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A STUDY OF

THE REGIONAL MEDICAL PROGRAM

Volume III - Regional Descriptions

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I. INTRODUCTION

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During the past two years spent in studying the Regional Medical Program, the ADL/OSTI study team has devoted many weeks of time to finding out what is happening in the field. Concentrated attention, by agreement with officials of RMPS, was given to four regions: North Carolina, New Jersey, Greater Delaware Valley, and Northlands. A fifth region, Memphis, proved to be of special interest because of its close formal ties to CHP under a joint council, the Memphis Mid-South Planning Council, which (along with many other activities) brought together all elements of the health system and wide public representation in a unified effort to improve the delivery of health services in the Greater Memphis area.

In each region, we began our work by interviewing representatives of all groups known to be interested in medicine. Within RMP we talked to staff, RAG members, and various people on committees and task forces. Outside RMP we talked to private physicians, hospital administrators, medical school faculty, and, in some cases, legislators. The people interviewed at the beginning usually referred us to others, and we learned much from these additional interviews. We also reviewed RMP records and reports and attended various staff and committee meetings.

As mentioned above, we have included Memphis because of its unique organization, which is of interest to all those involved in RMP and CHP. Our field work in the Memphis Region was not as exhaustive as in the four other regions described.

Our descriptions of the regions in this volume vary both in purpose and in level of detail. Our information on North Carolina, being based on a visit two years ago, is in some respects out of date. There is a new Coordinator, and much has changed since we were there.* Nevertheless, it was in North Carolina that we first began to understand the inherently shifting, flowing nature of the Regional Medical Programs. Therefore, instead of describing North Carolina's program at length, we have focused our discussion on ideas about RMP that emerged from our observations in North Carolina, but that have relevance for RMP as a whole.

The New Jersey RMP proved to be of special interest because of the way realities in the Region focused the attention of its Regional Advisory Group (contrary to its early expressed interests) increasingly on the massive ghetto problem. The write-up on the New Jersey RMP reflects that focus.

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*We have, however, kept in occasional touch with North Carolina RMP officials to follow particular activities (cited elsewhere in this report) which illustrate the "motion" of development.

The Greater Delaware Valley and Northlands RMPs are described in more detail, since in both cases the material is based entirely on visits in 1970. These regions are as representative as any two can be of the problems and opportunities of other regions, and the approaches adopted by their RMPs have been very different. Both have had some successes and some failures, again of differing kinds.

Memphis is a special case. Perhaps more than any other region, it has clung -- with considerable success -- to the center-periphery model of regionalization. Yet even here some of the most exciting developments have grown up with little dependence on that model.

II. NORTH CAROLINA RMP

II. NORTH CAROLINA: EMERGING VIEWS ON THE NATURE OF RMP

The North Carolina RMP was visited by the ADL/OSTI team in the late fall and early winter of 1968-1969. It was the consultants' first extensive visit in a region and as such was aimed at gathering information, learning (i.e. understanding) as much as possible, and talking with a wide variety of people so that we could begin to refine our tentative hypotheses about the RMP, its function, and its impact.

Because the work was done nearly two years ago, this paper cannot reflect the current situation in North Carolina, and we have made no systematic, overall attempt to keep up to date over the intervening time. We have instead used our experience in North Carolina as a springboard for our investigations in other regions. This paper summarizes and illustrates the themes we observed at that time and the concepts associated with them. We made oral reports to the Executive Committee of the North Carolina RMP and later to interested members of the national staff.

The coordinator of the North Carolina RMP at the time of our visit was Dr. Marc J. Musser. His core staff numbered some 22 people, and his budget for the year 1968-1969 was $1.8 million. The first group of operational projects, some 15 in all, had received funding in July 1968.

In accordance with the terms of our contract, our effort was aimed at discovering the important regionalizing and evaluative processes going on in the Region, studying its relationships with what was then called DRMP, and developing verbal formulations to describe the processes and relationships. We concentrated on collecting impressions, opinions, and the reports of various individuals on their experiences with RMP, rather than either accumulating statistical data about the Region and its RMP projects or trying to make sense out of the program primarily on the basis of such statistics as were available.

We went to North Carolina with a number of questions and tentative hypotheses based on a reading of the law and other documents pertinent to RMP, talks with people in (then) DRMP, brief visits to some half-dozen other regions, and our shared reflections on these experiences. The questions or hypotheses were not necessarily self-consistent. We had quite a number of potentially contradictory ideas in mind:

- Since RMP had no sanctions and was legally proscribed from interfering in the patterns and financing of health care, it was not obvious what RMP could do beyond conducting small training courses and demonstration projects in categorically indicated areas of disease.

- Without sanctions, RMP could still be a broker, or change agent, acting among the various health and medical interests in the regions. But its function was not obvious. Change in what and for what? How could RMP bring any changes about, considering the restrictions on it?

- Within the categorical disease areas permitted, what initiative could RMP take? If it was purely a grant program, how could it bring about anything recognizable along lines of "regionalization"?

- Was RMP really a mere medical school support program, a way to shore up the threatened NIH grant structure and the health-through-research strategy, as some opponents charged? Did the medical schools control RMP?

- Since regionalization apparently was not being centrally imposed and was not taking orderly administrative form, what, if anything could the process consist of? Was it, as we suspected, diverse? Was it subject to classification, perhaps five or six major types, corresponding to variations in demography or health care resources? Was regionalization somehow "growing out" from starting points or nuclei that were the original participants in action projects undertaken voluntarily? What would make regionalization happen?

- Of what did the NCRMP-DRMP relationship consist? Given the newness of the program, the dependence on review at the Federal level for funding, the anxieties concerned with pioneering a new program (and having to explain and justify it), and what other coordinators had told us, we hypothesized that the amount of meaningful communication between the Region and DRMP would be limited, the relationships rather distant, and mutual perceptions based on imagination and frustration as much as on experience.

- What kinds of evaluation were occurring at the regional level? We hypothesized that no single set of evaluative criteria would suffice, because RMP had so many constituencies, each with a different point of view. Moreover, the evaluation process itself should be flexible and ever-changing. But, because it was difficult to agree upon evaluation methods, the identity of the program was not yet established, and clear guidelines from Washington had not been published, evaluation efforts at the regional level were probably minimal.

Major themes which emerged from our North Carolina RMP experience, answering some of the questions and correcting or clarifying the hypotheses, are described in the paragraphs which follow. Readers of the main body of the report will see these themes echoed, reshaped, and refined in descriptions

of our subsequent visits and in our general formulations about the processes of the RMP and its impact on the health care system.

A. FACILITATION IS A KEY RMP STRATEGY

During our visits to North Carolina it became apparent to us, as it had to many of the people connected with the North Carolina RMP, that the program's ability to grow, to connect directly to what was going on medically in North Carolina, and ultimately to accomplish any kind of regionalization of health services depended to a large extent on its ability to avoid being perceived either as a heavy-handed federal program or as "another competitor" staking out territory or creating operating programs which could be viewed as pre-empting somebody else's already established sphere of activity. As an executive of the North Carolina Heart Association put it, "When RMP becomes a doer, it dies. Already established agencies and institutions will take the attitude that if RMP steps on their toes, they will scuttle it. But if RMP wants to cooperate with those agencies and institutions and help to stimulate their cooperation with others, they will support RMP and work for it."

This sentiment was expressed to us in various ways by a number of people in the Region. It seems to reflect the suspicion with which the proudly independent people in this state view federal programs which attempt to legislate or coerce behavior and patterns of relationships. We were told that the RMP made a conscious effort, particularly during its early stages, to allay those fears and clarify its function as a grassroots program aimed at stimulating and utilizing local initiative.

The North Carolina RMP had to work, at least initially, in two modes: as a convener of some of the key health interests in the Region (through the Board of Directors, the Regional Advisory Group, area study groups, and categorical committees) and as a supporter of activities which already established groups wanted to undertake but could not because of lack of funds or sanctions or both. Often, the RMP was able to provide some staff help and fresh viewpoints toward developing new activities within ongoing programs. Of the original group of 15 operational projects approved in July 1968, four were specifically identified as continuations of previous work of the grantee. Two more were projects which the sponsoring institutions had wanted to start but for which funds from traditional sources were lacking. For example, the assistance and support of the RMP enabled the Heart Association to shift its priorities toward certain community-related projects such as a coronary care unit training program and a cardio-pulmonary resuscitation project.

The RMP also picked up and supported the "Berryhill" project, a complex set of activities based at the University of North Carolina Medical School and aimed, in part, at outreach to community hospitals. As part of that project it provided air transportation for academic physicians and medical students to the large hospital in Wilmington (there

is an all-weather air strip within four miles of almost every community hospital of more than 100 beds in North Carolina) and for local doctors into the medical center as well as to and from other hospitals, thus enabling specialists from the university to see patients in their own communities, giving faculty and students an opportunity to see how medicine is actually practiced, and giving community physicians an exposure to the academic environment at Chapel Hill. The latter had the advantage of enabling local physicians to get a better sense of the utility of the capabilities at UNC and of their relevance to problems of the physician. The RMP's emphasis on collaboration and regionalization helped develop these activities beyond their earlier conception which had been more exclusively focused on sponsoring "circuit riders" going out to give lectures and consultations.

In the State of Franklin, which encompasses six counties in the westernmost part of North Carolina, the RMP gave active support to Dr. Karl Killian and others who, through a Development District under the Appalachian Regional Commission, were already attempting to knit together that part of the state economically, politically, and medically. Federal funds had already been attracted from a variety of sources, particularly the Office of Economic Opportunity, but the RMP also significantly helped people in that part of North Carolina to begin seriously working and planning together. The RMP presence was clear and strong in the State of Franklin, according to the people there. It materially assisted six community hospitals to begin to link together, helping with accreditation and promoting a cooperative coronary care unit training program in conjunction with Bowman Gray Medical School. It also supported the development of an "Academy of Medicine" which involved nearly all of the practitioners in that area. (This story is told in more detail in Addendum 1 to Chapter IV, Volume II.)

In these examples as related to us, it was clear that it was the RMP's imaginative and sympathetic support, not RMP domination and certainly not simply RMP dollars, which made the difference. Such examples spoke to the initial hypotheses we brought: the prohibition on interfering in patient-doctor relationships could be respected since the RMP operated only at second hand (through other institutions) in the instances we observed. Fully sanctioned physicians and hospitals carried on all patient care on a basis acceptable to them. The RMP's contribution was facilitative and supportive and was accepted quite voluntarily; "interference" was not an issue in the minds of the people we visited, with respect to any activities or conversations they knew about (though many were suspicious of RMP as a federal program, quite apart from what it did.)

Were the activities we saw highest in the priority of things that the North Carolina RMP should have been doing? What "should" it have been doing? Could it have behaved in other, different ways? We suspect that, given the need to develop operational projects quickly and the need to involve the medical schools and others in concrete ways, the avenues chosen were probably appropriate, at least in the examples cited above. The first

involved the Heart Association in a role closer to direct delivery of health services. The second involved UNC Medical School and made explicit some of the objectives of RMP regarding links between the medical schools and the community and regarding the continuing education of physicians. The third involved RMP in an ongoing regionalizing effort among community hospitals.

B. THE SHIFTING CONSTITUENCY IS AN IMPORTANT REALITY AND A STRENGTH FOR RMP, AS WELL AS A SOURCE OF CRITICISM.

The RMP in North Carolina was initiated by joint action of the deans of the three medical schools (University of North Carolina, Duke, and Bowman Gray) and the State Medical Society. These institutions furnished the core of the original Board of Directors and continue to make up the "Association for the North Carolina RMP." The deans of the three medical schools, in particular, provided much of the early impetus to the development of the RMP. Their concerted action was acknowledged by most informed people with whom we talked as having been extremely important to the RMP and also very interesting in that it represented the first substantive, positive, institutional agreement consummated among the three schools. According to the dean of one of the medical schools, the RMP was the only source of real contact among the three medical schools at that time. In addition to forming the basis for regular working communication among the deans (beyond a purely social level; they were already personal friends), it led to coordination of continuing education programs among the three medical schools.

Of course, medical school involvement in the RMP did not go unnoticed by other people in the state who were eyeing the program with both curiosity and apprehension, but in any case interest in seeing what could flow from it. To some of these people, there was clear evidence that the medical schools had "captured" or at least dominated the program and that RMP funds would probably never get past the walls of the medical school, let alone out into the community where in their view it could really do some good. The RMP's early sponsorship of the Berryhill project and its substantial investment in a medical school-based project to develop a demographic data base did nothing to quiet these suspicions. Indeed, the first constituency of the RMP could be said to be medical schools, and some commentators then on the scene in North Carolina thought these probably would remain the permanent and exclusive constituency of the RMP.

The initial group of operational projects, referred to as "the cover crop," were developed quickly to help the North Carolina RMP become operational. All but two were sponsored by or in cooperation with one or more of the medical schools. But the RMP had also begun to reach past the medical schools. Its activities in the State of Franklin were related to Bowman Gray, but by no means based there. While we watched the North Carolina RMP also increased the power of its Regional Advisory

Group by giving it policy and review functions. Changes were also proposed in the makeup of the Association, shifting membership in the Association from the medical schools to the universities themselves, authorizing formation of area-wide study groups and including the Dean of the University of North Carolina School of Public Health on the Board of Directors, along with other influential people. All this seemed to us to constitute or recognize a broadening or changing of the RMP constituency, in response to valid pressures from outside the original (medical school-medical society) constituency. By the time of our study in late 1968 and early 1969, the RMP was also making active efforts to find valid methods to involve community hospitals in its work. There was also growing interest in involving local practitioners. It seemed to us that steps would continue to have to be taken to prove RMP's openness and willingness to respond constructively to strong "outside" groups asking to be recognized and that this process could well continue indefinitely, with different groups successively becoming the principal current focus of RMP energies. Because so many action possibilities exist -- eg., project money, committee membership, RAG membership, Board membership, access to core staff support -- groups might differ greatly in what they wanted or in what they perceived as evidence of being included in the RMP constituency.

We came to view the inclusion of other people in the activities of RMP not so much as an expansion of RMP's activities, but rather as a shift involving a changing cast of characters, including partial disengagement from those who had previously been central to the program. We have likened this shifting process to a wave cresting at the point at which RMP becomes involved with and connected to a changing set of people and institutions, depending in part on who has clamored most loudly and worked most effectively to obtain RMP's attention and in part on where energy exists of interest to RMP. With limited funds and manpower, RMP has enough resources to be actively working with only some of the people and institutions and issues concerned with medicine and health care at any one time. As a result, there will always be a number of physicians, health care officials, and other people aware of RMP who feel that they have not yet been touched by the program. In North Carolina for example, we frequently heard that the RMP, to that time, has "done nothing to help the practicing physicians." The first opportunity to involve significant numbers of local practitioners in the work of RMP came through the area-wide planning or discussion groups set up as a result of a tentative sub-regionalization pattern proposed by Dr. Harvey Smith (who did the initial North Carolina demographic and health care resources study.) The data and interpretations developed by Dr. Smith provided both a rationale and a focus for these groups. It must be said, however, that what we perceived as involvement was not necessarily perceived by local practitioners as being done in their behalf. For many of them, a feeling of commitment to and involvement in, RMP work, would obviously still be slow in coming.

In terms of the life and vitality of the North Carolina RMP, it seemed to us likely, and probably also desirable, that the central constituency of RMP keep changing. We further postulated that if the RMP were

"captured" permanently by any one group or set of groups, then it would probably lose its ability to relate to others and thereby fail to respond to significant current health problems which might be represented by a prospective constituency. The need to (1) become relevant to particular people, groups, and problems, and consequently, (2) allow for continually changing relationships in order to involve new people, groups, and problems, together imply a rather delicate balancing act of enough importance in itself to constitute a central task of the local program coordinator.

We view the Regional Advisory Group as having a unique role to play in this shifting constituency process. In North Carolina, we were frequently told by RAG members that they felt they had little or no power with respect to policy formulations for the direction of the RMP. They saw themselves as useful for project review and for receiving reports from the Board of Directors, but felt, at least initially, that they could do relatively little to influence the course of the program. Later, as we have noted, the North Carolina RMP moved to strengthen the RAG by giving it the job of reviewing and commenting on policy decisions made by the Board of Directors. But the RAG seemed to us to serve even more importantly as a kind of intermediate staging area for newly emerging interests and groups to which RMP needed to relate, and which needed to discover how RMP could serve them.

C. IMPORTANT REALITIES IN THE RELATIONSHIPS AMONG PHYSICIANS AND MEDICAL INSTITUTIONS, OFTEN EXPRESSED IN A "HOPSCOTCH" OR "CHECKERBOARD" PATTERN OF REFERRALS, MAY HAMPER REGIONALIZATION ALONG LINES OF THE CENTER-PERIPHERY MODEL AND OBLIGE RMPs, AS ONE OF THEIR CENTRAL TASKS, TO FIND ALTERNATIVE MODELS.

In parts of North Carolina (as elsewhere), referral patterns tended to be based in part on the fear of physicians that if they referred patients to nearby specialists (10-100 miles away), particularly those engaged in the more general medical specialties, they could readily lose the patients. To guard against this, physicians tended to send referrals to medical specialists located some distance away from the referring physician. The resulting referral pattern looked to us more like a checkerboard or a hopscotch grid than a hub and spokes pattern. We saw this most clearly in the referral patterns between the State of Franklin and the City of Charlotte, located over 100 miles as the crow flies from the eastern edge of the State of Franklin. The City of Asheville is much closer to the State of Franklin, but referrals tended to bypass Asheville because in the opinion imputed to doctors in the State of Franklin by respondents there (medical and otherwise), "If you refer to Asheville, you don't get your patients back."

A report prepared by the Area I Study Committee set up by the North Carolina RMP, which covered the 17 western counties in North Carolina, acknowledged that there was a "communications barrier between physicians practicing in the Asheville-Buncombe area and the remainder

of Area I (State of Franklin)." The Area I Committee, on the grounds that it represented the entire Area I which included Asheville, offered to serve as a continuing mechanism for breaking down this barrier.

Similarly, in Area III we were told of the threat which Mecklenburg County physicians, particularly those affiliated with Charlotte Memorial Hospital, were perceived as posing to physicians in the surrounding counties, and of the defensive attempts on the part of at least one group of physicians to form a five-county association around a nearby community hospital. The RMP Area III Study Committee, while acknowledging substantial differences in geography, economic conditions, and medical services available in various parts of the Area (which encompassed 16 counties in the southwestern part of the state around Charlotte) nevertheless acknowledged the need to plan cooperatively and to identify health care needs on an area-wide basis.

We speculated that without change processes stimulated from outside, the checkerboard referral patterns would persist. We further speculated that their persistence, together with the reasons behind it, would tend to preclude regionalization in the form of the major center linked to its periphery. By the same token, we suspected that the establishment of sub-regions by the RMP explicitly for the purpose of creating a "regional hospital" as the center of the sub-regional referral pattern would probably not be accepted by either hospital or physicians, even if the RMP were authorized thus to anoint a hospital. To the extent that checkerboard referral patterns exist more broadly in the United States they represent part of the reality of which RMP needs to be aware, for they affect the kinds of regionalization efforts that will be possible for RMP.

The sub-regions (numbering six in all) were delineated in 1968 as the result of a two-year study conducted by Dr. Harvey Smith and his associates at the University of North Carolina. Dr. Smith asserted that North Carolina divided itself "naturally" according to the data into six sub-regions or service areas. Using the data for sanction, the RMP formed the committees mentioned above to consider the implication of Dr. Smith's data and to plan for the more effective delivery of health services in each service area. Each committee met and prepared a summary report to the RMP outlining the needs it perceived in its area. At least two of the area committees (Area I and Area III) indicated a desire to continue in operation at the time of filing their report. Other area committees either saw no reason for continuing their existence or suggested different patterns of area delineation. The Area II Committee, for example, felt that the Area artificially combined three rather distinct sub-areas with very different economic and medical characteristics and problems. The Area V Committee felt that "no functional unit could be created out of sub-region five."

Clearly, there was some resistance to the perceived imposition of a series of sub-regional center-periphery structures by RMP in North Carolina, even though the entire exercise was very clearly billed as sub-regionalization for data analysis and planning purposes only. Clearly,

too, if regionalization processes were to amount to anything, they must take account of such resistances. A form of "regionalization" that honored existing patterns might have more success than one, however reasonable, imposed from outside.

D. THE ASSUMPTION ON WHICH THE CENTER-PERIPHERY MODEL IS BASED--THAT MEDICAL EXCELLENCE IS LARGELY CONCENTRATED IN ACADEMIC MEDICAL CENTERS--IS WIDELY REJECTED OUTSIDE THESE INSTITUTIONS.

As one physician puts it, "The university medical centers can legitimately claim excellence in certain kinds of disgnosis and treatment of disease, depending upon the specific people at the university, but it cannot claim superiority across the board. In our hospital we can provide care similar in quality, scope, and content to the university medical center. Why, therefore, should we refer patients to the university?"

One fairly large community hospital, in particular, rejected the notion of being adjudged peripheral to the nearest university medical center, and actively set about to establish itself as a major referral center. It claimed that its substantial teaching program and comprehensive facilities made it equal, in essentially every way, to the university medical centers.

It must be stressed that there was no across-the-board derogation of the competence or excellence existing in the three university medical centers, and, in fact, each medical center was acknowledged by at least some of the people with whom we talked as being genuinely expert in one or more of the categorical diseases. Nor was it denied that there existed practicing physicians who simply dispensed "aspirin and sulpha drugs," and who might, in the opinion of their colleagues, need retraining. But the concept that concentric circles of excellence or competence radiate out from the university medical centers gained no additional acceptability from the mere fact that a regional medical program now existed.

E. EVALUATION OF RMP IS AN IMPORTANT, BUT IMMENSELY DIFFICULT AND MANY-FACETED UNDERTAKING.

At the time we began our North Carolina visits, we had not yet developed a positive theory of evaluation, although we did have some hypotheses about the need for different points of view and the need to evaluate the ongoing processes in a region as well as whatever tangible results were forthcoming from those processes.

During the time we spent in North Carolina, several parallel efforts were under way to develop the outlines of a general evaluative scheme; these led to the concept of various levels of evaluation related to the impact of RMP on different aspects of the health care system and, ultimately, on the health of people. We were fairly well convinced that simple indicators such as measures of mortality and morbidity in the cate-

gorical disease areas would be grossly inadequate as the basis for assessing RMP's performance, given both the length of time required for measurable change in those indices and the complex of factors affecting or potentially affecting them which were not directly related to RMP activity.

In the absence of a well-developed evaluation framework of our own, we attempted to be alert to the kinds of evaluative activities actually taking place in the North Carolina RMP. Individual project applications were reviewed by the categorical committees, the Board of Directors, and the Regional Advisory Group for content, appropriateness for RMP funding, and amount of funding desirable. Each project application had a general evaluative section but, at the time of our visit, no formal process was yet established to review progress of specific projects or to asses their results in any systematic way. (Bear in mind that active projects had been funded only a few months earlier.)

But evaluation of specific projects was only a part of the picture. Much of the RMP activity on which core staff and other interested people focused took place outside of the project context, strictly defined. Meetings of the RMP Advisory Group, Board, and committee, for example, were bringing together the health interests of the states. Core staff activities in the State of Franklin were affecting institutional relationships in that part of the region. Area planning committees were being convened to assess health care problems and to propose steps to deal with those problems.

Discussion and, presumably, evaluation of these activities seemed to be the task of the Board of Directors, and principally in the Executive Committee of the Board, functioning very much like boards and executive committees everywhere. The evaluation was usually limited to discussion of reports from the RMP Coordinator and others.

The Coordinator and other members of the Board were acutely aware that more systematic evaluation was needed, but at the time of our visit, no significant, explicit retrospective evaluation effort was being made either of projects or of the program as a whole. The schemes proposed up to that time were expensive and did not seem to accomplish measurement of anything important.

F. THE VIEW OF WASHINGTON TENDS TO BE REMOTE.

Except for Dr. Musser, few RMP people in North Carolina appeared to know the national staff, to be aware of its functions, or to see much advantage in connecting with it. The newness of RMP at the time, the distance between DRMP and the Region, and the vagueness of function at both levels all made it difficult for the North Carolina people to see much obvious advantage in connecting with DRMP. To some extent, this communications gap between national and local levels was evident in most of the RMPs visited.

There was little doubt that some individuals kept their eyes on the Washington scene for signs of policy change, for rumors of new programs, for indicators of how best to qualify for grants. If the administrators of mountainside hospitals felt remote from the processes of research grantsmanship, others had made it their business to learn these processes. However, this was a matter of individual initiative; it did not represent full and close communication between the regional and national components of RMP. As a result, there was too much uncertainty on what RMP was all about on the part of many RAG members, most of the core staff as it then was, and (of course) most particularly those whose participation was being courted.

We have recently spoken again with some people in the North Carolina RMP, who report that communications with Washington have improved. Our impression is that this is also true in other RMPs.

III. NEW JERSEY RMP

III. THE NEW JERSEY RMP

Our work in New Jersey was more recent than that in North Carolina, but even so it is now a year and a half old. Thus, the chief interest it holds for this report is, again, not the details of the program but the general conclusions we were able to draw from them. In New Jersey we found conditions that did not appear to favor a successful RMP, and an RMP that appeared to be moving ahead anyway. We attribute its progress to its readiness to take the initiative in identifying the Region's problems in health care delivery and mobilizing energies to attack them.

A. THE ENVIRONMENT FOR RMP

New Jersey is a heavily populated state squeezed between the two great metropolitan centers of New York and Philadelphia, for which it serves as an outsize bedroom community. Its industry is largely absentee-owned and controlled. Natives wryly refer to it as a barrel with a bunghole at each end.

There now seems to be a ground swell in New Jersey for "statehood" -- greater self-sufficiency within the state in all things -- and there is talk everywhere of the need for pulling together. This is more than just a cry for increased regional -- as opposed to federal -- control over the deployment of public funds. There is a sense that identity as a forward-looking state will improve life for all. Whether this will catch hold is not yet clear, but it presents a potentially promising background for the New Jersey RMP and is a theme heard frequently in conversations about RMP.

Medically, also, New Jersey has in the past been relatively unexciting. There are many powerful doctors in the state, but a large proportion of them spend their professional lives in institutions like Columbia Presbyterian Hospital in New York or the Children's Medical Center in Philadelphia. Most of the rest devote their primary attention to the middle-class white residents of suburban towns.

In terms of a center-periphery model of medical resources, New Jersey would seem to be a poor prospect for regionalization; it could be described as consisting mostly of a strong, but not always united, "periphery." The two medical schools in the state (which were recently merged at the urging of the Governor) have been desperately trying to gain a foothold in the established academic and medical community during the past few years. Much too young to have a great deal of momentum in their struggle for quality, they have been too poor to rise strongly above political forces in the State Government and equally weak in facing existing medical and academic institutions.

Against this background, the Medical Society of New Jersey has been an important factor in medical circles. Leadership in the Society

has been one of the most obvious ways for a physician to attain professional recognition in a state where positions of status are in short supply. Men have moved up to positions of leadership by building the personal respect of their peers. This takes time and, in the nature of things, encourages conservatism. The conservatism is intensified by the understandable fear of solo practitioners -- removed by the pressures of their daily work from the central political scene -- that someone in government might "put something over" on them. Thus, when the New Jersey RMP was started, the Medical Society can be believed to have been at least skeptical of what its impact would be.

There has been a very strong tradition of self-sufficiency in the many hospitals of New Jersey. Most of the hospitals have done very well and grown in their independence as middle-class institutions. This tradition of independence has been particularly marked in South Jersey, a primarily rural (except for Camden) area which was for many years largely ignored by the rest of the state, from the viewpoint of medicine. Since the end of World War II, the New Jersey Academy of Medicine, the continuing education branch of the New Jersey State Medical Society, has spent a lot of time trying to extend its influence to the southern counties. However, we were unable to find evidence that the Academy's program was having much impact, north or south.* South Jersey to this day remains in a medically ambiguous position, claimed by both the New Jersey RMP and the Greater Delaware Valley RMP centered at Philadelphia. On the one hand, it is pulled toward Philadelphia by its old school ties and its proximity; on the other hand it is pulled toward the rest of New Jersey by law, licensure regulations, and a natural repugnance to being seen as dependent on Philadelphia in a town/gown relationship.

Public interest in medicine in New Jersey extends through several agencies, whose aggregate power is considerable. In recent years most of them have had good leadership. The Department of Institutions and Agencies licenses hospitals, oversees the distribution of Hill-Burton funds, sets standards of various kinds in health care institutions, and is responsible for public assistance, child welfare, and mental health. The New Jersey Department of Health is engaged in environmental health, food and drug supervision, student and camp health, sanitation, chronic disease management, communicable disease control, blood banking, and quality control of laboratory services. It administers Medicare and Comprehensive Health Planning. The Department of Education is responsible for medical schools; and the Department of Law and Public Safety has a number of regulatory functions, including the registration of pharmacies. With strong attention now being given to poverty areas, the New Jersey State Department of Community Affairs has also become a force to reckon with in handling health care problems.

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*As of 1969, when we were in New Jersey, the Academy seemed still to be heavily dependent on the road-show, lecture system of continuing education, though aware of and experimenting with other approaches.

New Jersey has 568 municipal health officers and 21 county health departments. The municipal health officers, largely laymen, exercise considerable political influence because of a strong home-rule tradition in New Jersey.

Since the Newark riots of 1967, HEW and HUD have funded a number of programs in New Jersey's city ghettos, many of them related to health care. When these are added to the programs of state and local agencies, it becomes obvious that anyone who tries to set up new medical relationships faces an unusually formidable array of political forces in addition to the vested interests of the private sector.

B. BEGINNINGS OF THE PROGRAM

In early 1966, Dr. Roscoe Kandle of the State Health Department called together leading figures in the health field to consider the desirability of applying for approval of an RMP planning grant for New Jersey as a Region. Included in the discussions were key figures from the State Medical Society, the two medical schools, and interested departments of the State Government.

Following the hearings leading to Public Law 89-239, there was a widely shared fear in medical circles that somehow the Regional Medical Programs might be used to "make over" medicine in a socialized mold. We were told by members of the State Medical Society that this fear was strong in New Jersey and dominated the Society's attitude in assuming the leading role it chose to play in the early development of the RMP.

The New Jersey RMP received its initial planning grant effective July 1, 1967, and Dr. Alvin A. Florin was named Coordinator shortly thereafter. The environment in which Dr. Florin sought a strategy for making the RMP worthwhile has been described; to summarize, it was characterized by:

- A widely shared feeling that "statehood" would produce big rewards for everyone in New Jersey, with a corresponding resistance toward being dependent on either New York City or Philadelphia.
- A preponderance of solo practitioners, working largely with the white middle class in suburban towns.
- Young, poorly financed medical schools having difficulty finding their place in the sun.
- A conservative Medical Society whose support was indispensable for any action the doctors might be asked to join in on.
- Vigorously independent, competitive hospitals.
- Claims on South Jersey by both the Greater Delaware Valley and the New Jersey RMPs, with little obvious interest on the part of either.

- o A strong, but multiple, set of state health agencies.
- o Considerable HEW and HUD activity in health care in the ghettos, following the Newark riots of 1967.

During the planning stages, the principal strategy of the New Jersey RMP seems to have been to attract as many of these interests as possible. The RMP originally had a RAG of 57 members and an Executive Committee of 15. The latter was chaired by a former president of the Medical Society. The RMP was under strong pressure to become operational as soon as possible, and, like most RMPs at that time, began pragmatically by undertaking projects which would not engender much controversy; the projects which survived the Executive Committee and RAG during the planning stage were of a kind acceptable to most Medical Society Members. On April 1, 1969, the New Jersey RMP went operational with nine projects.

Meanwhile, there were changes in the making. On the national scene there was evidence that RMP was beginning to be seen as more than just a center-periphery continuing education program in three categorical diseases. Yet more significant in New Jersey was the growing realization that health care in the ghettos was a leading medical problem and one demanding responsible attention from organized leaders in medicine. The Newark riots and the ensuing move of the New Jersey College of Medicine to Newark brought this to the forefront of New Jersey RAG discussions.

Because of the cumbersome size of the RAG and the fact that it met infrequently, the Executive Committee found itself making most policy decisions for the Region in its monthly meetings. This situation did not appeal to the RAG as a whole, and in Washington there was some feeling that it did not conform to the spirit of the law.

In November 1968, the RAG was reduced to a manageable 25 and the Executive Committee was eliminated. The RAG began to meet on a regular monthly basis.

C. EMERGENCE OF RMP AS A FORCE FOR CHANGE

Here began a development that stands out in our experience of Regional Medical Programs: whether spontaneously or by plan, the RAG began to coalesce into an active unit seeking change. Prodded particularly by open controversy as to whether urban health care was a legitimate target for RMP concern, the RAG moved quickly to discussions of alternative courses and their implications. In short, the RAG took charge of the RMP's destiny; and with careful staff work by the core staff in support of each meeting, and thoughtful, provocative reports from working councils and task forces, it has managed slowly but surely ever since to become surprisingly cohesive in its support of change.

This was not easy, particularly in view of the fact that the nine approved projects which had been developed during the planning

stage were largely categorical and educational in concept (training courses for CCU nurses in three hospitals, training of physicians in cineangeography and of physicians and nurses in hemodialysis, training of instructors in external cardio-pulmonary resuscitation, a computerized pacemaker evaluation, medical tapes by telephone, and the establishment of tumor boards in 13 hospitals). But during the course of the first year, Dr. Florin was able to provide unexpended funds in support of RAG-approved explorations of health care delivery in ghetto areas. Also the RAG chose to support from core funds an innovative program for three ghetto cities: Newark, Hoboken, and Trenton.

From its own core staff the New Jersey RMP assigned an urban health coordinator to each of the Model Cities offices in these three cities. Their assignments were: (1) to draw up detailed plans for the health component in each Model City, (2) to meet with concerned community groups to involve them in the planning, and (3) to organize a decision-making process for working out answers to health problems.

This experiment in reaching the poor -- and especially the black -- community was followed very closely by a 25-member Urban Health Task Force, which undertook to evaluate the results in each city. The Urban Health Task Force was also responsible for working up plans for other attacks on the health care of disadvantaged persons: for example, a family-centered hospital-based ambulatory care service in New Brunswick; a pilot screening project to determine the morbidity associated with both diagnosed and undiagnosed heart disease; interviews of a sample of stroke rehabilitation patients in two Newark hospitals to learn the nature, extent, and cost of rehabilitation services they received; and interviews of 750 representative families in Hoboken to determine their health attitudes and health needs in the context of their general socioeconomic attitudes and outlook.

One of the 1969-1970 activities on which the New Jersey RMP would like to build in the coming year was the operation of a mobile van in Newark. Some 800 individuals were given EKGs and chest X-rays, as well as such general medical examinations as blood pressure measurement, open cavity inspection, and height and weight measurement. Community recruits were used successfully to persuade people to volunteer for the examinations. As part of the routine, the examiners appraised any previous care the people had received. Follow-up care was recommended, when indicated, to be provided by the individual's own physician or an appropriate clinic if he did not have one.

Another core-centered activity grew out of an application that was turned down as too conventional by the original RMP Executive Committee. The application was made by the Academy of Medicine for a continuing education project; its rejection led to the formation of a Council on Continuing Physician Education, with representatives of the Academy, the College of Medicine, Rutgers, and the Overlook Hospital in Summit, New Jersey. Dr. James E. Rogers of the RMP staff carried out for the Commission a survey of the ongoing continuing education in almost all of the hospitals

in the state. He found much of it to be weak in terms of the criteria he applied and has prepared a plan of state-wide improvement, of which more will be said later.

People we interviewed about the hospital situation in New Jersey were all in agreement on one thing: the hospitals need to cooperate in the interest of improved service and reduced over-all cost. This is seen as of particular importance in South Jersey. Yet with considerable energy coming from both the RMP and the voluntary agencies, progress has been very slow indeed. It has been difficult to achieve respectable attendance at meetings called to discuss possible hospital collaboration. In some cases, the mere suggestion has been met with what we were told could only be described as ridicule. The obstacles to progress in this direction in New Jersey are very strong, and proponents with the strength to overcome them have not yet appeared on the scene. Until strong local proponents appear, one can speculate, South Jersey may not be a place for much real RMP action involving collaboration of hospitals toward systems transformation.

During 1969-1970, Dr. Florin joined with Dr. Goodman of the Essex County Blood Bank to institute an experimental blood freezing program. It proved to be a successful way of preserving blood far longer than had heretofore been possible, thus adding greatly to the flexibility of reserve stocks. There are plans for extending this service next year and backing it with a statewide network of intelligence as to where and in what condition blood stocks are at any given time.

In New Jersey we encountered a widespread interest in consumer education. Those who were interested in the disadvantaged believed that little ground would be gained in improving their health until the poor people themselves came to understand what care was available to them and what it could do for them. Those who were interested in the middle class thought they ought to be taught both what is the most up-to-date medical practice and how to use it effectively. And in the background was a sense that the consumer has ideas about health care that deserve a hearing. A year ago, when we were there, these were all the glimmerings of an idea; little had been done to crystallize them into action programs. In an attempt to move constructively toward action, a Communications Council was established by the RAG in October 1969, with the objective of providing increased health information for the consumer. The membership of the Council includes individuals specializing in public relations and information, as well as representatives from Blue Cross-Blue Shield, the State Health Department, the Hospital Association, and the two medical schools.

D. LOOKING AHEAD WITH THE PROGRAM

During the planning stage of the Region, we see five themes running through the deliberations of the RAG: (1) conventional project support, (2) increased attention to the health of the disadvantaged,— (3) improvement of continuing physician education in the hospitals,

(4) increased collaboration of hospitals, with special attention to the more-or-less neglected South Jersey, and (5) stepped-up consumer participation and consumer education.

Although the RAG was already becoming a strong force in the RMP by the end of 1968, it was not until February 1969, when Dr. Cross addressed a challenging letter to its members that they began actively to face up to the establishment of program objectives and priorities, as distinct from evaluating project applications on an ad hoc basis. Since that time there has been a growing cohesiveness in the RAG behind the delivery of health care in urban areas as the number one priority. A significant component of the 1970-1971 operational budget is directed toward the ghetto. We understand that the first application to RMPS under the new Anniversary Review procedure, in November 1970, will ask for support for very large extensions of the urban service programs that were in an experimental, feasibility, or planning stage in 1969-1970. The New Jersey RAG is really acting on its own top priority.

Conventional continuing education projects in heart, cancer, and stroke remain a major part of the operational budget. This is perhaps a price that must be paid for the growing support of more conservative RAG members for the heavy emphasis on urban problems.

The role of the medical schools in RMP remains friendly, cooperative, and important, but not dominant. They appear to have been fully adequate in providing technical support when it was needed. Care will have to be exercised to see that their interests and responsibilities in the ghetto are not allowed to run into conflict with those of RMP. Continued openness in the RAG will probably prevent such a conflict.

The survey of continuing education in hospitals carried out by Dr. Rogers for the Council on Continuing Physician Education has already resulted in some agreement on action. The two medical schools (now one) have agreed to establish a Continuing Physician Education Department to coordinate, supervise, and evaluate continuing education programs statewide, to offer expertise in educational methodology, and to provide experts in medical matters. A Basic Unit within the Department will be headed by a Director of Medical Education, who will prepare curricula for use throughout the state, assure that subject matter is not duplicated at adjacent locations, and form a balanced faculty to assist in local continuing education. An Intermediate Organization, staffed by existing Medical Societies, will be responsible for arranging programs on a regional basis.

Another cooperative step in continuing education is the merger of central medical libraries in the state. The Academy of Medicine, the State Medical Libraries, and the Medical School Libraries are all being merged into the New Jersey College Library.

So far as we can tell, very little progress has been made in developing meaningful voluntary cooperative arrangements among the hospitals of South Jersey. The hospitals in the more congested North Jersey

have shown some disposition to participate together in activities directed toward the disadvantaged.

While it is too early to know what will be accomplished with regard to communications between the providers of health care and its consumers, the RMP is moving ahead in an organized way. As has been mentioned, a Communications Council has been established to take the lead for RMP in improving consumer education. The Urban Health Task Force has been increased in size from 25 to 32, to permit the inclusion of seven Model Cities representatives, including administrators, citizens' health panel members, and consumers. And finally there have been discussions of the possibility of merging RMP and CHP in New Jersey under a common Advisory Group with 51% consumer representation. It is felt by many that RMP might be strengthened by this degree of consumer participation.

So, where is New Jersey RMP going? When we visited New Jersey in the late spring of 1969, our first impression was that while a lot of things were under discussion and even being worked on, little clear progress was evident. Even then, however, we thought we saw most of the RAG, the Urban Health Task Force, and the core staff closing in on tangible goals. We encountered a real appreciation of the fact that RMP could do little itself but would have to persuade others to do the things that needed to be done. We thought we saw the Urban Health Task Force, with help from RAG members, "facilitating" a change in point of view of the Medical Society -- no mean accomplishment.

Fifteen months later, there seems to have been real movement in the New Jersey RMP. Yet there are some unanswered questions.

The drive for integration under the "statehood" label is a weak reed. It does offer the State Health Departments a rationale for lifting the center of gravity of public health from the local level. It offers the new combined medical school an argument for money from the State Treasury. It provides the doctors a basis for urging that more patients stay in the state. But the fact remains that New Jersey will long remain overshadowed by neighboring New York City and Philadelphia. And the plea for "statehood" is not nearly as powerful a tool for the RMP in inducing change as is the RMP's own very careful staff work in support of those who have tangible ends in view.

Progress toward ends in view is, naturally, uneven. It looks as if the involvement in the urban health scene is vigorous, growing in support, and imaginatively fresh in concept. But with the traditional conservative bent of the medical profession in New Jersey always in the background, RMP's outreach into the ghettos will need every possible break to continue to succeed. If federal financial support becomes too limited for the perceived potentials of the program, the result could be extremely destructive competition among the cities.

From what we are told, continuing education in New Jersey, especially for nurses, seems to be comparable in quality and impact to

what we have seen in other regions. But it is easier to see in New Jersey than in some regions that building projects around the dissemination of technology is far from the only route to improved health care. The dissemination of knowledge about need is at least equally important.

When it comes to the goal of hospital cooperation and collaboration, most particularly in South Jersey, there is little progress to date. It is to be hoped that some of the smaller hospitals will join together in Dr. Rogers' plan for sharing DMEs when the statewide continuing education program starts up. There are efforts to enlist participation by groups of hospitals in collaborative family care programs for underprivileged families in North Jersey cities.

What have made the greatest strides in New Jersey are those activities of the RAG, its councils and task forces, and the RMP core staff that have stretched the imagination in trying out new combinations of people and ideas. The RAG now sees RMP as a catalyst more importantly than as a distributor of money for projects. And it has just about completely accepted the idea that all possible RMP money should go to the distribution of care, largely in the ghettos.

IV. GREATER DELEWARE VALLEY RMP

IV. THE GREATER DELAWARE VALLEY RMP

The Greater Delaware Valley RMP combines a number of characteristics of interest to this study. It encompasses a major metropolitan center and several highly esteemed medical schools, covers more than one state, shares territory with another RMP (New Jersey), is oriented toward both center-periphery and geographic types of regionalization, and finally, is representative of the great urban-centered regions which, because of their complexity, have moved less rapidly in some respects than regions which have not had large urban concentrations and multiple medical schools. Thus, RMPS and the ADL/OSTI team agreed that the Greater Delaware Valley Region should be among those chosen for close examination. Since our work there was more recent than in North Carolina and New Jersey, our report is in greater detail.

An early draft of this discussion was checked with several members of the Greater Delaware Valley RMP coordinating committee and staff, who pointed out errors of fact and took vigorous exception to what they regarded as a distorted emphasis on the negative in our description of the Region. We have tried to correct the errors and to put in fair perspective those aspects of the program that may not be going as well as some might hope.

A. THE ENVIRONMENT FOR RMP

We believe that economic, social, and cultural conditions in a community have a good deal to do with how ready the medical community is to contemplate the kinds of changes in relationships which can accompany a regionalization effort. Because of the long-established, carefully worked out positions of the medical schools in the Greater Delaware Valley, both with respect to one another and in relation to the periphery for referral and outreach, there has probably been less obvious need to "regionalize" (in the sense of encouraging a shift in relationships or power balance) than in regions with a lower concentration of high-quality medical resources. Also, Philadelphia and its environs have prospered for 100 years without interruption except for the Great Depression. The Wilmington catch basin has had a similar experience. The virtues of stable institutions and established relationships have been amply demonstrated.

As for the northern counties, the almost steady decline of the extractive industries for two generations may have created a climate in which many people feel that their ability to cause significant change is dwarfed by conditions beyond their control.

In South Central Jersey, the institutions of medicine are local, and locally oriented. From the perspective of South Jersey, closer association with the strong medical and health institutions of Philadelphia (or elsewhere) looks like a mixed blessing at best. The prospect of closer association with Philadelphia through RMP was viewed by many with some apprehension.

As for the ghetto poor, Greater Delaware Valley has its share. But as things have been going, Philadelphia and other cities in the region

have had rather less conspicuous trouble with their minorities than many cities of comparable size (i.e., less violence than Newark, Washington, and Watts). While it is probably true that the national contagion of interest in righting the wrongs of minorities has been caught by some of the leaders of medicine in and around Philadelphia, it is a new phenomenon and has not progressed very far.

An outstanding feature of the medical system in Greater Delaware Valley is its extraordinary strength and quality. There are few places where such a concentration of talent, competence, and facilities can be found.

To the extent that regionalization implied that the autonomy of strong medical institutions might be reduced, it cannot have seemed very attractive to some medical people in the Greater Delaware Valley. People in the relatively strong and well-staffed medical and health care institutions of Greater Delaware Valley can easily conceive larger tasks for themselves and their own hospitals, schools, or professions. They have more difficulty perceiving as useful a role for themselves in which their skills might be diffused in the process of regionalization. There are, of course, those who do see opportunity in new kinds of collaboration among the medical schools and hospitals and between the medical centers in Philadelphia and the practitioners and community hospitals in the countryside, and who are accordingly, willing to devote substantial time and energy to developing such collaborative arrangements.

When Public Law 89-239 was passed, the State Medical Society indicated its desire to oversee the initial development of RMP in Pennsylvania. It was the primary agent which brought together representatives of all medical schools in the Commonwealth and of practically all other formal medical institutions and groups.

It was quickly decided that the Commonwealth split quite naturally into three parts: the Pittsburgh medical watershed, the Philadelphia medical watershed, and the central territory between them. The first two were geographically related to existing medical schools, and the initiative was left to them. The third region, to be called the Susquehanna Valley RMP, became the direct responsibility of the Medical Society, since at that time no medical schools were operating in central Pennsylvania.

B. APPROACH TO REGIONALIZATION

The Greater Delaware Valley RMP was shaped at the start by the deans of the five medical schools (prior to the active involvement of the School of Osteopathy). They, like many other deans around the country, seem to have interpreted the law and the signals from Washington to mean that RMP was a practical extension of the NIH-sponsored research program which for the preceding decade had given so much support to medical schools. Categorical in nature, designed on the theme of disseminating the latest medical knowledge, RMP was (in that interpretation) a plausible if somewhat unusual program to base in medical schools. It could provide some additional impetus to continuing education of physicians and other forms of "outreach"

advocated by some people in every medical faculty, and might also contribute to the broadening and deepening of faculty capabilities that is the hope of medical school deans everywhere. These were surely not the only, or necessarily even the most compelling, reasons for the involvement of the medical school deans, but congressional testimony from leading medical school spokesmen during hearings on PL 82-239 and our own discussions with deans indicate that there was at least the possibility of RMP becoming a direct supporter of the medical schools.

The requirement for cooperative arrangements specified in PL 89-239 caused no serious concern. What was continuing education but cooperation between schools and their affiliated hospitals for the purpose of educating local doctors? RMP came at a time when medical schools were seeking actively to anticipate or compensate for potential losses in suitable teaching cases brought about by vast expansions in third-party financing programs in health care services, notably Medicare. Many "charity" cases previously referred to teaching hospitals were (or soon would be) treated on a fee-for-service basis in community hospitals. It was at least reasonable to expect that cooperative arrangements under RMP with outlying hospitals could provide new channels through which to sustain the teaching case load. The possibility of diffusing high-technology medicine and research-oriented knowledge (which NIH money had supported as means for improving medical practice) and so moving toward the Surgeon General's ultimate objective of the best care for all, was clear. Did the deans of the medical schools in Philadelphia share in all of these concerns? We suspect so, although we were not there so we cannot know in specific terms.

Understandable competition among the medical schools in Philadelphia had results that tended to reinforce the "technology diffusion" interpretation of RMP. Although the University of Pennsylvania Medical School had gone furthest and earliest in the direction of increasing specialization and research, by the mid-1960's even such a large and practitioner-oriented school as Jefferson was well on the same road. To the medical schools, RMP appeared to be compatible with these professional strengths. A categorical emphasis in interpreting RMP's mandate fitted this view quite nicely, as did the notion that the medical school specialists had something important to bring to practicing physicians through continuing education.

Categorical focus, technical diffusion, and continuing education have retained their position as top-priority objectives in the Greater Delaware Valley RMP. In line with the official RMP Guidelines, project grants are viewed as being of primary importance, both as an evidence of real output and as a way to interest people in the RMP. This emphasis continues, even though it is now understood that project funding for the next few years may be severely limited.

With respect to categorical diseases, the Greater Delaware Valley has sought to improve patient care by stimulating more and better referrals in heart disease, cancer, and stroke and by supporting projects that make the clinical techniques and knowledge of the medical faculties available to local practitioners. Continuing education has been seen as a valid objective in itself and a natural task for the medical schools to undertake. It lubricates relationships that may result in referrals, and it is a

direct way to expose new knowledge to a wide audience. It is, of course, seen by many as potentially improving the quality of health care.

People oriented toward fostering more profound change in the system for delivery of health care and the relationships among medical institutions have not been in a strong position to influence the direction of the Greater Delaware Valley RMP. Pioneering in the delivery of services requires risking the strengths of medical institutions already stretched thin and already committed to other goals around whose pursuit the leaders of these institutions are more or less amicably arranged. An overview of all approved Greater Delaware Valley projects suggests that ideas for improving the quality or quantity of care have been found most acceptable when they depended on strengthening rather than shifting the relationships among the schools, other strong institutions, and those providing primary health care.

At least two patterns or concepts of regionalization can be identified in the development of the Greater Delaware Valley RMP. The first is a center-periphery model consistent with, but extending, the historical pattern of relationships between the great center in Philadelphia and other medical institutions and practitioners. In this model, "knowledge" flows outward from centers of excellence, and patients flow "inward" or "upward." The second, and more recently developed, pattern, reflecting an interest in giving a more direct voice to concerned people in various parts of Greater Delaware Valley RMP, consists of geographic sub-regionalization through the establishment of Areas. Other possible models of regionalization described in Chapter III of Volume II of this report -- centerless networks, merger processes, shared services and regional agreements to cut down on duplication of services -- seem to have received little explicit attention, at least to this point, from RMP staff members. At the area level, discussion of these kinds of possibilities has occurred, but it has not yet progressed to the stage of planned action.

Physicians who are deeply troubled by their awareness of a crisis in health care delivery to the poor have felt that they could take only limited initiative to turn RMP's attention to that problem. But spreading realization that the underprivileged experience more difficulties with the categorical diseases than the more fortunate population groups has begun to turn this problem group into an accepted target for RMP attention. The community medicine departments of the medical schools, in some cases with participation of community groups, have begun to be active in the Region. RMP support, small, but significant in indicating a new commitment, has helped to make these activities possible.

In a region as complex as Greater Delaware Valley, it is not easy to reconcile, or even to balance, all the conflicting views of what directions RMP should take or what its basic posture or stance should be, either in general or on specific issues. Washington has been looked to for help and guidance, but because much of the initiative must come from the actions of the regions, clear, authoritative, unambiguous guidelines have not been forthcoming. On the one hand, the Airlie House meetings in the Fall of 1969 seemed to promote "systems change" and call for a focus

on people for whom primary health care is not available; on the other hand, Guidelines unchanged in substance since May 1968 seem to confirm an emphasis on the categorical diseases, technological diffusion, and continuing education.

Under these conditions, forces which once sounded pioneering but now seem conservative have tended to retain their influence in the Greater Delaware Valley RMP. Those who look on RMP essentially as a federal professional grants program find themselves supported by those who wish to change the priorities and the goals but dare not do so for fear of becoming vulnerable to the charge of deviating from the stated intent of the law. "If we are to change, somebody from outside has to indicate what direction we are to go." Both in turn are supported by those for whom the system is working very well and who do not see the need for significant change. We encountered some people representative of each of these positions in Greater Delaware Valley. We also encountered a number of people who see systems change as needed and see RMP as an appropriate vehicle for the medical profession to use in contributing to that change. The balance between the two views can shift and, if the area groups move into a more central position, may indeed shift in some significant ways. But, for the present, the tone seems to be one of reasoned caution, with decisions governed largely by a strict interpretation of the 1967 Guidelines.

C. BEGINNINGS OF THE PROGRAM

The Greater Delaware Valley RMP came into existence on April 1, 1967. The deans of the five medical schools were heavily involved and strongly influential in its development.* To engage the energies and support of the medical schools, half the RMP core staff budget was turned over to the schools to manage. This move served also to recognize the importance of continuing education and technological diffusion as central aspects of the Greater Delaware Valley RMP. This half of the core staff was domiciled largely on medical school premises and recruited or selected by the deans. The head of the Greater Delaware Valley RMP was until recently paid less than at least some of the men (presumably responsible to him) who headed up the RMP staffs attached to the schools. While such a situation is not uncommon in medical schools, in this case it was seen by some as raising questions about these authority relationships in RMP.

Consistent with the view of a center-periphery system, and with some apparent support from Washington, the deans considered the desirability of dividing the Region into sub-regions aligned with the several medical schools. By this time, the School of Osteopathy had become a formal member of the RMP in Greater Delaware Valley. Osteopathic physicians were relatively numerous (e.g., 400 of 4400 physicians in Philadelphia), and they had been recognized since about 1960 as providing about half of the "primary care" in the Greater

* Imputations of "control" of the program by the deans (as articulated by some respondents) may be too strong. The Program Committee (GDVRMP's executive board) included a minority of five members from other powerful health agencies. It should be noted, also, that from the very beginning of the program the deans prepared the way for sooner or later moving into a less dominant position.

Delaware Valley. In Philadelphia and indeed, generally in the Greater Delaware Valley, most GPs are ODs.

It quickly became evident that the "referral" turf is already divided, at least at the periphery, by pre-existing affiliation agreements between individual medical school departments and corresponding services in suburban or more distant hospitals. These relationships, few of which would lightly be sacrificed, had been arranged without any necessity for geographical congruence of outreach boundaries among the several departments of a given school. Geography per se, except within Metropolitan Philadelphia itself, still remains a most unpromising basis on which to try to build cooperative relationships between individual schools and any delineated, exclusive segments within the outlying areas.

Although division of turf has historically been one of the most effective methods of avoiding head-on competition among medical centers for referrals, this effort was not the only instance of collaboration among medical schools in the Greater Delaware Valley. Some fifteen years prior to RMP, the State Government had considered establishing a state-supported medical school in Philadelphia. The medical schools suggested their receiving a state subsidy as an alternative, and had subsequently collaborated in their approaches to the Pennsylvania legislature, in a relationship unusual in the United States for private medical schools. Similarly, when a staffing crisis arose at the local Veterans Hospital, they had to their advantage found a satisfactory answer through cooperation. Finally, they or the universities to which they are attached had just agreed to the founding of the University City Science Center as a vehicle for obtaining contracts or grants for their staffs. RMP looked like (and became) a natural means of bringing in the first significant income to the Center and so contributing to a larger and partially shared objective.

To make this all a reality, the founders of the Greater Delaware Valley RMP, in the spirit of PL 89-239, invited in as participants members of other institutionalized medical groups. Representatives of hospital administration, voluntary agencies, public health, planning agencies, and the Medical Society were all included in the central policy board, the Program Committee. Even wider representation, including lay participation, was assigned to the Regional Advisory Group; but its agendas were at first devoted largely to reviewing and approving (or disapproving) grant applications prepared within the Region, as required by law. All members of the original Program Committee were identified with Philadelphia. Five of the ten (later, six of the eleven) members were deans of the medical schools. Both of these facts tended from the outset to enhance suspicions that some non-Philadelphians felt of those from the city, and the suspicions that many medical practitioners have of those in academic medicine.

This, then, was the RMP as it began business under the fiscal agency of the Science Center. Immediately, and quite naturally, conflicting objectives and strains of new associations became obvious and, as has been the case in other regions having complex medical systems, very hard to deal with. Prospects for interinstitutional collaboration in situations of this sort tend to become overwhelmed in the dynamism of the individual

institutions. It is not surprising to find that institutional interests continued to command primary loyalties of the members of program and coordinating committees in the Greater Delaware Valley RMP.

The Science Center, perceiving RMP as a potentially important responsibility and its principal business at the outset, tried in a variety of ways to make itself genuinely accountable. These attempts could be, and to an extent were by some people, viewed as an attempt to take over general control of the program, as distinct from merely holding fiscal responsibility. The Science Center did select the first RMP coordinator, but it was finally established that the Greater Delaware Valley RMP could operate without management exerted from the Science Center, that the Program Committee could enforce its own program, and that the role of the Science Center with respect to RMP was to be confined to its accounting responsibilities. Plans to locate RMP within the Science Center building were dropped.

D. PROGRESS AND PROBLEMS TO DATE

Not too long after the RMP was organized, it became evident that regionalization would mean little to the Delaware Valley as a whole if Philadelphia was the only scene of action. If something was to be done to share the RMP wealth with outlying areas, they would have to be organized in some way and assisted in submitting projects for approval. In support of this thinking at the regional level, Washington appeared to be calling for action at a distance from the medical schools. The RMP Program Committee encouraged the Coordinator to set about to sub-regionalize, and over a period of time six sub-regional Areas were established.

Liaison officers were assigned to the Areas and asked to set up area-wide committees with broad representation in terms of geography, institutional affiliation, and occupation. Other qualifications appear to have been that members be known at least indirectly to the liaison officer and be readily available for meetings. The committees, in turn, were urged to set up categorical task forces which, it was hoped, would generate project ideas and applications for funding. Much of the time given by the medical community to RMP for over two years has been devoted to organizing area committees and task forces. This process has been carried out with a good deal of thoroughness, in the sense that someone meeting residential, professional, and sub-specialty qualifications has generally been located to fill slots in the committees and task forces. But, whether the liaison officers will have systematically mobilized the health care professional power structures in the smaller communities, only time will demonstrate for certain. The quality and imagination of the liaison officers will be a critical determinant.

Since the medical schools were heavily involved with RMP from the first, since they were already familiar with federal grant-in-aid programs, and since they were given resident RMP core staff members, it was not surprising that only about half of the project money was allocated to work outside Philadelphia. Under the circumstances, it is noteworthy that even this high a percentage was developed away from the medical schools.

Of the total 1969-1970 budget of the Region, 67% was devoted to the core staff and half of that was domiciled in the medical schools. Thus, while activity outside of Philadelphia was being supported, the medical schools have been receiving half the total budget. 82% of the total RMP budget has been assigned to Philadelphia and Haverford taken together. This has resulted in political counterpressures from other cities and suburbs, the results of which will be discussed later. It has also led some people in the areas to think it possible that CHP might be more effective than RMP as a tool to bring federal money into health care improvement projects outside the immediate vicinity of the medical schools, and as a health system planning tool.

Several other forces are also working to change the historical situation somewhat. The schools themselves are coming to resemble each other much more as to program, the "mix" of students, and the specialized capabilities they afford in the teaching hospitals. This potentially broadens the referral options of community physicians. Simultaneously, as teaching material begins to become less readily available to the medical schools, the "boondocks," which used to be of relatively limited interest, became more important as a source of specialized clinical cases; and the increasing interest in community medicine makes populations and health care services a matter of direct concern to faculty and students alike. Finally, the larger community hospitals have been gaining in competence and capability, and a growing number of MDs have become qualified specialists; thus some of these hospitals can challenge the teaching hospitals in specific instances, services, and specialties.

If we may make a judgment, it would be that RMP has progressed further in the Greater Delaware Valley than in most Regions that encompass both large cities and many powerful medical schools. But, by all odds, the most significant achievement of the Region so far has been to excite the interest of more than 500 people -- largely professional; some lay -- in joining in repeated discussions about what the Greater Delaware Valley RMP can and should do. The people have given more than token attention to the program. In committees and task forces, both centrally and in the areas, they have confronted issues and forged at least initial recommendations for program design, policy, and plans for action.

There has been, and still is, both disagreement and an understandable lack of clarity about RMP, and its usefulness. Again, let it be said that this is by no means unique to the Greater Delaware Valley.

With many divergent and important interests to reconcile, it is not strange to find that the procedures for processing ideas and projects are somewhat time-consuming. The reviewing machinery has the objective of producing neutral and objective results. In a system designed to encourage collaboration, almost everyone has a vested interest in being informed, and many regard it as a right to review and comment. This stretches out the project processing and review procedure in Greater Delaware Valley longer than anyone really likes. Scheduled to take four months, the approval process more often takes as long as nine months,

according to the people with whom we spoke. As of March 1970, the record of project approvals since the beginning of the program was as follows:

Projects approved	April 1, 1969	5
Projects approved	October 23, 1969	3
Submitted to RMPS	December 1, 1969	8
In process in Greater Delaware Valley RMP	March 2, 1970	44
		60
Withdrawn, rejected or inactive		55

The eight approved projects are based in medical schools or large community hospitals, are clearly within the "RMP" disease categories, have to do with continuing medical education, and for the most part involve medical techniques rather well-sanctioned by previous experience. They are easy to interpret as attempts to build up individual institutions, more difficult to interpret as attempt to build institutions together.

Six of the eight are rather conventional programs, though each is distinguished from the traditional single-institution-based continuing education program by drawing on both faculty and students from more than one institution. The other two (pediatric pulmonary disease, and centers for respiratory care) have elements of exploration into new ways of doing things that represent potential changes in the system of health care.

We did not attempt to review rejected project applications and so have no knowledge of the total "menu" from which the approved projects were selected. But the three-year record of approvals shows a high degree of caution as compared to other Regions we have visited.

A Task Force for Health Care to the Poor has been developing ideas for involving RMP directly in this critical problem area. Its preliminary report was sent back by the Program Committee for further development. There are at least two very interesting experimental activities in the ghetto, funded out of planning grants for the medical schools. These are clearly dedicated to getting medical services to people in dire need of them, and to doing this by creating new links among existing institutions. But, in the context of the whole Greater Delaware Valley RMP, the amount of effort and funds directed toward stimulating the provision of health care to the poor has been very limited.

There are beginning attempts to direct RMP money more heavily into the departments of community medicine in the medical schools. Some of this is being aimed at changing the relationships of the schools in the community. But, as yet, there are few evidences of significant health care system change.* There are growing pressures to that end, and tensions exist to test new relationships and prepare the stage for issue-resolutions or at least confrontations. (The community medicine departments themselves have not resolved on one position, either, and what services and how much health care

* Once again, this is not unique to Greater Delaware Valley.

service they decide the "medical schools" should deliver will make a lot of differece as to who will support them.)

As RMP project funding becomes increasingly difficult, the core staff and area-wide committees, who see projects as the principal means of getting anything done, tend to be mildly depressed about the impact of what they have been able to accomplish; and, more serious in our view, they are not as hopeful as they would like to be that things can be speeded up. What ardor the task forces had is reputedly diminishing, both at the regional and area levels. Their activities are coming to be seen by them as perhaps not worth the effort -- by the pressure to produce proposals with what some of their members see as insufficient attention to the potential value of the proposed projects, by the unavailability of staff to help them, by the time-consuming selection process, and by the realization that there probably isn't any money to be had anyway. The processes and procedures continue to be most appropriate to the generation of really ambitious grants centered where alone sizeable grants can be prepared -- at the universities. The people who live outside Philadelphia are skeptical; everywhere the questions come: can RMP become other than a grant program for the medical schools?

Let us place these widely shared concerns in a broader context. The Greater Delaware Valley RMP took shape within a given set of conditions, and the options open to it were to some extent limited by these conditions. The most important of these were the following: the number and strength of the institutions involved (notably the medical schools), the pre-existing conflicts among the medical schools, the tacit divisions of turf, and the great bundle of almost impenetrable influence and agencies that bear upon medicine and health care from outside the immediate control of any single institution, all in the special context of a relatively stable community and a rather conservative institutional development in eastern Pennsylvania. The mere formation of an RMP structure important enough for many powerful people to worry over and disagree about is an accomplishment in itself. Bringing it to a point where it is cocked, poised, and ready to be aimed, responsive to a much broader array of interests than could originally bear on it, is a further accomplishment.

Some specific steps toward progress can be cited. First, the medical school deans won useful independence for the program from the University City Science Center, allowing program accountability and control to be vested in a sense internally within RMP. As the major figures within the most powerful medical institutions in the Greater Delaware Valley, the deans understandably wanted a strong voice in the RMP, and their contribution at the outset was probably essential if RMP was ever to become viable. With the help of key area figures, they were able to free the RMP of one perceived threat of dominance, ensure its continued physical separation from the Science Center building, and bring about a relocation responsive to evolving regionalization. Sub-regionalization has gained enough strength to earn six positions on the Board of Directors (formerly the Program Committee).* And while the deans never or rarely saw themselves as a unified

* Thus was achieved the first major step in the deans' early-set plan to move in due course to a position of less dominance in the program than was necessary at the start.

majority power bloc, there is now a clear majority of non-deans, a fact that should go a long way toward meeting the suspicions of interested parties not privy to the inner workings of the medical schools. This change has clearly reawakened some interest in RMP outside Philadelphia.

E. RELATIONSHIPS WITH RMPS AND THE AREAS

For reasons that are not at all self-evident, communications of philosophy and policy between the Greater Delaware Valley RMP headquarters and the RMPS on the one hand, and the headquarters and area-wide committees on the other hand, have been weak. The Greater Delaware Valley Board of Directors, RAG, and Coordinating Committee all express concern about the direction the program should take, especially since Airlie House. Their uncertainty has been compounded by the signals from Washington suggesting that new project money (which they have viewed as their life's blood) will be very scarce.

Some members of the Greater Delaware Valley RMP governing committees are uneasy about how to move toward more direct attention to primary health care in the face of (1) the prohibition in PL 89-239 against interfering "with the patterns or the methods...of patient care or professional practice" and (2) RMP Guidelines that have remained unchanged since long before Airlie House, where primary health care received such high-level support. Others are unsure of how core staff and planning funds should be directed under a grants program when the funding for the new grants dries up. There is no commonly held idea of how to use area-wide committees and categorical task forces if the preparation of project applications is likely to go unrewarded. The degree to which the program should restrict itself to heart disease, cancer, and stroke is still an unresolved question.

These uncertainties lead to repeated expressions in the Greater Delaware Valley RMP such as, "Why doesn't RMPS tell us what we ought to do?" While we suspect that many people associated with the program in the Greater Delaware Valley would be highly resentful if RMPS did tell them what to do, there is a widely shared feeling that somehow RMPS ought to be able to provide more leadership short of dictating program content.

Area-wide committees and area task forces were set up when it looked as if promising, well-prepared project applications were likely to be funded. The work of liaison officers in organizing and motivating prestigious people to join in these committees was impressive in these sub-regions.

So long as the committees could keep busy on the organizing procedure itself, a sense of progress could be maintained. However, at about the time they were prepared for action, the question of what kind of action they could profitably take began to go unanswered. The uncertainties that beset the Greater Delaware Valley RMP Headquarters were reflected in a certain vagueness with which liaison officers responded to the area pleas, "What ought we to do, and what can we do?" Significant numbers of

people are fearful that inactivity may lead to a serious loss of hard-earned momentum.

Interest in the Areas has, however, received a shot in the arm from recent events in the Region. The six Areas are now entitled to representation on the Board of Directors. There is hope that this will result in a greater flow of money out to them. Earlier feelings that Philadelphia was getting an unreasonable share of RMP money had grown so strong as to draw the unfavorable attention of Congressmen Flood and Rooney, both members of health committees in the House of Representatives. The inclusion of Area members on the Greater Delaware Valley RMP board has at least for the time being satisfied these important figures.

Another indication that the Areas outside Philadelphia may receive greater attention was the recent invitation to area-wide committees to submit modest budget applications for carrying out activities of particular interest to them. The invitation in effect offered planning funds to the Areas, as opposed to operational funds with all their attendant complex approval requirements.*

These moves should go a long way toward relieving the tensions that were building up in the Areas against the Greater Delaware Valley RMP headquarters. More is needed, however, if local interest in RMP is to be sustained. The Areas want stronger RMP staff support to help them formulate proposals for local cooperative activities they believe would be productive. This condition could largely be met if the liaison officers were instructed to give their first loyalty to the Areas and trained to act as their partisan (but sensitive and responsible) supporters within the headquarters office, and if the efforts of other members of the headquarters core staff could be redirected to provide at least limited staff support to the area-wide committees on request. Their knowledge of the specific capabilities and internal processes in the medical schools and other Philadelphia institutions could also be helpful to the Areas in understanding what could be developed through ties to the center.

In short, relationships between the Greater Delaware Valley RMP headquarters and the outlying Areas seem to be improving at this time. But strong, supportive action will be needed if this improvement is to continue, and to develop into more than the mere forms of regionalization.

A more active core staff could do a lot to facilitate the movement of the Region in any chosen direction and could help clarify the direction. At the present time the core staff tends to act as if it had only a single carrot -- money -- and that shriveled. More money would help; but when facilitation is successful in opening perspectives and changing attitudes, it can move mountains on short funds, even where a large, heavily funded project is not available -- and money might not even budge the mountain anyway. Emphasis on facilitative skills in future recruiting of core staff might prove very beneficial.

* As yet, the Areas have not submitted any such applications.

F. DEVELOPMENT OF EVALUATION

Only in mid-1969 did the Greater Delaware Valley RMP appoint a Director of Data and Evaluation. Thus, early evaluation schemes understandably lacked a certain crispness of design and tightness of administration. Now, however, the Region seems to be preparing itself for more sophisticated evaluation procedures and closer follow-up.

1. Program Evaluation

It was not until 1969 that overall formal goals were set for the Greater Delaware Valley RMP. Goals for 1970 were established prior to the beginning of the year, as follows:

GOALS 1970

(1) Refine and update overall plan consistent with new national trends of RMPS.

(2) Maintain or expand level of fiscal support.

(3) Increase mutual awareness and understanding of the unique and significant contributions from both the sub-regions and the medical schools that are essential to an effective, cooperative program for improved health care.

(4) Increase involvement of the core staff, including the medical schools, in sub-regional activities.

(5) Increase sub-regional involvement in planning and project development.

(6) Increase attention to disease prevention and primary health care.

(7) Continue recruitment efforts, primarily: Director of Medical Education, Northeast Pennsylvania; Associate Director for Continuing Education; Associate Director for Project and Proposals, and supportive staff.

(8) Increase emphasis on planning for health care of the poor.

(9) Expand demonstration and training programs and encourage formulation of appropriate operational proposals.

(10) Continue efforts to improve communications.

(11) Improve the review process.

(12) Further develop cooperative relationships with Comprehensive Health Planning.

These goals are receiving continuous thoughtful attention from the Program Committee and give a real sense of purpose. They reflect new national trends toward more attention to primary health care and health care of the poor. They reflect movement in the direction of action, whereas the previous year's goals focused on organization and internal relationships.

However, in their present form, they can serve only as a starting point for evaluation of program results. They provide a sense of direction, but neither a sense of pace nor of distance to be achieved during the year. What is needed to make them effective operating tools is another level of specificity and timetables for reaching preset benchmarks of accomplishment.

2. Project Evaluation

Projects themselves have for the most part had evaluation criteria built into them at the start. However, because of the difficulty of establishing early direct cause-and-effect relationships between projects and health statistics, these criteria have been less than fully satisfactory. There is little of a tangible nature against which an evaluator can check progress, either on the level of attaining goals as originally defined, or in clarifying new goals discovered in process of a project. The difficulty is one shared by all RMPs.

The Task Force for Continuing Education published on September 25, 1969, "Guidelines for Evaluation of Program Grants for Continuing Medical Evaluation...." These Guidelines have been prepared with great insight and might well serve as a model for other regions. To the extent that project formulation and evaluation review follow these guidelines, tangible results should become readily demonstrable. The Guidelines refer to long-range, intermediate, and immediate goals for projects, but this is their only reference to the timing of planned accomplishments. The factor of timing deserves explicit attention in any evaluation system, and in this respect we think the Guidelines could be strengthened.

3. The Project Application Review Process

The review and approval process in the Greater Delaware Valley is designed deliberately to include all groups who can reasonably be expected to be concerned with what is proposed. While this is a constructive attempt to involve many people, it can result in a drawn-out process of approval. It may, in fact, account for the impression people in the Greater Delaware Valley outside of Philadelphia have that it takes at least nine months for an application originating in an Area to clear all steps before it is ready to be submitted to RMPS.

There are a minimum of eight such steps for an Area-originated project at the present time; and considering the difficulty of getting the appropriate people together and the necessity of carrying out all steps in

a predetermined sequence, the scheduled four months may indeed be theoretical. The system does have the effect of discouraging busy people out in the Areas from pursuing some of their ideas in the form of proposals. It is quite possible that there is a range of elapsed times for project approvals such as to confirm the impression of those near the center that proposal processing is reasonably quick, while at the same time supporting the view of those less closely tied to the center that the processing is disappointingly slow.

For the period from April 1967, the inception of the Region, to March 1970, only eight projects became fully eligible and were funded to become operational. These eight are the fruit of 115 serious project applications. About 40% of the 115 are still under consideration at some stage in the procedure, while about 55% have been withdrawn, rejected, or become inactive.

4. The Finance Committee as a Force Behind Evaluation

In November 1967, the Program Committee established a Finance Committee of three members to oversee the preparation of budgets for the period April 1970 through March 1971, and otherwise to guide the Program Committee in financial management. The Finance Committee, supported strongly by the Program Committee, has assumed what seems to us to be a tough-minded attitude toward expenditures, even when full funding has previously been approved.

Project directors are now being required rigorously to state how and when they intend to spend approved funds, and with what tangible result. Program people (core staff) are being required to explain what "open" positions can really be expected to add to the Region's services. Against the background of questions like these, the Director of Data and Evaluation should find it much easier in the future to devise appropriate assessment techniques for self-judgment of the progress of the Region.

The appointment of the Finance Committee to provide a more intensive and extensive review is probably a good move. The Committee could prove to be a potent and constructive force toward achieving a shared sense of priorities and goals. It could also serve powerfully to help in implementing the emerging program of the Greater Delaware Valley RMP and to improve its capability for self-evaluation. We sincerely hope the Committee will continue in being after the reorganization of the Program Committee.

V. NORTHLANDS RMP

V. THE NORTHLANDS RMP

Like the Greater Delaware Valley, the State of Minnesota has a wealth of medical resources. However, the two regions are different in almost every other respect. Together, they exemplify the wide range of conditions that RMP can face from one region to another and the diversity of the problems it may find itself addressing.

A. THE ENVIRONMENT FOR RMP

The Northlands RMP covers the State of Minnesota, an area of 84,000 square miles, which is large for an RMP. There are slighly more than 3.5 million people in the state, 800,000 of whom are in the Greater Metropolitan Twin Cities. It is entirely likely that half the population in the state will be in this area within the next decade or so.

Rural parts of the state are characterized by the independence of the little community. In Minnesota, as in many other parts of the country, adjacent communities are frequently rivalrous on levels ranging from sporting events to health care. This makes it more than usually difficult to build up cooperative relationships between community hospitals and the surrounding physicians. It is exacerbated when surrounding physicians feel that they may not get their referred patients (and the families or friends of these patients) back from the specialists associated with nearby community hospitals. This can result in the "checkerboard" referral pattern described in our discussion of North Carolina; patients are referred to specialists sufficiently far away that they will probably be retained by the referring physician. This happens despite the fact that most physicians, rural or urban, have more business than they could comfortably handle and would probably be the first to say that more physicians and related manpower are needed in the region. Yet some of them are getting old and feel challenged by the new technology and high-powered specialists.

Associated with these background factors has been the development of an outstanding educational system led by the University of Minnesota. There has been considerable willingness to experiment with new ways of doing things, which has competed with an underlying conservatism based on the sense of the middle class majority that things have gone rather well in Minnesota so far and that many proposed changes tend to violate well-established ideas of individual rights and interests.

Minnesota has few non-whites; only 2% in the Twin Cities and only 3.4% in the northwest corner of the state where the Indians are concentrated. There is, however, a large population of rural farm poor whose average age rises steadily. But even the inhospitable agricultural territory is in quite good recreation country, with obvious prospects for economic development.

Agriculture, which has always been the highest employment category in the state, stands at 14% of the employment, down from 22% only a few years ago. Mining and flour milling, which were leading industries for many years are now reduced in importance. Since World War II, three very large manufacturers, (3M, Honeywell, and IBM) together with a variety of fairly large independent companies, have promoted industrial growth in the state.

Minnesota has no single outstanding power bloc. Farm organizations have lost much of their influence, industries are diverse, and churches primarily either Catholic or one of seven branches of the Lutheran Church, are not sufficiently unified to be leading influences in the social scene, either as prime movers for change or as an obstacle to it.

In medicine the state has long had a prominent position, with the University of Minnesota Medical School near the forefront of such institutions, and the Mayo Foundation having an international reputation for quality medicine. Well trained doctors have been distributed quite broadly across the state throughout most of its history. However, in recent years, doctors have become less willing to live and work in rural communities that they see as declining, stagnant, and in any case dull. The shift to hospital practice and increased specialization has meant that as older doctors have been succeeded by younger men there has been a tendency for physicians to cluster around hospitals, and increasingly around the larger hospitals. This means that many of the smaller towns are concerned at the prospect of having no immediate access to a doctor. This clustering of doctors has been accompanied by the largest concentration of group practices anywhere in the country. Forty-one percent of the doctors in Minnesota today are in groups, which produces a somewhat more relaxed point of view about systematic health care than is found in places where more fragmented practice is the norm.

The concentration of high quality medicine at the University and at Mayo has brought into focus the town-gown split which is so familiar almost everywhere, especially around Rochester and the Twin Cities and between these centers. At these centers, research scientists and chiefs of major hospital clinical services still tend to rule, but there is real pressure to focus more of both service delivery and medical education around outreach and ambulatory care. The University is being asked to recognize that the delivery of health care to a defined body of people is something it cannot ignore or accomplish merely incidentally to its garnering of clinical material. Mayo is learning that it is becoming increasingly dependent on local referrals as the growth of first-rate medical centers worldwide absorbs the international and nationwide referrals Mayo had long been able to count on.

There are still vestiges of the attitude, long justified, that these two medical centers are the only ones of any consequence west of Chicago, and north of the mid-continent. When the Northlands RMP was started, its sponsors undertook without self-consciousness to establish a Regional Advisory Group that included representatives from western Wisconsin, all of Minnesota, Iowa, and North and South Dakota. Hence the name "Northlands," which survived the cutback of the region to cover only Minnesota.

Minnesota must be regarded as over-supplied with hospitals and hospital beds. There are some 200 hospitals in the state, of which 87 are state or local government owned and financed. Fifteen of these are state mental hospitals. Most of the rural community hospitals that are owned or sponsored by local government units are very small, and several are quite new though often lacking in facilities that larger community hospitals aspire to these days. Yet to the extent that the community,

through its electorate and its governing bodies, is seen as more directly involved in the hospital, these institutions may well represent unusual opportunities, especially in network building and in the provision of primary care away from the big medical centers. Possible confirmation of this thought is found in the quality of occasional administrators of these tiny hospitals who seem readier to think and talk about the delivery system than is typical in the middle-size towns.

Another straw in the wind is the attitude and posture of the nurses in Minnesota. While they are preoccupied with many of the same concerns that one finds everywhere, they appear -- with active RMP support -- to be more openly questioning established nursing practices than in most places we have been. They are engaged in open discussion with the physicians about the relationships between the two professions.

Despite all this, Minnesota is in some ways nearing a political health crisis. Unlike some other regions where crushing ghetto problems are dominant, the crisis is one of costs, a perceived overemphasis on specialties, poor medical coverage of rural areas, and very high, if ambivalent, expectations on the part of the public. And the highly scientific orientation of both the University Medical School and Mayo has, right up to the immediate past, encouraged academically oriented internships, residencies, and fellowships, which in turn added to the shortage of replacement stock of practicing physicians, particularly those willing to practice general medicine in the rural areas.

B. BEGINNINGS OF THE PROGRAM

Shortly after the enactment of the RMP legislation, J. Minott Stickney, M.D., a member of the Board of Governors of Mayo, and at the time President of the State Medical Society, met with Robert Howard, M.D., then Dean of the Medical School of the University of Minnesota, and some others to consider applying for an RMP planning grant. While acknowledging the existence of only two true centers of excellence in Minnesota, Dr. Stickney and Dean Howard came quickly to the conclusion that an RMP to be successful could not be dominated by the University or by Mayo. It must, instead, from the very beginning enlist the cooperation of the major nonacademic institutions having an interest in health. They decided upon an Executive Committee made up of representatives of:

The Mayo Clinic
The University Medical School
The State Health Department
The State Hospital Association
The State Medical Society
The Heart Association
The Cancer Society
The American Rehabilitation Foundation (incorporating the Sister Kenney Institute)

The grant application was turned over to a professor at the University, Dr. Ivan Frantz, and a section head at Mayo, Dr. Jack P. Whisnant, for preparation. The Systems Development Corporation was engaged to help them. The original planning application, approved on January 1, 1967, included the multistate territory described above. But before the first operational phase application was submitted, over a year later, the surrounding states had developed their own regional medical programs. In response to this, the operational application was re-submitted with the boundaries confined to Minnesota.

There remained the question of who would be the grantee and who the fiscal agent. With the University considered unacceptable and Mayo not anxious for the responsibility either, the State Medical Society offered its Charitable Foundation in both roles. DRMP accepted the Foundation as grantee but objected that its limited financial resources barred it as fiscal agent. Mayo, by default, became the fiscal agent, with the Foundation remaining as grantee. The Foundation, in turn, insisted on having a representative on the Executive Committee, which in effect gave the Medical Society two members. This caused a minor upset within the University, but in the end it acquiesced.

When Northlands was cut back to the Minnesota borders, it was decided to set up a new nonprofit corporation as grantee. The RAG had to be reconstituted, and since it is impossible to change grantees in midstream, Northlands had to wait for the changeover until it went operational.

The RAG, which was staffed by people sent to represent particular interests, tended at first to be highly protective of these interests. A very skillful chairman, Judge Stephen L. Maxwell, J.D., was able to convert the group to a position much more in support of cooperation for improvements, but the RAG still was not, and has not yet become, a powerful force in setting the direction of the RMP. Its size, 42 members, is unwieldy, often enough to give it a really strong voice in RMP. Unless the number is reduced or ways are found to do more work through committees, it is unlikely to become very much more effective. In addition, the RAG meets only one day each quarter, which is not enough.

The Program Director, Dr. Winston R. Miller, shortly after taking charge on November 1, 1967, began building a highly trained professional staff. It now consists of a central staff plus a few full-time people at Mayo and the University. One staff member spends half his time at the American Rehabilitation Foundation. A Core Council has been set up to oversee and coordinate staff efforts in the various locations. It is made up of the Program Director, the Deputy Director, and the associate directors from the Mayo and University contingents. To some people, particularly at the periphery, the staff appears to be remote from what is really going on out in the field. We suspect that it may be true as charged that most of the staff devotes a high proportion of its time to work within the office or with related boards of the RMP. The appointment

of several community coordinators is intended to bring better balance in these terms.

The Northlands RMP became operational on August 1, 1968, with five approved projects. All of these projects, as with most other regions which went operational early in the life of RMP, were either essentially of a continuing education type or dealt with improving access of information to the local physician. More than half the funding for projects went into training for intensive coronary care units.

Early in the life of Northlands RMP, again as in others at the time, it was common to find an interpretation that RMP was essentially just an extension of the familiar NIH research grant system. Several project applications prepared by the University of Minnesota Medical School and by Mayo so heavily emphasized the research nature of proposed work -- as opposed to building cooperative relationships -- as to receive immediate rejection either at the Northlands RAG level or in Washington.

C. CHARACTER OF REGIONALIZATION

1. A Change of Direction

Not long after Northlands went operational, and perhaps in part because of the experience encountered in trying to get project approval, the Region turned sharply in a new direction. At a "retreat" of several Executive Committee and RAG members in November 1968, agreement was reached on a complete reorganization of the Northlands RMP. Committees of the RAG for planning, review, and management were established as a focus for all activities: one in continuing education, another in health services development, and a third in health manpower. All activities of the Region report to these committees, which in turn are supported by advisory committees dealing with the more technical aspects of the work. These cover: intensive care units, the DIAL Access system, nursing, dentistry, library services, rehabilitation services, radiation therapy services, and communications. The attention of the advisory committees is given to identifying needs and resources and suggesting potential ways of meeting the needs. Their data and recommendations feed, as appropriate, into one of the three major committees.

Action is carried out through approved projects and contract studies. Core staff prepares background studies, offers consultation, and stimulates members of the medical community to think in terms of new or improved means of meeting medical needs. All this falls under the direction of the Core Council.

A year after the reorganization, at a meeting of the Northlands RAG on November 21, 1969, Dr. Miller described the function of a Regional Medical Program as follows:

"A Regional Medical Program has dual overlapping functions:

1. To plan, review and manage operational projects,

2. To stimulate or catalyze improvements in the health care system.

Planning and catalytical functions of an RMP are more nebulous, more widely misunderstood, and more difficult to accomplish. Yet they probably offer greater potential for bringing about lasting solutions to the problems of our time."

At a time when some other regions were still having difficulty accepting a role as stimulators of change in the health care system, Northlands was already well embarked on a program of catalyzing change. The approach seems to be through cautious persuasion rather than dogmatic assertion. Dr. Miller appears to try to limit himself and his staff to quietly calling to the attention of those in positions of power and responsibility conditions that need changing. To those taking very strong positions on issues, Dr. Miller's unwillingness to commit himself wholeheartedly to their positions sometimes leads to the conclusion (depending on their side of the fence) either that he is giving the radicals their heads or that he is digging in his heels and permitting no change to occur. The truth of the matter, as nearly as we can make out, is that he remains uncommitted in these confrontations, wanting to keep in touch with all groups that have a stake in health care, while doing whatever he can to make sure confrontation of issues takes place in the interest of getting resolution, and through resolution, progress.

The budget request in the continuation grant application to RMPS for March 1970 through February 1971 emphasizes the significance of the reorganization which began more than a year earlier. In this application, core activities take on an explicit and positive importance. Correspondingly, the early projects, with their emphasis on continuing education and information access, have partially given way to projects emphasizing improved quality of medical care, or more active collaboration across institutional boundaries. The ICCU training budget, which took up more than half the project funding in the first year with very high priority, has dropped to less than one third of the total project funding requested and has been moved to a B-rated priority.

The figures for the continuation grant application (March 1, 1970, through February 28, 1971) shown below highlight these shifts in priority:

A great deal of energy has gone into the development and training of people to man ICCUs. In December 1968, there were 53 of these in the state, 17 of them permanent. Much of the training and impetus behind these came from the RMP and the people who staffed its training programs. The doctor and nurse who head up the ICCU training program have kept closely in touch with the operation of these units in an endeavor to ensure high quality care across the state.

The cross-professional character of the Northlands RMP is evident in many activities. For example, in coronary care unit training, doctors, nurses, hospital administrators, engineers, and TV repairmen all learn about the functioning of the units. When they get home, therefore, every member of a hospital staff who has anything to do with the coronary care unit knows his role and how it relates to the roles of other people. Under the plans for the new University Family Practice curriculum, there is a mixed student body, including doctors, nurses, practical nurses, therapists, technicians, and social workers in some courses. Participating together in their studies, these people are expected to learn how interdependent they really are. The 500 part-time clinical physicians who work alongside the 100 permanent faculty members of the Medical School contribute to the classroom a personal sense of what first-line health care is all about. We must qualify this by saying that all is not a bed of roses. The Academy of General Practice, which originally fought the new Family Practice Program, still is not happy with it, even though it has agreed to design one of its postgraduate courses.

As in most other regions, one of the approaches to regionalization that was considered by the Northlands RMP was the so-called DeBakey model, where centers of excellence are viewed as taking responsibility for specific geographical territories. Under this model, Mayo and the University Medical School would divide up the territory of Minnesota, assuming separate responsibility for regional hospitals, community hospitals, and primary health care within their own respective territories. It quickly became evident that the existing patient collection patterns and needs of these two great institutions did not readily accommodate themselves to such geographical division. Indeed, except for the area of rehabilitation, discussed later, the entire state is related in different ways to both institutions.

The Northlands RMP has initiated close ties with CHP in Minnesota. At the state (a) agency level, regular joint meetings are held between the RMP core staff and the (a) agency staff. Both CHP and RMP work together with the State Health Department in helping to shape legislation. Wherever (b) agencies are approved, RMP seeks a position on their boards. In turn, the directors of the (b) agencies usually find a place on the RMP RAG. In at least one case, the local RMP Community Coordinator has assumed responsibility for starting up a (b) agency, in addition to working for RMP.

RMP is supporting and using whatever sub-regionalization around market towns is accomplished by CHP. It does not confine itself to such regionalization as CHP chooses; it also recognizes pre-existing divisions such as the nine Medical Society councilor districts.

RMP's penetration into the peripheral areas of the Region has built up slowly. Several of the core staff have spent a good deal of time out in the Region away from the RMP office. Contacts have been established in Austin and Albert Lea, for example, to encourage the efforts toward hospital merger that have been in process for about a year. The physical therapist and the library professional have been busily pushing forward their activities away from the Twin Cities.

Under the stimulus of the core staffs located at the University Medical School and at Mayo, these institutions have become increasingly aware of the need for and possibilities of outreach. At the University, this is taking several forms. First, whereas for many years it took weeks or sometimes months after a referral for the general practitioner to receive the results of workups, diagnoses, and treatment from the University, the University now seems to be trying to speed this reporting back to the practitioner. RMP cannot be said to be responsible for this change in attitude but is actively encouraging it. To the extent that this can be accomplished, it should help to narrow the gap between town and gown in this instance.

More importantly, in its complete redesign of its curriculum, the Medical School is now seeking inputs from local physicians. The RMP Associate Director at the School is deeply involved. As has already been mentioned, the 500 part-time clinical members of the faculty are actively participating in the curriculum redesign, and the Academy of General Practice is actively sharing in the design of a particular course. A revamped concept of medical education is being instituted, in which the education of doctors is regarded as a continuum, beginning when they enter medical school and continuing right through their careers in practice. It is contemplated that students will rub elbows with practicing physicians during this educational process in such a way as to invigorate both sides.

The RMP core staff at Mayo has participated in community outreach. For example, OEO has funded the Citizens Action Group in Southeast Minnesota to deal with health problems in the rural areas. Part of the funding comes through the RMP core staff of the Mayo Clinic. A medical advisor and a physician from the Mayo Clinic serve on the CAG. In practice, a registered nurse and social worker man a unit which goes out into the rural areas and deals with patients who otherwise would presumably not seek medical care. Before the unit arrives, aides have already obtained medical histories and sorted out potential patients. From Mayo's point of view, this project has been highly useful in that the institution has had a chance to see what the real medical needs are in the rural areas, and people have received medical care in this new entry point that they ordinarily would not have received.

In quite a different direction, Mayo is engaging in an effort to strengthen outlying medical resources so that laboratory and X-ray results obtained in the community can be used as a basis for diagnosis without the need for repetition when the patient arrives at Mayo. This has for years been a bone of contention between community physicians and Mayo. To effectuate the change, Mayo has begun a training program under which technicians in the outlying areas can come to Mayo to perfect their techniques, using standardized procedures and common approaches to interpretation of laboratory data. Physicians in the outlying areas are encouraged to attend seminars at Mayo, where they can learn these standard techniques and approaches.

Additionally, Mayo intends eventually to serve as a referral laboratory for hospitals throughout the state to make it unnecessary for them to continue the practice of sending complex tests all the way to the West Coast. RMP is partially supporting the microbiologist who is working on these new arrangements.

The physical therapist on the RMP core staff has been very active in helping to build a connection between the Mayo Clinic and some community hospitals around physical medicine. It is expected that this newly developing activity will involve both referral and outreach.

Finally, within the last year or so, RMP has begun the assignment of community coordinators whose job is to familiarize medical people in the outlying areas of the state with the RMP, and coincidentally to make the headquarters office of RMP aware of the thinking and developments outside the Twin Cities and Rochester. Just how these coordinators will work out is not entirely clear. Indeed, there is within RMP itself some difference of opinion about how best to get the "periphery" actively engaged. Some feel that the core staff should undertake responsibility for initiating RMP activity wherever it may become appropriate; others believe that the initiative for undertaking new activities or building new relationships should rest in the field, with RMP's role that of encourager. With the shortage of funds for new projects, what can be done by RMP in either case must revolve around the stimulation of closer cooperation, encouragement to use manpower more fully, and attempts to combine services wherever that makes sense.

The ongoing projects serve to produce some effects of regionalization. All of these projects, in fact, bring together people and institutions which have never before worked together in quite such a direct way. An outstanding example is the intermingling of several disciplines in the coronary care unit training course. It is much more common to see only doctors and nurses being trained and these separately. The medical standards study described later in this chapter will certainly introduce new relationships between the physicians whose work is being evaluated and those who do the evaluating. DIAL Access in a rather limited way builds contact between local physicians and specialists with whom they have never previously had any direct contact. Stroke education, as in many other regions, is

highlighting the value of intermingling disciplines throughout the care-cycle of the individual patient. The attitude of core staff and principal committees encourages regionalization on an opportunistic basis.

This is made explicit in the policy statement prepared by the Committee on Continuing Education in September 1969, urging that "educational programs be designed to advance cooperative relationships and planning among health institutions, organizations, and personnel." This passage goes on to say that RMP includes among its intentions the utilization of regional cooperative agreements to permit sharing of limited manpower and other resources. While these are, to be sure, mere words, they have been published and are serving as guidelines for Dr. Laysemeyer to use in her development of continuing education activities.

If and when ways are found to involve the Regional Advisory Group more actively, the RAG could serve as the initial constituency of RMP and as a principal vehicle for constituency building outside RMP. The mechanism is to identify, concentrate, and create active communication among all the significant energy sources for dealing with health service delivery, quality, and access. A secondary mechanism appears to be to stimulate activities of as many kinds and in as many locales as possible, and to help these activities grow into such autonomous processes that they can become self-sustaining. As these activities are pursued, new data come to the surface and can begin to influence the thinking and actions of the RMP constituency.

All of this can be seen as a strategy of regionalization through the creation of new working relationships across professional, institutional, and community lines. It is an attempt at identifying new sources of energy and decision and encouraging them to coalesce.

3. Impact and Strategies of RMP

It is notable that wherever there is experimentation or change in the medical scene in Minnesota, RMP is there. With a significant number of staff people domiciled both at the University and at Mayo, the RMP is in intimate touch with all new outreach activities of these great institutions. RMP is playing a leading role in the comprehensive review by the nursing profession of its long accepted practices. Its core staff is active in rehabilitation and has been highly visible in the movement to introduce more extensive and advanced paramedical training in the junior colleges. Wherever there has been discussion of hospital consolidations, RMP staff is there.

It is easy for supporters to claim that RMP is the prime mover in whatever looks attractive; it is equally easy for those who are skeptical about RMP to believe that RMP has either no influence or very little. This is a quality of the facilitator: to be so collaboratively related to others that his claim to primacy is usually poor, but to be involved so constructively in so much of what is going on as to be considered very useful.

Northlands is about to engage more directly in action designed to improve the quality of delivered care. Under a project sponsored by the State Medical Society, half the cost of which is being borne by RMP, an audit will be undertaken of records in hospitals and nursing homes widely scattered throughout the state. The plan is to read records of randomly selected cases from randomly selected hospitals involving twenty different hospital-based medical procedures. A similar procedure will apply to nursing homes. The individual ratings given by the reviewing doctors to the work reported will be a major factor in trying to tease out criteria for what represents high-quality hospital care. Initially, only general practitioners will judge the work of other general practitioners, only surgeons will judge the work of surgeons, and so on. In the long run, surely, specialists, pathologists, and others will be found to have important inputs to the general practitioners, to one another, and vice versa. As a starter, this is a progressive step and notable because of the positive attitude of the Medical Society. It will familiarize people with quality review and the concept of explicit, repeated judgments made not only within given institutions, but across institutional boundaries.

In building a program of regionalization, the Program Director must build a concerned and active constituency with either enough political power of its own or enough of the power of public opinion to deal with the major forces bearing on the medical system. Each region has institutions that behave rather predictably. Predicting these is an essential approach to laying plans for regionalization. In Northlands, Dr. Miller has recognized characteristics of the Mayo Clinic and of the University that set significant limits on how they can be handled in regionalization relationships. For example, the interests of the Mayo Clinic are institutionally unique, being subject to a governing board whose accountability is ethically impeccable but unavoidably conditioned by the self-interest of the business enterprise itself. Mayo's existence, growth, and quality leadership have all been financed from the operations of the Clinic. For the Program Director of RMP, Mayo can be dealt with as a coordinated whole. In contrast, the University of Minnesota, typical as it is of huge state universities, is a collection of mutually disconnected, often isolated, educational research and service activities that simply cannot be mobilized effectively from any single point inside. It may be that Dean Howard's reluctance to have the University assume a dominating role arose out of his realization that interior mobilization was to all intents and purposes out of the question. From what we know, he seems to have been more explicitly cautious than other medical school deans when he made it clear that the University did not want to, and could not, dominate the Northlands RMP.

Looking across the state at all the ongoing activities, it is quite clear that regionalization in Northlands takes on almost all of the possible characteristics in some activity or other: center-periphery, network building, and to a lesser degree sub-regionalization. RMP pushes wherever anyone is found who is willing to pick up the cudgels.

Since the Program Director is dependent on persuading other people to take the initiative and move constructively toward change, he also is

forced to be tolerant of existing complexities and internal contradictions. For example, the rehabilitation networks seem quite naturally to follow well-established lines and relationships that are quite different from the sub-regionalization that is being followed in the design of the CHP (b) agencies and of the RMP RAG. The pre-existence of a strong medical program at Mayo Clinic has made rehabilitation functions in the southern third of the state fall quite naturally on Mayo. The long outreach of the Sister Kenney Foundation from its location in the Twin Cities relates it quite naturally to a series of institutions and communities stretching from just to the north of the Mayo Clinic area to slightly north of the Twin Cities; east in the general direction of Wausau, Wisconsin; and west into North and South Dakota as far as Pierre. The University, in turn, having had some previous connections in the rehabilitation field in Duluth, has begun to exploit others, with the effect of giving the University the whole northern part of Minnesota. This is an example of the single-purpose regionalization with defined centers and peripheries, determined by the needs and backgrounds of that program.

4. Looking Ahead

The evidence is strong that the RMP is doing very well in embracing the rich opportunities and resources available to it. Our discussions with the Coordinator and the core staff suggest that there are conscious efforts to put push behind regionalization, when one examines the actual activities, they take on a kind of ad hoc characteristic. In a voluntary setting this is perhaps inevitable. However, there does seem to be a certain degree of detachment between the Coordinator and the rest of his staff, and among the members of the staff vis-a-vis each other. The Coordinator, being himself a physician, thinks most easily in terms of medical education and medical practice. The core staff members, none of whom are physicians, are all highly professional each in his own field. We have a sense that these professionals have a tendency to focus strongly and independently on their own fields of specialization without a full appreciation of how what each of them is doing might relate to what the others are doing. It is not entirely clear how a broader sense of program might be introduced without losing some of the freedom to move wherever action seems likely to occur.

Dr. Miller has chosen to run the risk of losing some flexibility in favor of building a program. Priorities are being established among the problems RMP chooses to deal with and among the major approaches that are expected to be most useful in bringing about significant transformation of the health care system. Recognition of priorities in the latest application for funds from RMPS reflects this.

A slowly emerging priority appears to be the need for more focused attention on manpower. The question of availability of appropriate health care services is most pressing in the rural areas and in the newly burgeoning communities around the Twin Cities. It looks as if the training and retraining of nurses, technicians, LPNs, and dieticians to meet immediate needs will by the force of circumstances move up to a top-level priority.

RMP can be helpful, particularly in association with CHP, in seeing that this training of primary health care workers is useful, not only to meet the present needs, but by being conceived in the expectation of future needs. In facilitating manpower development programs, RMP must constantly tread lightly. For example, given the intensity of conflict between the Academy of General Practice and the University over the Medical School's new Program of Family Practice, RMP has to remain as removed from the scene as possible.

The signs for RMP continuing its development as a force in encouraging change are positive. Not only has the RAG endorsed the reorganization which is designed to encourage this direction for the Region, but the Board of Trustees seems to support change as well. This Board, which for the most part is made up of representatives of the successful institutions whose practices RMP hopes to alter, has supported Dr. Miller's formulation of explicit health care system transformation goals in Minnesota. So far as we can tell from the outside, no one on the Board is dragging his heels. Under these circumstances, if even a fairly small but articulate minority takes the view that it is the Board's job to support change, this position will probably be sustained.

D. RELATIONSHIP WITH RMPS

The Northlands RMP seems to have a somewhat easier relationship with RMPS than most regions we know of. There was a minimum of complaint within the Northlands RMP about unresolved misunderstandings between the Region and RMPS. As we have talked to people in RMPS about Northlands, we find at the Bethesda end a widely shared feeling that the Northlands RMP is headed in good directions. However, some of the RMPS staff a few months ago expressed disappointment at the failure of the Northlands RMP to pick up momentum after what was regarded as a very strong start. They were unable, when pressed, to particularize what expectations they had built up had failed to materialize.

At the Twin Cities end there is a sense that Northlands' priorities are accepted at RMPS. We heard from some of the core staff that it is difficult to learn through RMPS what people in other regions are doing that might be useful to Northlands. Nevertheless, some individual core members appear to have their own direct communications with at least some of their counterparts in other regions, so they did not feel really isolated. The core staff member who had been developing a data base for Northlands RMP has worked closely with people in Texas engaged in a similar effort. The librarian is in close touch with librarians across the country. The two core staff members assigned to the categorical side of the program keep in touch with voluntary agencies and others whose interests correspond.

However he does it, Dr. Miller seems to keep in tune with the thinking at RMPS. For example, the National Advisory Council has been increasingly wanting help from the regions in setting priorities among

competing programs and projects for which there are insufficient funds. The Council has been reluctant to choose priorities for the regions, in view of the generally accepted policy of leaving initiative with the regions. Yet it has had difficulty in getting clear statements of priorities from the regions. Just as this was becoming a frustration of some importance, the Northlands Region submitted a continuation application that arranged all its requests in order of regional priority.

E. DEVELOPMENT OF EVALUATION

When one talks of evaluation in the Regional Medical Programs, it is usually in terms of the testing of progress against objectives from a base line. Early in its history, the Northlands RMP set about developing a "descriptive" base line for the delivery of health care in the state. Northlands chose a relatively inexpensive approach to the assembling of demographic and health resource data, Dr. Miller having chosen to use existing published data from AMA and other sources in preference to specially collected material. He thought the latter would probably prove to be subject to almost as great attack as the published material, which admittedly contained some inaccuracies. The data were grouped for seven sub-regions which had been established for more general purposes by the State Planning Offices. When the material was released, people in the sub-regions were indeed able to identify specific inaccuracies which they felt limited its usefulness. But while it is true that the inaccuracies presented problems, the data taken as a whole spoke loudly about some of the Region's medical needs. The actual sub-regional breakdown chosen by the State Planning Offices has been under attack from other than medical quarters, and it seems likely that in time some improved rearrangement will be agreed upon. The choice of sub-regions used for other purposes has the advantage of permitting a matching of health data to other social data -- a desirable feature in view of the interconnectedness of health and other social fields.

Objectives for the Northlands RMP are slow in being formally spelled out. Starting with the reorganization of November 1968, it became an explicit objective of the Region to place chief emphasis on getting health services to all segments of the population rather than on addressing specific diseases. Apart from this general statement of policy, however, of the three functional committees under which the RMP is now organized, only the Committee on Continuing Education has agreed upon a written statement of goals. Apparently, the Health Services Development Committee is wrestling with serious philosophical questions about the extent to which the RMP can properly interfere in the health services delivery function. As for the Manpower Committee, many individual training objectives have been stated, but we did not encounter any overall statement.

Despite the lack of much formal evaluation structure up to this point, a great deal of informal evaluation is constantly going on. For example, in the Communications Committee, there has been open questioning of whether Northlands RMP is an out-and-out boondoggle. Active discussions about the balance of RMP between the Twin Cities and the rest of the state

has also received vigorous discussion from many points of view. Research versus service is a frequent topic of discussion, as is the question of how much consumer attention versus provider participation is right for RMP. The RAG Chairman is continually challenging the activities of the Northlands RMP. He challenges whether the core staff is sufficiently dynamic and tough in trying to encourage really innovative change; his definition of innovation is "something that is new and sounds workable but is almost surely opposed by 90% of the experts." He presses for increasingly great activity outside of the University of Minnesota and the Mayo Institute, because he thinks that what needs to be changed is largely away from these centers.

Some people in the core staff feel that more needs to be done to enlist the interest and participation of people more removed from the great centers. These people believe that the RMP has already identified enough ideas to get a really good start for exerting leadership in the greater communities. These people go on to say that unless RMP and its constituency gets away from the notion that RMP is a "shower of gold" they will not be able to attract the kinds of activists who might be willing to undertake leadership for change. It is not even yet agreed whether the Board of Trustees, the Regional Advisory Group, the Core Council, or the committees should seek to take this leadership. At the present, all seem to feel that someone else should take on that job. As one of the core staff said, "RMP has a great opportunity to involve and make responsible the great constituency we have almost acquired."

Project evaluation has not yet come into its own. The objective of the ICCU project, for example, is "to further decrease the mortality from coronary heart disease in the state of Minnesota through a multi-disciplinary improvement of medical, and to some extent paramedical, care." This objective by itself is too broad for short-run evaluative purposes. Needed also, for example, is the objective of ensuring that the physician or nurse who is going to work on a coronary care unit knows the equipment and the diagnosis that goes with it. These are things that can be observed, and behavioral changes can be noted. Testing doctors and nurses before and after training programs might be one measurement technique. Mere attendance as an expression of the popularity of the training programs is probably not enough. Some progress has been made in checking the success of the program with nurses. For example, videotapes of advanced students' attendance to patients and their handling of the equipment have proven to be dramatic ways of not only testing what was learned but demonstrating what was not learned, so that it can be taught again in better ways. We were told that doctors, even in the medical centers, were uneasy about submitting to tests of this kind, but more of this kind of testing in this and other projects would seem to be well within reach. Certainly cognitive evaluation attempts are being made in the rehabilitation training project at the American Rehabilitation Foundation. Perhaps the medical practices audit referred to early in this paper will make a breakthrough from which much more can be started.

There are other forces in the Northlands RMP working toward the development of better formal evaluation. The use of team seminars, for example, in the new University Medical School program and under some of the ongoing RMP projects encourages a climate in which friendly criticism is encouraged. This can be a very good stimulator of self-evaluation.

F. ACCOMPLISHMENTS, PROBLEMS, AND OPEN OPPORTUNITIES

Northlands is one region that early accepted a catalytic, or facilitative role. This provided a point of contact with some other regions for comparing accomplishments over the past two years.

We encountered both within the Northlands Region and in RMPS conflicting opinions as to the rate of progress in the Region. We found it difficult ourselves, after interviewing scores of people in the Region, to agree on how well accomplishments compared to what might have been possible.

It soon becomes evident to those who look closely that many things are taking place in Minnesota medicine, and we found the RMP presence wherever we learned of motion in the medical field. It cannot be said for very many of the developments that RMP is responsible for initiating or driving them, but the fact that it is almost always there suggests that its contribution is seen as useful by those who are active.

Conventional tools of evaluation throw little light on the question of how well the Northlands RMP is doing. As we point out in Volume II, Chapter V, the test of progress in facilitation must be set up in terms of carefully described "starting conditions" and thoughtful "ends in view." What is seen as possible in moving from given starting conditions to chosen ends in view is unavoidably a matter of judgment which we believe can best be developed and tested through the kind of dialogue that is also described in Volume II., Chapter V. Only when the strategies for moving from one to the other have been fully understood can one look back and evaluate their effectiveness. Even then there is no certainty that other strategies might not have been more effective. As in most other RMP regions, the Northlands RMP strategy has not been made clear; and in the view of some people, in fact, Northlands has no strategy. Our view is that the strategy is to create a committed constituency, more willing to look at existing gaps and over-specialization in medical care, but this strategy is largely unstated.

So we have in Northlands a region operating in a facilitative role before appropriate tools of evaluation have been designed. Having said this we move to changes that are in process in Minnesota, indicating where appropriate problems that have not progressed very far toward solution, or opportunities for even greater RMP participation.

1. Health Services

- It is reported in a number of quarters that the close relationship between RMP and the State Health Department has perceptably increased the level of attention of the Health Department to the total health care system as contrasted with its more traditional and narrower focus on epidemiology and preventive medicine.

- We were told that Mayo, stimulated by its RMP core staff, has succeeded in interesting the State Legislature in investing $100,000 in a study to look for possible improvements in rural health services. Special attention is being given to local communities and to OEO rural health programs.

- Mayo physicians told us they have begun to change their thinking about Mayo's laboratory services in relation to those of nearby communities. They are offering training for technicians, offering standard analytical procedures to neighboring laboratories, and are trying to merge into a single system the laboratory services in an adjacent territory to eliminate the necessity for duplicate testing as patients move from the community into the Mayo Clinic, all with active participation of its RMP core staff.

- RMP has participated in the Austin-Albert Lea discussions about merging their hospital facilities. RMP's Community Coordinator in St. Cloud is engaged in trying to bring about twelve hospitals into a cooperative program.

- The RMP core staff has been active in planning rehabilitation services for the greater community around Rochester and also in Duluth.

- If the project is funded, the proposal for auditing medical records to be carried out by the State Medical Society, with 50% of the financial support coming from RMP, could well become a pilot for other RMPs seeking to upgrade the quality of health care, particularly if pursued with increasing commitment into successive phases, in which other aspects of the quality question are added to those now under scrutiny.

2. Continuing Education

- The University of Minnesota's RMP core staff is actively working with 17 advisory committees on what has been described to us as a complete revision of the curriculum in the School of Medicine. Its principal role has been to lubricate the connections between the faculty, practicing physicians, and students. RMP's goals are stated to be:

(a) Improved methods of self-instruction at all levels,

(b) Getting these improved methods out to practicing physicians,

(c) Exploring cyclic curricula for lifetime learning by physicians.

- In one subregion, the RMP coordinator is developing a program of continuing education for physicians in 10-15 community hospitals, the idea being that several hospitals joined together can afford more frequent and higher-quality continuing education than would be possible for them separately.

- The central core staff librarian has taken a nationally sanctioned list of professional materials that any moderate-size community hospital can afford, and offers her services to assist such hospitals in tailoring the material to their own particular needs. However, she has not yet succeeded in obtaining full support for the RMP behind the development of a complete network of library services to cover the entire state, which she believes would have great value.

3. Allied Health Professionals

- Paralleling the inventorying of physicians described below, under Evaluation; the Mayo RMP core staff has been surveying facilities for training allied health professionals and reviewing the potentials for training to match future needs for these professionals. Taken together with the inventory of physicians, this will put the region in a position to recognize most of the professional personnel and training needs that will face it.

- With assistance from the RMP core staff nurse, all nurses' organizations in the state are undertaking a study of existing nursing practices and the possibilities of making them more appropriate to needs.

- RMP has been instrumental in encouraging a junior college for the handicapped to train its students as physical therapists, a role in which their personal interests can be expected to be very high.

- Despite all of these activities directed toward improving the supply and quality of allied health professionals, however, we were left with the impression that the Northlands RMP is not putting very much direct support behind the buildup of paramedical manpower.

4. Evaluation

- The Northlands RMP has surveyed the resources and needs for health services in all of the sub-regions of the state. Working jointly with the CHP (a) agency it is planning on keeping these materials up to date and making them more accurate and useful.

- In 1969 a bill was recommended to the State Legislature by the Senate Interim Commission on Medical Education providing for more accurate reporting of the type of medical practice of each physician when he seeks to be relicensed. There is a reasonable expectation that some time in the near future such a law will be passed permitting more accurate inventories of the physician resources in the state.

- As in other regions, the evaluation schemes for individual projects did not strike us as highly sophisticated. For the most part, they seemed to be too general and not to lend themselves to checking progress throughout the life of the project. More recent proposals have moved in the direction of correcting this weakness.

- Evaluation of the Northlands RMP as a whole has been the topic of lively conversation, but not of highly formalized procedures. In the latter regard it is rather typical of the RMPs in general, but in the former, it must be recognized as much more positively self-critical than most; that is, the criticism is actionable, given RMP as it is, and the criticism frequently seems to stem from "insiders" who have first-hand experience of RMP.

5. Communications

- The Northlands RMP produces publications at frequent intervals and offers displays and visual aids in support of projects and programs to improve Minnesota's health system. It also acts as a consultant on innovation in communications for project leaders and core staff members.

- On the other hand, the Northlands RMP's public interface seems to be quite weak. Persons we encountered in the state who were not directly involved with the RMP knew little about it. The public relations officer is new, and so far there has been little widespread publicizing of the program. Some people who are active in the Region feel that the RMP should play a much more direct part in consumer education about medical problems and health care in all its aspects. Yet there are risks for a facilitative program in publicizing its activities in any depth before it has rather fully won over its constituency.

- A misunderstanding on the part of the faculty in the University of Minnesota Medical School and the medical staff at Mayo grew up early in the life of Northlands, when not many people were quite sure what the program was all about. The faculty and senior Mayo physicians, by and large, assumed that the RMP was simply an extension of the NIH type of research grant program and did not take very seriously the requirement for cooperative efforts. Acting on this misconception, University faculty members, as well as some of the senior staff at Mayo, submitted proposals for projects, which were turned down, rather peremptorily from their point of view. The resentment over this misunderstanding has not entirely disappeared. It is believed that with the new chief of the University RMP core staff, relations there will markedly improve. Much of the resentment at Mayo has reportedly subsided.

- There are strong indications that, as is true in most regions, the further one gets out into the country the less well understood RMP is. Dr. Miller has started to deal with this problem by building up a complement of community coordinators to close the communications gap. It will not be an easy task; because of the widespread fear among practicing physicians of interference by the Federal Government in medical practice.

VI. MEMPHIS RMP

VI. MEMPHIS

The Midsouth Medical Center Council and the Regional Medical Program

The Arthur D. Little/OSTI team went to Memphis to study the connection between the Memphis RMP and the Memphis Comprehensive Health Planning Agency, both of which operate under the auspices of the Midsouth Medical Center Council. We wanted also to gain as clear an impression as we could of RMP outreach in a multi-region setting. The Memphis Region shares territory with other Regional Medical Programs in Mississippi, Arkansas, Missouri, Kentucky, and Tennessee.

What we found was a possibly unique and certainly outstanding example of private medicine taking initiative in health planning and regionalization. The Midsouth Medical Center depends upon direct collaboration between leading private physicians and influential people in other lines of business and professional activity. In this sense, Memphis represents a development that is almost the contrary of what is found in RMP in most places in the country. Private doctors provide professional leadership in the Council, which acts as the major board to guide both RMP and the CHP (b) agency. RMP itself had its origins as a medical school program in Memphis, and it continues to maintain close medical school contacts; but it is under the Council's general jurisdiction and is expected by the Council to be responsive to the CHP staff.

The ADL/OSTI team did not make an extensive study of the Memphis Regional Medical Program. But because the Midsouth does contain elements that are not evident elsewhere, we want to include some account of the situation in Memphis as we saw it.

The Memphis RMP had early developed a centralizing strategy, more recently supplemented or supplanted by an outreach strategy. Seven of the eight operational projects first funded in Memphis were located or managed in the City of Memphis hospitals, which serve as teaching hospitals of the medical school of the University of Tennessee. Many of these projects were intended to serve the entire region from the center by improving the capabilities of the center to screen, diagnose, and get into working communication with patients and physicians in outlying communities. The emphasis now has switched to attempts toward encouraging, stimulating, and identifying promising activities in outlying areas.

Preconditions of Regionalization

In the Midsouth, Memphis is the hub, and virtually everyone expects it to be. Not only the rivers, but railroads and super-highways, lead to and away from Memphis. Transportation helps make it possible for Memphis to maintain its importance as a regional headquarters for

trade, commerce, and the marketing of agricultural produce. In medical terms, the same pattern exists. There are 1300 physicians in Memphis, close to two thirds of the total to be found in the five-state region (about 70 counties) associated with Memphis RMP.

Private medicine in Memphis includes many well equipped specialists. The Baptist Hospital, with 1400 beds, is the largest private acute-care hospital in the country; it is one of several strong institutions with a total of 3500 community or teaching hospital beds for acute care in Shelby County, Tennessee alone. Medical resources include the University of Tennessee medical school, among the largest medical schools in the country; it made the same concerted effort that most state schools did in the 1950s and 60s to develop a high degree of subspecialization and a relatively large research program. Since the population of Shelby County is around 750,000 and the region as a whole is populated by about 2.5 million, the number and concentration of physicians and their supporting facilities suggests that Memphis draws patients from much of the area and serves as a regional medical center. Those who are in the health care field in Memphis have a considerable interest in attempting to maintain their position as a regional center in the future.

Outreach

Interregional relationships take on a special form in the Mid-south because of the widespread willingness to take advantage of the existing transportation and trade patterns just mentioned. For example, three RMPs have some degree of interest in the southeastern counties in Missouri, the so-called boot heel region. These are Memphis, Missouri, and Bi-State (St. Louis). It seems to be in the interest of the people in these counties to keep in touch with all three RMPs. This privilege increases the likelihood that these areas, equally remote from all three RMP centers, will be able to profit from association with all of them, if only by trying to induce adjacent RMPs to compete with one another. We found a similar situation in north-central Mississippi. In Arkansas, things were a little different. Arkansans in health care activities in West Memphis, immediately across the Mississippi River from Memphis itself, regard themselves as strongly oriented toward Arkansas and as likely to drift toward that relationship as toward Memphis, only ten miles away.

All of these relationships with RMP should be described as relatively weak in the eyes of the people in communities outside Memphis. Most of the associations were initiated in the expectation of receiving RMP project money. In two towns in the borderland of the Memphis RMP region, we found partly finished coronary care units for which expectations had built up that RMP would provide additional funds for the purchase of equipment. Given those expectations, it is not surprising that the eventual drying up of project funds reduced RMP's credibility in these outlying districts.

The categorical restrictions on RMP proved a further barrier. People in small towns 150 miles from Memphis do not approach health and

medical care in categorical terms, and accordingly find RMP somewhat hard to understand.

Nevertheless, where the Memphis RMP has been able to identify with people of energy, interesting activities of great potential significance are under way. Outstanding examples include integrated community health care in Iuka, Mississippi; constructive collaboration between the community hospitals in Paragould, Arkansas, and Kannett, Missouri (in blood-banking, chemistry lab work, physical therapy, radiology, and a home health care agency); subregionalization efforts of varying extent and nature in a number of places (particularly notable in Jonesboro, Arkansas, and Jackson, Tennessee, both college towns with built-in possibilities for paramedical training). These places displayed considerable activity in the spring of 1970, and it was easy to see how they were stimulating some of their neighbors into a competitive subregionalization which might or might not turn out to be constructive. It was easy to imagine how their success would lead to emulation and the eventual creation of networks for health care improvement through shared regionalizing efforts.

Our overall impression of outreach from the Memphis RMP is that it is spotty and as yet at an early stage of development, though at least as far advanced as that generally found elsewhere in the spring of 1970. If the RMP message as heard in outlying areas was weak and sometimes distorted, still RMP seemed to us to be at that time quite capable of further expansion and indeed, to be on the move positively to deal with this handicap.

The Midsouth Medical Center Council (MMCC)

We were in Memphis too short a time to develop a genuinely detailed and systematic historical description of the Midsouth Medical Center Council. What we did see left us with strong impressions.

MMCC started as an attempt on the part of private medicine to take initiative. As a much less highly formalized structure, it preceded passage of Public Laws 89-239 and 89-749 and the earlier Medicare legislation.

In addition to anticipating Federal legislation, it was in a position immediately to react to local professionally dominated planning activities that were beginning to act within the health field -- especially the local Health and Welfare Council. MMCC had a different constituency and different power base from the start. Influential physicians saw health and medicine as a field in itself, not as a connected part of a health and welfare totality, and they questioned the necessity and appropriateness of the Health and Welfare Council's taking independent action on health affairs -- an independence that has apparently since been reduced or resolved.

We heard that in its earlier days the MMCC was strongly oriented toward outreach, apparently because ideas about regionalization were

already strong. Like-minded men were ready to pitch in and help in some of the market towns at a distance from Memphis. Perhaps most important, the proponents of MMCC could see a continuing and even a growing need to keep open channels to a larger patient population than existed in Memphis alone. But these first plans were later modified by the appearance of CHP.

Evidently, PL 89-749 had greater positive influence on MMCC than did the passage of PL 89-239. Very early, MMCC became the local (b) Agency Council, with the result that MMCC tended to limit itself more to the counties immediately around Memphis while CHP got established. RMP, though also organized quite early in Memphis, and formally subordinated to the MMCC, seems to have been early identified as more of a medical school program, whose real use to regionalization or to health planning was either less clear or less available.

Two significant issues appear to have been basic to the Memphis situation during and since 1968. These questions and issues formed around the evolving role of the medical school in the community and the hospital strike.

The medical school had substantially converted itself to the research and specialists' model. Like several other very large schools formerly devoted to training relatively large numbers of general practitioners, this conversion took place somewhat late in the game; and the medical school was vulnerable when Federal research money began to dry up. But it was also frustrated in its attempts to obtain sanction for admitting private patients of full-time medical school faculty members to a modern acute-care, municipally owned hospital. Private practitioners saw this proposal as something of an invasion of the private sector by the medical school, and it was never accepted. The incident was one of several that tended to define and in the view of some, to confine, the activities and prerogatives of the medical school.

The Memphis hospital strike and the conditions and conflicts leading to it constituted the major set of issues against which to consider the situation of the MMCC. The range of issues involved is too complex to be contained in any simple statement. On the basis of what we heard, emotions ran high and heroes and villains were invented for every confrontation. But the more understanding one had of the situation the less clear became the distinctions between right and wrong. The hospital strike was many things. It was an incident in a labor-management struggle fought on a survival level. It was an issue concerning differing values and priorities for dealing with social problems in health and economic development. It was a power struggle, a problem in race relations, and a challenge to organize the administration of Memphis hospitals to work and share in common planning. More generally, the hospital strike was an aspect of the agony accompanying any of a hundred or a thousand conflicts in the United States today: expectations are high (in this instance, expectations for wages, for salaries, for income from professional practice, for health care, for disease cures, for a blissful future); capabilities are far less than expectations can meet; each of

the projected scenarios for improvement are fatally objectionable to persons in positions to exercise a veto.

The MMCC came through these crises possibly strengthened, certainly very much alive, and with at least a part of the community giving it credit for having participated constructively in the hospital strike settlement. But we are not here concerned with the role of MMCC in these crises, which we have not studied directly and cannot describe with confidence. Our point is that real issues in health care organization and the delivery of health care services are being directly brought to the surface in Memphis, and MMCC is there with the power to choose whether to involve or not involve itself in their resolution.

Given the prevailing ideology of the local private medical practitioners and their allies, MMCC appears as a statesman-like and successful innovation to help society work its way through conflicting needs and expectations that could easily get out of control.

But there are also other perspectives on MMCC which should be mentioned. From a "welfare" perspective, MMCC looks overly cautious and does not seem to be actively addressing the "real" problems of health care in the region and metropolitan area except just to the point necessary to preserve its own and its leaders' influence.

We did not check out the perspective of the full-time medical school faculty member. We speculate, however, that to such a person MMCC could look still different. It might well seem to him to be a constraining or restraining mechanism on faculty or administrative efforts to expand the traditional role of the medical school and in some measure to modify its traditional relationships with private fee-for-service medicine.

Given the considerable pressures on health care everywhere, and especially in Memphis, we agree that MMCC is in a spot where the need to find a way to exert genuine and generally acceptable control is very real. The issue is whether MMCC leadership -- indeed, whether any possible human leadership -- can remain cool and relaxed enough in the presence of conflict, opposition, uncertainty, and basic questions about controllability ("keeping the lid on"). As it feels the heat, MMCC has to be cool enough to dare swiftly to recruit and co-opt new leaders from outside the establishment if it is to achieve the broad acceptability on which useful and effective planning of the health care system will depend.

MMCC needs broad acceptance to cope fully with the problem it has taken on. MMCC has placed itself where it can potentially confront basic problems of health care and its organization. The combination of the influential figures in private, public, and academic medicine, powerful people in other segments of society, CHP, and RMP is remarkable and unusual. In few places in the United States does anything exist which is comparable, analogous, or equally exposed to potential public attack.

This uniqueness deserves attention; the effort behind it deserves credit; the difficulties it faces deserve sympathetic understanding. While

these difficulties are no different in kind from those found in health care in many other places, they seem more intense in some respects, still symbolized by the seriousness of the hospital strike. Polarized attitudes, available resources -- concentrated and inaccessible to many patients -- and relatively severe poverty problems are principal issues. Nor have all the problems there are in joint development and use of CHP and RMP staffs yet been solved to their mutual satisfaction.

The MMCC potential, however, is great. We went to Memphis with curiosity and experienced a period of ambivalence about what we observed there. In the end we came away with healthy respect for what we view as a conscious and serious attempt to line up, to legitimate, and to use the available community power in the long-run interest of rationalizing health care in the Midsouth. Future broadening and deepening of the MMCC programs should be most interesting.