculty

An effort, similar to university-community collaboration in medicine, has been made in the nursing area. Here the tradition of a university nursing school as a regional resource is recent, the potential of nursing playing an expanded role in health care delivery is evolving, and the presence of a male chauvinism as well as modest program goals with consequent minimal funding, have led to modest efforts exclusively in continuing education. Issues such as nursing practice, new forms of regional organization of nursing service and the role of specially prepared nurses all remain, and all needing more effective regional solutions. Therefore, much remains to be done in improving nursing education and practice, which will require extensive university nursing participation.

Regional Sub-Speciality Health and Education Programs

Perhaps the areas best understood by health providers and appreciated by health consumers have been programs offering help in direct patient care. Here there has been an explicit patient care emphasis, committed and enthusiastic university faculty leader(s), a network of informal relationships with practitioners, and the opportunity to integrate education and patient care. Two programs expanded with CRMP funding, the Connecticut Regional Blood Program and Yale-New Haven Continuing Care Program, now continue under sponsoring agency auspices. The Yale-led statewide Diabetes and Gastroenterology Programs have established a network of community-based educational and patient care activities with high promise of permanence through alternate funding. The multi-faceted Kidney Disease program offering diagnostic, dialysis and transplant service is well on its way to becoming a model of specialty care organization. A similar opportunity is ahead for the Connecticut Regional Drug Information Service as it builds up the hospital as a dynamic center of modern drug therapy.

Regional Education and Communications Efforts

Allied Health Manpower Coordination at Yale has demonstrated the feasibility of a consortium arrangement linking hospitals, colleges and the secondary school systems for allied health education. The need and opportunity for replication elsewhere in the state is great. At UConn, with CRMP help, a School of Allied Health has been established which can now forge new alliances for interprofessional health care delivery activity and extend relationships to other community and senior colleges. The activities in these areas in the past were most timely because there are plans for cuts in direct federal aid for such programs in Fiscal '74.

Hopefully the availability of critical manpower data to guide realistic educational planning can come through the CRMP-funded Manpower Information Forecasting Systems and Regional Health Education Programs, both at Yale. The need Yale has to rationalize its extramural educational alliances with affiliated institutions hopefully can be guided toward solutions from these previously mentioned data collection, analysis and program development mechanisms. The newly emerging Connecticut Institute of Health Manpower Resources can serve as a neutral convener, catalyst and source of expertise in statewide manpower planning, while being of help to CHP (b) agencies as they come to grips with local health manpower issues.

The Connecticut Medical Communications System has successfully demonstrated the feasibility of linkage between university facilities and peripheral institutions. The need now is maximum utilization of communications technology and extending the number of institutional participants. The parallel effort of helping hospitals develop expertise in educational media (non-print material) has successfully dovetailed with an acknowledged "winner", The Regional Library Program. The necessity for an integration of library, drug information and audio-visual services into some permanent structure of university-community hospital shared services remains to be pursued.

SIGNIFICANCE OF CRMP IMPACT

University medical center regional activities offer an interesting platform both to gauge university social leadership and community need-response. On both scores, an affirmative judgment must be rendered due in large part to CRMP's stimulus and support over the past six years. As convener, prodder and broker among special interest groups, CRMP has rather successfully forged an alliance among major health care providers. Its permanent form will obviously be a university-affiliated hospital system which, if CRMP continues, can easily be extended to the few remaining small community hospitals and 8-10 public speciality institutions.

Obviously the institutional needs and aspirations of Yale and UConn differ and it may well be that whereas Yale School of Medicine played a dominant role in beginning and launching CRMP, UConn might well play the dominant role in utilizing this foundation for an integrated undergraduate, graduate and post-graduate educational system of unique proportions compared to the rest of the country.

If CRMP goes out of existence, as President Nixon is projecting, an instrument, similar in organization and function to CRMP, appears central to health policy development in Connecticut. A quasi-public forum and a capacity to convene major health power forces for resolute action will remain a requirement if there is to be significant progress in the delivery of health care.

CONCLUDING COMMENT

I cannot conclude without a major bow and expression of thanks to the CRMP Core Staff who, although funded through Yale, have functioned as independent regional agents of planned change. I have spent many years in University settings and I have never seen a departmental staff surpass the effort, enthusiasm, and workload of this group, from the creativeness of Dr. Henry Clark and Ed Morrissey through to the last "harassed" clerk. Perhaps I should have said from the "harassed" Dr. Clark to the last creative clerk but, on this day, I would prefer the emphasis on the tribute rather than on problems.

Moreover, as we venture into full implementation of CHP's, HMO's, PSRO's and perhaps a state health policy group to augment the State Health Department and the CHP (a) Agency, it is hard to imagine this State of Connecticut without the equivalent of CRMP to pick up areas of health care which need implementation and to provide a new health care delivery form which no other one agency or vested interest can perform. The presence of rapidly developing medical schools to the south (New York Medical College at Valhalla) and to the north (University of Massachusetts Medical School at Worcester) are indications of a need for inter-regional cooperation and opportunities which extend beyond state boundaries.

As an educator and consumer, I know of the availability of students and the needs of patients who are still outside the "Inn". Regional cooperation has been and must continue to be expanded, with the only limitation being relative to what can be administered efficiently. Institutional outreach has just begun, especially for our disadvantaged citizens. Moreover, there are so many aspects to the team approach to medical care left unfinished that the efforts such as we have been a part of, through CRMP, cannot cease.

John A. Barone, Ph.D.
Provost, Fairfield University
Chairman, Review and Evaluation
Committee Panel

Yale University *New Haven, Connecticut 06510*

SCHOOL OF MEDICINE
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March 8, 1973

COMMUNITY HOSPITAL FULL-TIME CHIEFS PROGRAM
REVIEW AND EVALUATION COMMITTEE
CONNECTICUT REGIONAL MEDICAL PROGRAM

INTRODUCTION

A panel of the Review and Evaluation Committee, supplemented by several members of the CRMP Advisory Board, met on February 10, 1973 to assess reports from 33 community hospitals concerning hospital-based regional faculty. Subsequently, site visits were made to seven hospitals. The reports by individual chiefs of service were more detailed and specific than those for previous years, thus obviating the need for other site visits. The panel's assessments were reviewed on February 17 and on March 1 by the full R & E Committee whose recommendations are summarized in the minutes of the March 1 meeting. Almost without exception, the programs are functioning very well and we favor continuing support for some 30 chiefs as detailed in the minutes.

OVERVIEW OF FULL-TIME CHIEFS PROGRAM

The balance of this report is a commentary on the community hospital full-time physician program.

In 1968, there were six full-time chiefs of service; three community hospitals accounted for these. In 1973, there were 57 full-time chiefs on hand, with 21 more being recruited, involving 27 of the 33 community hospitals of Connecticut. In addition, other full-time physicians and supporting personnel have been recruited as part of the movement to improve services and education.

What has been accomplished? From hospital reports and site visits over the course of several years, some specific findings and distinct impressions emerge. Hospitals without strong internal medical leadership were characterized as "floating." Practitioners usually were busy in their offices. Working relationships between personnel in the hospital were "loose." Nurses were left to improvise in the face of uncertainty and crisis. Equipment sometimes was available but no one knew how to use it. There was little education, minimal discharge planning, few productive medical staff committees, probable overutilization of hospital beds, and almost no useful data about the effectiveness of the care of patients. Often nurses, administrators and physicians were aware of many deficiencies in their hospital and for their own personal care said they went elsewhere. Some practitioners claimed a good performance, but their views were not convincing.

When medical leadership in the hospital was strong, a lot of this was changed, as you have seen in the many reports coming through that frenzied CRMP copying machine at 272 George Street in New Haven. To avoid repetition, details will be omitted here. However, a few illustrations may be instructive. One hospital began a new medical utilization and audit program while plans were being made to expand bed capacity. Unnecessary use of beds was found at such a level that the number of beds being added was reduced by about 50 percent. Another hospital has improved its intern and residency training program and has recruited many more house staff from American medical schools. In a third hospital, a review of patient care in one department has yielded data indicating the complication rates associated with each physician's care of patients. Physician performances there can be classified as "good," "need improvement," or "poor." The remedies will include education and discipline; and in rare cases, the trustees will receive a recommendation that a physician be dropped from the medical staff.

Specialty Services and Outreach

Apart from such in-hospital activities, several chiefs having a special field of expertise like infectious disease, for example, frequently have been consulted by community and hospital based practitioners in the region. Such contacts often lead to improvements in services and possibly in efficiency. In addition, many chiefs have been concerned with out-patient activities and "outreach" to persons needing care. Four to six such programs aim to reduce expensive inpatient use by providing more adequate primary care in clinics or, through referrals, in practitioners offices. As a result of such changes, there is no doubt that patients can be justified in feeling safer and better served in many Connecticut hospitals. And CRMP leadership and money are due much credit for this. It seems fortunate, too, that the hospitals take much credit for the changes and to the best of their respective abilities expect to continue the programs even if CRMP support ends.

Some Problems

However, the R & E Committee has become acquainted with some troubling issues regarding the relationships among full-time community hospital chiefs, practitioners, and medical school faculty. To solve their problems, the community hospital chiefs must bring together members of the other two groups. But these groups have widely divergent interests and this has important consequences.

Though the issues are complex, there are recurrent themes. Practitioners, for example, complain that faculty place laboratory research above patient interests; have an institutional rather than a patient or family orientation; emphasize a cosmopolitan view to the exclusion of local interests; and seek control of hospitals regardless of patient and practitioner interests. University faculty complain that practitioners are poorly equipped to deal with complicated hospital-based activities; often misuse drugs, hospital beds, and surgery; emphasize "individualization" of patient care sometimesto the point of a fetish; and ignore the value of studies of groups of patients to derive useful generalizations for the care of individuals. The R & E Committee considers that complaints in both directions are well based and that some neutral "ground" such as CRMP is essential. It is acknowledged that this "ground" is more aptly called an "arena."

Medical Audit

Why should this be so? While the historical roots of these contests are beyond the scope of this report, there is one aspect above all others which seems to be basic to the resolution of the conflicts. This is medical audit. There has been a long-standing resistance to audit, both in medical centers and elsewhere. At present, auditing the results of disease treatment is beginning to show some promise, but auditing the processes of care and the end results seems foreign to both faculty and practitioners who contend that only the physician can decide what care is needed and its results. Physicians resist audit by friends (which is probably more a rubber stamping process than an objective assessment), are uneasy about disinterested medical audit, and are frightened over the threat of lay audit. However, medical audit in Connecticut, limited though it is, has been shown to stop argument when it is well done. There is a very fundamental issue here: to what extent will management of health services be founded on knowledge and to what extent on power?

SUMMARY COMMENT

If CRMP comes to an end, as the federal administration is projecting, there is no doubt in my view that interchanges between medical centers and community hospitals will decline, many good educational and service programs will terminate or be compromised, and many hospitals now interested in making changes will be delayed in making them. As the center of many complex service and educational activities, the modern hospital simply cannot carry out its mission without strong medical leadership. And the development and continuation of such leadership requires that medical schools and practitioners be brought together. Where this happens, hospital administrators, physicians and trustees have a much better chance to become sufficiently knowledgeable to manage wisely.

The R & E Committee recommends that steps be taken to protect and to enhance the hard-earned benefits of several years of CRMP work. Maintenance of some neutral force, such as CRMP, for the exploration of issues, continued liaison between medical schools, community hospitals, and practitioners, and emphasis upon disinterested audit of patient care are essential.

Raymond Duff, M.D.
Associate Professor of Pediatrics
Yale University School of Medicine
Chairman, Review and Evaluation
Committee Panel

THE UNIVERSITY OF CONNECTICUT
HEALTH CENTER

March 8, 1973

RESEARCH AND PLANNING ACTIVITIES
REVIEW AND EVALUATION COMMITTEE
CONNECTICUT REGIONAL MEDICAL PROGRAM

INTRODUCTION

The Panel on Research and Planning Activities reviewed sixteen programs in this area of CRMP support. The panel membership was drawn from the Review and Evaluation Committee, augmented by several CRMP Advisory Board members including CHP (b) agency representatives. The Panel examined each of the progress reports filed by the Program Directors on January 29. The procedure was to assign a Primary Reviewer major responsibility for analysis of the progress report; to lead Panel, and then total Review and Evaluation Committee, discussion on major issues, including the need for a site visit to clarify program and fiscal matters; and to prepare a final report summarizing findings and recommendations on that activity. It is important to emphasize that the discussions, both in the Panel and in the total Review and Evaluation Committee, sought to establish for each program a priority ranking based on assessment of performance, adherence to CRMP's criteria for support, and long-range potential for program continuity including alternate fiscal support. Put another way, two questions faced the Panel and the Review and Evaluation Committee: (1) Did circumstances associated either with the program performance or with the announced plan of the Nixon Adminstration to terminate RMP dictate a change in the support level previously projected for May-June, 1973? and (2) What program and fiscal recommendations should be made for the period beyond June 30, 1973?

OVERALL PROGRAM ASSESSMENT

Based upon review of the individual progress reports, augmented by Panel analysis and two site visit reports, the Review and Evaluation Committee sustained Panel recommendations that most programs for which 1973-74 support was sought in the November 1, 1972 Grant Request Application were making significant progress toward the attainment of expressed work objectives and that they merit support for the May-June, 1973 period. Several programs contain special circumstances which lead to special recommendations and they require more detailed comment as follows.

Personal Health Services, Southcentral Comprehensive Health Planning Agency

The importance of community in-put into the organization and decision-making process of New Haven Health Care Inc. (an Experimental Health Services and Delivery Systems program) was recognized by the Panel and the Review and Evaluation Committee. It was further recognized that CRMP's financial support to the CHP (b) agency had been instrumental in initiating that in-put and, further, that such support had provided the necessary professional staff leadership from CHP to bring NHHC to its beginning operational phase.

The Panel and the Review and Evaluation Committee now feel that continued reliance by NHHC upon CHP to interpret and promote regional involvement in the health management plan poses conceptual and programmatic problems which are not likely to be resolved in the short run availability of CRMP grant support beyond April 30, 1973. It was the recommendation, therefore, that CRMP support be terminated as of April 30, 1973 and that NHHC and SCCHP consider the advisability of negotiating a contract between them. Such a contract would delineate a specific plan of action for the CHP agency to carry out in support of NHHC objectives consistent with CHP's role and function as a community organization agency.

Connecticut Institute for Health Manpower Resources, Inc.

This program was awarded a three-year grant July 1, 1972 by RMPS utilizing special "earmarked" funds. The program's objective is to develop a state level policy and coordinating body in the area of health manpower program and resource development. Despite its relatively recent beginning, the Institute appears to have made a significant impact in a highly complex and essential area.

Since the funds for three years' support have been awarded and are in hand, it did not appear to the Committee that this program comes within the RMPS Guidelines for phasing out support. It further appeared that continuing support for this program should not come from the two-month RMPS assignment of funds for May-June, 1973 nor from funds to be requested in the "phase-out" period beyond June 30. It was therefore recommended that special efforts be made by CRMP on behalf of the CIHMR to confirm the continued availability of the three-year Award.

Emergency Medical Services

This program builds upon an application submitted by CRMP in the spring of 1972 to develop a state and regional program for strengthening emergency medical services throughout Connecticut. That application for "earmarked" funds in the amount of approximately $400,000 resulted in an award of $19,000 in FY 1973 to promote a statewide consortium and to set the stage for the emergence of the state and regional programs.

The CRMP supported aspect of this program has been formally active only since January 1, 1973, but it has been able to build on a firm base of study and planning work carried out by the Yale Trauma Program over the past three years. The Panel, site team and full Review and Evaluation Committee were much impressed with the activity underway; with the evident commitment to joint planning and action by all major EMS interests and organizations in Connecticut through their active participation in the work of the Connecticut Advisory Committee on EMS; with the availability as of November 1, 1972, of a 750-page statewide study presented to Governor Meskill which defines both needs and a proposed plan of action; with the high expectancy for passage of state legislation based upon that study report and drafted by the Advisory Committee which will significantly improve the level of EMS in Connecticut; with the participation and support of the State

Health Department and the State Department of Transportation in the work of the Advisory Committee, including their official endorsement of the Committee as their advisor on EMS matters; and with the expressed readiness of the Governor to support major changes in EMS programming and policy formulation.

The Review and Evaluation Committee strongly endorsed the conclusions of the site visit report for continuation of CRMP support to January 31, 1974 with expectation that a high level of program activity will continue; that state legislation will provide adequate fund support beyond January, 1974; and that presently indicated interest by the Robert Wood Johnson Foundation in strengthening EMS nationwide offers another significant opportunity to support the program plan of action represented by the Advisory Committee.

Library Services

The Connecticut Health Library Services Program has achieved substantial progress in improving and coordinating library utilization and document delivery throughout the state. As of January 1, 1973, the National Library of Medicine approved a second year grant of a three year award to CRMP to provide reference backup, technical supervision, and the communication linkages between community hospitals, library users, and the national biomedical communications network. As planned, the cost of document delivery has been supported by an expanding fee-for-service schedule adopted in 1972. User fees will be increased as of May 1, 1973, with high expectancy that, if CRMP support can be maintained throughout the remainder of 1973, the National Library of Medicine, through the Regional Library in Boston, will pick up on some of the CRMP costs of the delivery service. It therefore recommended that continued funding for this program be requested through CRMP beyond June 30, 1973, to allow for full transition to Regional Library and fee-for-service assumption of support.

CRMP Staff

Although technically within the jurisdiction of the Research and Planning Activity Panel, the assessment of program staff was conducted by several groups. Speaking for the Review and Evaluation Committee, however, I want to emphasize that group's strong feeling that the present staff size, particularly given Dr. Clark's forthcoming resignation and another individual's planned retirement, would be required merely to complete required final reports and to phase out operating programs. But, in addition, actions by the Executive Committee and the Advisory Board clearly indicate a much more aggressive staff activity, particularly in the area of staff efforts to assist individual projects in explorations of alternate sources of funding. It is therefore extremely important that the request submitted to RMPS for support beyond June 30th also provide for staff capability to maintain the forward thrust of CRMP's catalyst and coordination role, at least until such time as some alternate statewide organization can be developed to assist in developing guidelines for decision-making and priority-setting in the health area.

THE ROLE OF RESEARCH AND PLANNING ACTIVITIES

It is important to conclude this report with several comments about the role of Research and Planning Activities in the Connecticut Regional Medical Program. In particular, it is important to emphasize some of the accomplishments resulting from expenditures in this area and to suggest what will be missed if CRMP, or something remarkably like it, is not on the scene. I make these comments not in the sense of a eulogy, but as a challenge that we not let some important things fade from the Connecticut health scene.

First, while it is possible to find examples which show productive expenditures or non-productive expenditures, I think everyone would agree that succeeding CRMP annual reports have detailed an evolution of research and planning activities from (a) the initial research on local health conditions and practices necessary for the development of CRMP's overall plan of action; to (b) the utilization of Health Service Area Program Assistance funds to foster planning activities leading to demonstration operating programs; to (c) more recently, a concern with the evaluation of the impact of the central components of the CRMP.

Thus, one major accomplishment has been the use of flexible research and planning funds both to stimulate new ideas or programs and to assess critically the current state of the system and its component parts. This has not occurred without problems. Many would argue CRMP has been overly stimulative and critical. This may be true in specific cases, but one wonders who will have the courage to continue this general role.

Second, is the fact that the Research and Planning Activities contemplated within the coming year place emphasis on the evaluation of the central components of the CRMP program. These central components--the development of the full-time chiefs concept and the establishment of linkages between the community hospitals and the University Medical Centers--are largely in place. Loss of funding therefore comes at a time when major attention could be, should be, and was being, turned to the question of program effectiveness. Who will have the flexibility and funds to adequately examine the impact of these developments?

Third, Research and Planning Activities have not been limited to studies. In fact, a number of programs were initially supported totally or in part by expenditures from this area of the CRMP budget. Some of the supported projects have since become self-supporting, or have obtained other support, and are ongoing activities benefitting various segments of the Connecticut population. Illustrative of these were the Connecticut Regional Blood Bank Survey which resulted in an active consultation and educational program, a statewide, computerized blood inventory system, and a formal program of interhospital cooperation and sharing of blood on a regional basis; the support of individuals to help develop plans or grant requests in such varied areas as hospital chiefs, OEO Model Cities programs, and CHP (b) agencies; and the planning, development, and operation by a ten-agency consortium of a community-based health research publication series which, for example, distributed the Radiation Therapy Guidelines developed by the Connecticut Hospital Planning Commission with financial support from CRMP.

A number of other projects designed to promote regionalization and effective organization of services or to encourage improved patient care to specific groups, financed as part of the research and planning effort of CRMP are well on the way to self-support and/or significant influence. Whether these programs will be able to realize their full potential without the last crucial support is difficult to predict. Illustrative of these are the Association of Community Health Service Agencies Inc. which seeks to develop a statewide central coordinating agency specifically concerned with improving the quality, organization and economical delivery of home health care; the program being developed by Dr. Evans Daniels (Community Health Services) to improve the quality and quantity of medical care available to the urban poor in a minority area of Hartford; and the hospital-based home care coordinating program at St. Raphael's Hospital.

It would be possible, of course, to cull through previous CRMP reports and pull out examples of "failures." To do so misses the essential point which is that another major accomplishment of CRMP has been its ability and willingness to provide "risk capital" for potentially good, but unproven, efforts. Indeed, since the announcement that the Nixon FY 1974 program called for the termination of the Regional Medical Program, I've heard many people say "Where now can we get either the seed money or the leadership necessary to bring people together even to discuss such things as . . .". In attempting to estimate what the loss of CRMP might mean, I suggest that question might be an apt summary.

Fourth, to emphasize programs which fell short of achieving their full potential ignores the fact that many of these produce some very useful results. For example, the Connecticut Stroke Program, though terminated from CRMP support earlier than planned, left a significant body of knowledge on the stroke patient and services in Connecticut. Thus, still another accomplishment of the Research and Planning Activities has been the development and distribution of a vast and wide-ranging set of baseline information about the Connecticut health system. Much of this will remain available, but continuous upgrading of the kind of basic data necessary for the development of an overall health policy may not occur unless someone assumes the job CRMP has attempted to perform for the state.

A fifth accomplishment of the Research and Planning Activities is to be found in various programs which CRMP helped bring to fruition and which will remain even if CRMP does not. Several of these have already been mentioned. One other worthy of mention is the Regional Hospice Program, described in the November 1, 1972 Grant Application.

What I'm suggesting, in essence, is that the accomplishments of CRMP as an organization in the past, and the challenge for the future, is not to be found so much in what it has done as in what it is. And that is a forum in which there is an opportunity for a variety of groups--private and public, voluntary and governmental, provider and consumer--to come together and attempt to develop a statewide health policy and resultant system of priorities.

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March 8, 1973

THE IMPACT OF CRMP ON THE MEDICAL PRACTITIONER

REVIEW AND EVALUATION COMMITTEE
CONNECTICUT REGIONAL MEDICAL PROGRAM

The topic of my presentation is the impact of the Connecticut Regional Medical Program (CRMP) on the practicing physician. While there are many facets and many areas in which the practicing physician has been affected by the programs supported by CRMP, the chief areas in which there has been help lie in the following fields.

First, is the advent of the full-time chiefs based in community hospitals. The full-time chief program became a necessity because part time chiefs with busy practices found themselves unable to devote enough time to supervision and monitoring of patient care, and to development and delivery of an effective educational program for continuing education in the community hospital setting. Almost always in Connecticut the decision to have a full-time chief has originated within the attending staff itself as they realized the complexities of the demands of various accrediting agencies, the haphazard organization of the local educational programs and the need to leave their practices and go out of town for any desirable education. As a result of the large increase in full-time chiefs, medical education programs have improved remarkably within community hospitals. Physicians and various staff with qualifications for teaching are incorporated into programs affiliated with the University Medical Schools. The schools provide the services of their most capable faculty members through CRMP supported programs.

Another important fact is that these new opportunities in the educational programs are being provided at the site that the doctors prefer. In many of the surveys that have been made, when physicians are asked "where would you like your continuing medical education to take place", the majority replied they would prefer it within their own communities. This allows them to continue their educational programs without leaving the site of their work. In other words, they are able to continue their practices and their education at the same time.

There has been an improvement in the quality of care for patients. It is recognized that quality of care is a very difficult thing to evaluate. It depends on the availability, utilization and delivery of the best in medical care. All three are necessary. The lack of one vitiates the others.

Full-time chiefs of services have become a fact in most of the community hospitals of Connecticut. As a result of their activity there has been a much better monitoring of utilization of services plus peer review of diagnosis, treatment, records and length of stay. All of this results in a better quality of care and a reduction in length of stay in the hospital. Because local educational programs have improved, and university affilations developed with the advent of full-time chiefs, American medical school graduates are applying to community hospitals for internship and residency training in larger numbers. The impact of this is that these American

graduates have a high probability of remaining within the community in which they are trained.

This, in turn, means an increase in the number of physicians who are available to provide primary care in the community. There has been a very dramatic example of this in the Waterbury area where there has been a recent marked increase in the number of new physicians in the fields of Pediatrics, Psychiatry and Obstetrics. In these specialties many of the physicians providing service were moving into the upper age bracket and the outlook for replacement, up to the start of the full chief program, had been limited.

Another development which has been stimulated by CRMP has been the increase in outreach services, especially in Pediatrics and Psychiatry. These are sorely needed services in communities such as Norwalk and Hartford with large disadvantaged groups. I would like to point out that, in the recent CHP (b) agency report from the Bridgeport area, one of the comments on CRMP-sponsored programs was the recommendation for continued support of full-time chiefs, especially in Pediatrics and Medicine, because of the outreach programs into deprived areas.

With regard to another CRMP-sponsored program, there has been a tremendous improvement in the availability and use of library services in these hospitals. An evaluation of library facilities in these hospitals prior to the CRMP program showed serious deficiencies of newer books, journals, facilities for reading or studying and, staff assistance. The CRMP Library Program reviewed the library programs in local hospitals in 1967, and made recommendations as to the basic needs in books, journals, facilities and staff services. Through affiliation with the libraries of UConn and Yale Medical Schools CRMP helped to make their book and journal collections available to practicing physicians throughout the state. CRMP also provided the main stimulus and consultant help to improve the resources and services of local hospital libraries.

The CRMP-sponsored Renal Dialysis Program has trained technical personnel for service in many communities and has helped develop programs for home dialysis throughout the state.

The CRMP-sponsored Diabetes Program, in its outreach activities, has helped physicians, dealing especially with disadvantaged and Spanish speaking groups, to provide information, nursing advice and consultation help throughout southern Connecticut.

The CRMP-supported Gastroenterology Program has improved the diagnostic and therapeutic acumen of many physicians by a network of educational activities brought into some 15 community hospitals.

These are only a few examples of many in which the CRMP programs have assisted practicing physicians to provide better care for their patients.

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March 8, 1973

THE IMPACT OF CRMP ON THE COMMUNITY HOSPITAL
REVIEW AND EVALUATION COMMITTEE
CONNECTICUT REGIONAL MEDICAL PROGRAM

Much of my experience with Regional Medical Programs has been in other states. I have been associated with CRMP for approximately 2-1/2 years; however, during that time I believe I have acquired a full understanding of the program in Connecticut.

One of the justifications given by President Nixon for cutting out the RMP program nationally is that it has not significantly changed and improved the delivery of health care in the country. It is my opinion that in many states this conclusion is true. However, the opposite is true in Connecticut. I have observed that a few people feel that CRMP has had too great an impact on delivery of health care in this State. The improvements are significant.

WHAT ARE SOME OF THE ACHIEVEMENTS OF CRMP?

In summarizing the activities of CRMP which are contributing to improved functioning of community hospitals the following programs should be mentioned: (1) the Community Studies Program based at the University of Connecticut; (2)the Community Studies Program based at Yale University; (3) the Health Service Area Planning Support Program; (4) the State-wide Library Program, including consultation and training activities to build up libraries in community hospitals and the document delivery services provided by the biomedical libraries at Yale and the University of Connecticut; (5) the University-Based Regional Medical Faculty Programs at Yale and the University of Connecticut; (6) the Connecticut Kidney Disease Program; (7) the Regional Blood Bank Survey and Supporting Services Program; (8) the Connecticut Stroke Program; (9) the Yale-affiliated Gastroenterology Program; (10) the Southern Connecticut Diabetes Program; (11) Southcentral Connecticut Continuing Care Program; (12) the UConn stimulated Connecticut Network for Bio-medical Communications; (13) the Connecticut Drug Information Service; (14) the University-based Regional Nursing Program, stemming from both Yale and the University of Connecticut; (15) the developing Statewide Emergency Medical Services Program; and (16) especially, the Full-Time Chiefs of Service Program.

All of the above programs, and many others, are described in detail in The CRMP Story, 1970-1971-1972, which is a 250 page volume published on November 1, 1972, and widely distributed throughout Connecticut. Copies are available at CRMP headquarters in New Haven.

Special reference should be made to the Full-Time Chiefs Program. In 1968 there were 6 Full-Time Chiefs in selected patient care services located in 3 community hospitals of Connecticut. In 1973 there are 57 additional Full-Time Chiefs in those services with 21 more being recruited in a total of 27 community hospitals. Those Chiefs have all been approved by their respective Medical Staff groups, have received faculty appointments at Yale or the University of Connecticut, and give medical supervision in their hospitals to delivery of health care, educational programs, and outreach activities. Each program develops in terms of the needs of the respective communities, but all programs move in harmony with the overall objectives of CRMP. At a time when special procedures, specialized equipment and laboratories and a wide variety of allied health personnel, all require careful supervision, checking, asceptic techniques, and continuing education, medical supervision on a continuing basis is more and more important. Affiliations with the universities bring the most advanced knowledge and techniques to the staffs of the respective hospitals. Aid is given in developing outreach programs. Audits, reviews, and utilization studies can be performed in a more systematic manner. Approximately 40 full-time chiefs have been supported in part by CRMP.

IF CRMP COULD CONTINUE, WHAT MIGHT BE ACHIEVED?

Further coordination and regionalization of new, expensive medical modalities as they are developed.

Continuing progress in medical and allied health education.

Service as a neutral integrator of different health groups, i.e. hospitals, doctors, university health centers, etc.

Assist the 7 hospitals which are currently searching for their first full-time chief to complete their searches and encourage the remaining 6 hospitals which have not adopted the full-time chief concept to move forward with such a program.

WHAT WILL REMAIN PERMANENTLY EVEN IF CRMP DISAPPEARS?

It is believed that almost all, if not all of the full-time Chiefs currently on hand in 20 hospitals will continue. The hospitals recognize the need for and value of having full-time responsible medical supervision within the hospitals for health care, education, and outreach activities.

It is believed that the advances already made in the specialized programs listed above will continue even though further advances may not be made.

It is believed that the most profitable University affiliations will continue, but probably not all.

It is believed that the changes in attitudes of professional groups toward the various programs already inititated will support their continuance.

It is believed that most of the educational activities, audits and utilization activities will continue at least at their present levels.

IF CRMP IS DISCONTINUED, WHAT WILL BE MISSED?

Universities will probably not be as involved in improving health delivery and education in community hospitals as in the past.

CRMP's constructive influence in regionalization and the placing of new medical modalities will disappear and developments in this regard will slow down.

Its function of serving as catalyst of new ideas for all hospital groups and services will be missed.

The progress in establishing full-time Chiefs in the remaining Connecticut hospitals will undoubtedly be delayed.

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March 8, 1973

THE IMPACT OF CRMP ON THE UNIVERSITY HEALTH CENTERS
REVIEW AND EVALUATION COMMITTEE
CONNECTICUT REGIONAL MEDICAL PROGRAM

Terms such as crisis, nonsystem, cottage industry, efficiency, obsolescence innovative and impact are among the code words of our time. They are eminently versatile and, depending on which body of incomplete data or what set of unsuitable measuring techniques you care to use, these terms can serve virtually any point of view.

Thus hospitals are told to outreach, provide more services and cut their costs. Practicing physicians are told to fill out more forms, delineate their capabilities, spend more time in self education and, above all, "the socially aware" would prefer they not earn twice as much as someone working one half as many hours. Medical centers are admonished about impersonal attitudes, alienation, loss of dignity simultaneously with reminders of accountability, utilization review, and that morning's computer print out. The nurse, psychiatrist, social worker, clinical theologian, and the politician have assumed a responsibility for holistic man while we also develop our program in family practice and, I might add, while the culturally avant-garde are telling us to get over our hang ups on the nuclear family.

For those with a talent for planning and futuristic thinking the questions have already been raised, "Are coherence and pluralism contradictory concepts?" and "Isn't the most pertinent question about planning what can be left unplanned?"

Each of us is entitled to his own set of reactions to comments such as these. They by no means cover the conceptual confusion, indeed, they don't even touch on the speaker's most fundamental problems which are: laboratories in which precision has left little room for accuracy; the Surgeon General's library transformed into a multimedia electronic zoo; the specter of rendering my best value judgment on a patient whose history has been obtained by the computer; and finally the shame I feel when I admit an addiction to knowledge for knowledge's sake.

So much for the sublime and the ridiculous. Mr. Nixon says he will do something about all this by his Welfare Reform Bill, HR-I, National Health Insurance Partnership Act, by encouraging the development of HMO's and by a variety of specific actions aimed at Cancer, Heart Disease, Sickle Cell Anemia, Family Planning, Alcoholism, etc., etc. These came closer to the realities, and interwoven throughout is that we must and will have a system so that influx funds are not solely inflationary. This notion of a system is, however, in the same message in which the President states that to "get quality regardless of income or residence remains an item of highest priority on my unfinished agenda for America of the 70's". System and quality-wise the university

is thus in the act. It's thoroughly in the act because:

(a) university health centers face decreased support for building and financing the University Hospital;

(b) they face a diversion of teaching patients to community hospitals;

(c) there is the trend to research in health care and away from biomedical research;

(d) they are being asked to provide a wider spectrum of experiences for a wider variety of health professionals.

In this circumstance universities are being urged to evolve through the stage of a multischool academic center into multi-institutional, regionalized health sciences consortia. Pedagogic aims and academic organization are supposed to be brought into closer conformity with public expectations. They are supposed to develop departments of family and community medicine and they have been cautioned to "find the balance between responsible involvement and careless over immersion in service obligations". They are also asked to exhibit a new form of academic statesmanship and create a new form of managerial leadership.

It was exhortations such as these that led to my resignation as an Associate Dean of a medical school and to my coming home to Connecticut. Beyond any native conceptual difficulties one might have, they are given a special poignance in that these mandates come from on high without enabling funds, a detail that is not considered mitigating.

The difficulties are immense because they involve the nature, the character, the identity, indeed, some would hold the very authenticity of the university. They are formidable if you're a new state school starting to develop clinical facilities and they are formidable if you're an established private school hoping to consolidate what you already have. Will anyone in this room wager that the University of Connecticut and the Hartford Hospital will be optimally configured in the interests of the commonweal before some members of the Yale faculty grant professional equivalence to those not practicing on Cedar Street?

The difficulties are great because universities are not particularly adept at managing the students, the department chairmen, or the university's portfolio - so why the health care system? The difficulties are great because the role of the university is inflated, exaggerated, and generally distorted in these schemes. The university is not the repository of ultimate justice; it is not the institution to set quality standards for community hospital; it is not the cauldron for progressive action. Indeed Oxford is known as the home of lost causes and faculties have been reminded for years that they are politically liberal and pedagogically conservative. The university is a collection of specialized talents: its mission is education in a defined sense; it is a resource; but in character it is closer to a library or a laboratory than to a legislature or an agency.

Viewed within this context both of the medical schools in Connecticut have made progress. The University of Connecticut is committed to the partnership

concept and in the persons of Doctors Gaintner and Kramer they have two outstanding and resourceful representatives. The school offers the rather unique opportunity of observing the development of clinical programs in the virtual absence of a department of medicine. Departments of medicine are usually the biggest department in a school and to a bystander the Connecticut phenomenon is interesting; to the accrediting committee it could be viewed as fatal. Someone should explain this to the head of the State Personnel Dept.

Individual members of the Yale faculty have made committments to individual hospitals and by and large the Yale presence is felt. I cannot speak for the entire Yale faculty but would like to believe progress has been made at least in the way of understanding.

Both schools recognize there are things they must do in order to do the things they want to do. Linkages have been formed and some of them will be enduring but the majority need nuturing. Area health education centers should be developed in Bridgeport, Waterbury, and Stamford. Like the Stony Brook model it would be preferable if each had its own Dean or District Medical Officer. This individual would be the responsible executive officer for the particular center and work closely with the parent organization. The centers in turn would relate to their surrounding areas. It will be interesting to see if they evolve into yet another community college.

I would like to see house officers centrally recruited and some sort of standard personnel policy, possibly managed by the Connecticut Hospital Association. It would be desirable if faculty members moved in both directions for pro tem periods of say one week or one month rather than the "sing for your supper" arrangement we have now. The idea is a network, a lattice and a ladder that assures the patient the best we have available, that reminds us all of a broader horizon than that provided by our own self interests. It is a committment to open mindedness as well as to human welfare. It is an act of humility as well as a strategy for service.

Multi-institutional regionalized academic health centers: note the term academic and at least in some of the discussion this is the key word. The academic center is really intended to be the nuclear force, the site of the truly fundamental particles. I obviously question this and am inclined to the view that the academic health sciences is an essential component but hardly the *alpha* and the *omega*. The period in which education was an omnipotent concept and a totipotent notion is drawing to a close; and hopefully its use will henceforth be more precise, be it in connection with percent effort of the faculty, house officers salaries or as a means of fulfilling human expectations.

Institutions with self images vs. those with personalities, the public vs. the private sector, physicians vs. nurses, sociologists vs. planners, the rich vs. the poor, the provider vs. the consumer, the insurance companies vs. the social security administration, center city vs. rural regions, the emergency room vs. the laboratory; are we not naive to hope for a blend? The Connecticut Regional Medical Program, to my knowledge, is the closest

anyone has come to such a hope. Its impact has been remarkable; it is a presence as well as a disposition of mind; it is a convener and a conveyor; and its leadership has given it a style. If it expires, business will go on about as usual, unavoidable affiliations will remain intact, mutual self interests will continue to be served, but there will be less in the way of a community of interests!

My comments dealt with the Universities within a perspective and perhaps I should have simply repeated what President Griswold once said of Yale in relation to the City of New Haven, namely, that it should be neither incubus nor octopus. I would, however, like to end on a thought taken from his successor who stated that the Yale Corporation was the symbol of University integrity.

In health affairs this forum should be a symbol of integrity to work for a comprehensive health program for Connecticut. If CRMP goes the problems will remain and there will still be the same insistence on a system. Then we may find ourselves without federal backup, without federal experience and resources and competing for revenue sharing dollars. For those of us interested in health services I would remind them that elected municipal and state officials rank it after police and fire protection, garbage removal and elementary schools.

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