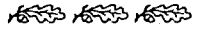
california regional medical program

profile

winter 1974



The California Regional Medical Program (CRMP) invests capital and technical assistance in the development of improved health care services in California. It helps to unite doctors, nurses, pharmacists, hospital administrators, medical teachers, public and private health agency officials, patients and anyone else committed to better health in a crusade to solve health problems.

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ONCE THE PATIENT HAS BEEN STABILIZED, he is transported by private ambulance to the hospital. The ambulance attendants and the paramedics place an accident victim on a stretcher as onlookers watch at the scene of a busy Long Beach intersection.

A System That Saves Lives

The shrieking, blaring sirens of the Fire Department used to bother Jim Cox whose north Long Beach home is only blocks away from the neighborhood fire station. But that was before last June 25, the day the 46-year-old oil driller's heart almost stopped beating.

"They can make all the noise they want to as far as I'm concerned," says Cox today of the engine company and paramedic rescue team who are credited with saving his life. "They are my friends."

Cox suffered a ventricular tachycardia, an excessively rapid heart beat which, according to his cardiologist, Alan J. Hermer, M.D., would have resulted in immediate death had life-saving drugs not been promptly administered by the paramedics.

Fortunately for Cox, he lives in one of a growing number of communities whose firemen are not only trained to the level of Emergency Medical Technician (EMT) II, but which has developed an organized system of delivering emergency care to its residents.

The Long Beach mobile emergency medical program links together the Fire Department, a private ambulance company and four hospitals. St. Mary's Hospital is the base station with which the paramedics establish initial communications in an emergency and Pacific, Memorial and Community Hospitals serve as satellites. All are capable of receiving and transmitting on-the-scene information, including EKGs via telemetry.

THREE MINUTE RESPONSE

These linkages make it possible to respond to any medical emergency within the city in three minutes. Take Joseph Duhem, who was sitting in a Pacific Coast Highway restaurant last February when he was struck in the head with a blast from a 20-gauge shotgun.

The proprietor placed a call to the Fire Depart-

ment. The closest engine company, an ambulance and one of the city's four paramedic units were dispatched to the scene. Within two minutes the unconscious Duhem was receiving mouth-to-mouth resuscitation from the firemen. Less than a minute later the paramedics arrived, took his vital signs and on the orders of an emergency physician inserted an esophageal airway and began giving him intravenous fluids.

Once stabilized, Duhem—accompanied by a paramedic—was transported by ambulance to Community Hospital. The emergency room staff not only anticipated his arrival, but they knew in advance the care he had already received. Although the incident resulted in the loss of his right eye, Joseph Duhem could have lost his life.

In a very real sense the "system" saved him. It enabled the medical community to respond with the appropriate skills at the time they were most needed.

SYSTEM DIDN'T JUST HAPPEN

This capability didn't just happen. The community working with the former Long Beach Regional Medical Program Committee made it happen. More than a year was spent bringing together medical and related interests, designing the system and testing its feasibility. But the time was well spent in the view of Irvin Ungar, M.D., who directs the base station operations at St. Mary's Hospital.

"We were able to develop a system that included all the necessary components and to assure they all functioned together," Dr. Ungar said. "We also tried to focus on some of the needs that were peculiar to the Long Beach community."

To the Long Beach planners, however, the system is not static. Rather, it is evolving.

As an example, they expected a greater number of coronary emergencies because more than 13 percent of the city's population is over 65 years old. When that didn't occur, the paramedic curriculum was modified.

Also unpredictable were the traffic control problems at the scene of an emergency which has led to an informal working agreement with the Long Beach Police Department.

As with any major effort, costs were an important consideration in the design of the program. RMP's announced phase-out (retracted in September, 1973) had severely curtailed funds available for the Long Beach system.

One of the first questions they tackled was whether to use existing firemen as paramedics or to train new personnel. Even though it was felt that former medical corpsmen and many ambulance personnel could qualify, they chose the firemen because of the city's willingness to underwrite the training and equipment costs—the bulk of the $370,000 spent in developing the system. An estimated $50,000 will be required annually to maintain the system.

CONCERN ABOUT ECONOMICS

"I don't think any city can afford not to be concerned about economics," noted recently retired Fire Chief Tullio J. Rizzo, "and the main thing we found out from our field research was that it was the cost of additional salaries that killed other programs."

But the decision to use existing personnel also posed some additional hardships on the Fire Department. It meant that most of the paramedics would have a dual responsibility to respond to fires as well as medical emergencies.

As an alternative, some cities are considering separate paramedic units in their Fire Departments, which Long Beach does not rule out.

SENIOR PARAMEDIC GARY ROBERTSON uses biocom equipment at the scene to communicate with emergency physicians at St. Mary's Hospital, the base station for Long Beach's emergency medical system. Here he awaits orders after reading the patient's vital signs. **(Photo by Reinhardt)**

That possibility appeals strongly to most of the paramedics whose only avenue for promotion is through regular Fire Department channels. One of the original 28 trainees already has dropped out to accept a promotion to Captain—a salary differential of $400 a month.

The paramedics receive an additional $35 more a month, yet most acknowledge that it was other things that brought them into the paramedic ranks.

"It was so frustrating before to respond to an emergency and not be able to save someone's life because your skills are limited," explained Officer Gary Robertson, one of the senior members of Rescue Unit I.

But neither he nor his counterparts in the other three rescue units functions with that handicap today. Their training encompasses almost six months, including didactic and clinical instruction at County-USC and Harbor General Hospitals and an internship in the various departments of local hospitals. The trainees spend a month riding with a rescue unit before their assignment as paramedics.

Just like many other professionals, the paramedics also must meet continuing education requirements to be recertified. They receive a 40-hour refresher course every year to reinforce their basic skills and extend their knowledge in the management of cardiac conditions, shock, burns, orthopedic and other emergencies. This instruction is offered by local emergency physicians and other medical specialists who volunteer their time. It is hoped, however, to integrate these courses into the junior college system so that the paramedics can receive college credits.

DOCTORS NO LONGER SKEPTICAL

Despite the paramedics' extensive preparation, many physicians viewed them with a "jaundiced eye" at first, recalls Frank Hurtebise, M.D., a general surgeon and emergency room director at Memorial Hospital.

"A vocal minority was skeptical that something could be done to save lives in the field," he noted, "but now they admit it can and is being done."

Jeff McDonald, M.D., an emergency physician at St. Mary's Hospital, is quick to reinforce that view.

"Hemorrhaging stops at the scene rather than in the hospital," he stressed. "People who would have died earlier are walking out of the hospital today." He estimated that DOA (dead on arrival) patients have dropped from 10 to 15 a month to two to four since the program was initiated.

Although pleased with the technical performance and judgment demonstrated by most paramedics, Jerry Hughes, M.D., director of both St. Mary's and Community Hospital's emergency departments, would like to see greater emphasis placed on team training in emergency care.

"We need to develop closer working relationships among the emergency room staff, the ambulance attendants and the paramedics because *they are the emergency system," he said.* "To think of the private physician or other specialist being available during those critical first hours is a dream."

CALLS EXCEED 900 A MONTH

It is increasingly obvious over the past 18 months that Long Beach residents are relying more and more heavily on their emergency system and the paramedics in their critical role.

The Fire Department used to get an average of 125 calls a month but since the system's initiation that number has increased more than 900 a month. The nature of the calls also has changed—from first aid to life-threatening emergencies.

In a recent month 55 percent of the paramedic responses involved trauma victims and central nervous disorders, ranging from seizures to overdoses; another 25 percent were cardio-respiratory. More than 75 percent of the patients were transported to a hospital.

Although the public's acceptance of the program is welcomed, the program's administrators express concern about the potential for over-utilization of the system for non-emergencies.

Gene Haufler, alarm superintendent in charge of dispatch operations, observed that too many people expect the paramedics to come out and see them like a doctor.

"We suggest they call their family physician," he said.

To better inform the public, the four hospitals and the Fire Department are embarking on a city-wide education program, although they acknowledge that such an effort represents a long-term commitment. The program not only focuses on when to call the paramedics but on what to expect when they arrive.

(Continued)

STABILIZATION—THE PARAMEDIC FUNCTION

"Many people still think the paramedics are there to transport the patient," Captain George Morgan, paramedic coordinator for the Fire Department pointed out. "But their job is to stabilize the patient's condition so he can be transported by ambulance to the hospital."

R. B. (Bob) Shue, one of 28 paramedics trained to date, concurs, recalling a patient with a congestive heart failure and pulmonary edema.

"A neighbor really gave us a bad time, insisting we take the patient directly to the hospital," he said. "Six months later when we responded to another call in her building, she couldn't say enough good things."

Neither can most other Long Beach citizens if the mail coming into the Fire Department and City Hall is an example.

Writes Mrs. James I. Eighmy after her husband's heart attack: "The doctor told me that night—if it wasn't for the immediate and excellent care he received from you he wouldn't be here now. I can't sing your praises loud enough."

Echoing her sentiments is T. C. Donovan who was back on the job as Pacific Southwest Regional Sales Manager for the Kaiser Gypsum Company the day after suffering a reaction to an allergy shot. "Little did I believe before the day ended I would be indebted to men I didn't even know for saving my life," he wrote.

Perhaps, the greatest tribute of all to the life-saving capabilities of the Long Beach system was paid by Al Caplan, Jr., a coronary victim. The first thing he did after his release from Community Hospital was to walk to his neighborhood Fire Station with a word of thanks.

Jackie K. Reinhardt

THE JIM COX'S THANK the Long Beach paramedics for the opportunity to enjoy a morning coffee break on the porch of the couple's north Long Beach home. The prompt administration of drugs after Mr. Cox suffered a heart attack is credited with saving his life.

Community Center Cuts Red Tape

Nestled between the foothills of Ventura County is a unique community—Santa Paula. It's a quiet friendly little town where sun ripened citrus orchards blanket the surrounding hillsides. People say Santa Paula hasn't changed much in the last 20 years and for the most part residents like it that way, with one notable exception—health care.

It wasn't that health services in Santa Paula and nearby Fillmore and Piru were out-of-date, but that a full spectrum of services was not available to a broad cross-section of the area's population. This was especially true of the rural dweller, the migrant, the federally subsidized patient and the private patient who had not found his own physician. Today that is no longer the case, thanks to local physicians, county health officers, residents and the California Regional Medical Program, which provided financial support.

Working together they generated an unusual solution to a common problem; tying existing resources to existing needs. This was done not only by expanding some of the county's health services in the area, but more importantly, by capitalizing on close neighborhood commitments and a spirit of community involvement. A Health Care Referral Center was created which uses neighborhood volunteers or block leaders to help people solve their own health problems.

Defining health problems broadly as "anything which impairs or impedes good health," the Center strives toward problem solving and sometimes its methods are unorthodox.

"If our block leaders find a family assigned to sub-standard housing, they go to work with the local housing authority to see that the derelict is upgraded or that more sanitary conditions are provided elsewhere," says Hazel McHenry, R.N., staffer at the Center. She notes that prevention of illness or injury costs much less than hospitalization or surgery.

"By educating the community, especially those receiving subsidies, about preventive health care, the costs to them and to the public will decline."

"CLIENTS" NOT ALWAYS PATIENTS

Sometimes the Center's "clients" aren't patients, but physicians or hospitals with a problem.

The Center works closely with the area's physicians, dentists, optometrists, pharmacists and other health providers to cut short some of the red tape often associated with subsidized patients. When a local dentist reported difficulty in meeting a billing submission deadline because his patient, who had received considerable services, had lost the eligibility sticker that must accompany all billing to Medi-Cal, the Center took immediate action. Proof-of-eligibility was established and the proper documents hand carried from patient to doctor, who then submitted the forms to the appropriate agency before the deadline expired. With this assistance the dentist collected his $700 fee.

"Very often Medi-Cal patients who are only allotted two medi-labels and four proof-of-eligibility stickers a month, don't understand they must bring these stickers in when they come for treatment," said the office manager for Santa Paula's only orthopedic surgeon.

"We've had instances where the Center has saved us considerable time by contacting patients who don't have telephones or who don't speak English. Block leaders remind them of their appointments, see that they bring their stickers and sometimes even provide transportation. For us, that's a real time saver."

The Center helps in other ways too. Recently the business office of a local hospital called the Center for help. One of the Center's clients, who received nearly $300 worth of medical services and had not paid anything to the hospital, was about to move. The Center ironed out the difficulty by contacting the patient and arranging for installment payments to be forwarded from Los Angeles.

BLOCK LEADERS GAIN ACCESS TO SYSTEM

"Our goal is to bring good health services to everyone in the community," says Nurse McHenry. "That means teaching them how to gain access to the system."

Volunteer block leader Gloria Rico, a bus driver for a local education program, tells how she first gained access to the system.

"At one of our training sessions we were given Referral Center identification pins to wear when doing block leader work. Naturally, the first time I took a bus load of clients to the General Hospital in Ventura, I forgot to wear my pin.

"Even though the Center reached an agreement with the hospital staff to treat my people first so we could get them back to Santa Paula, Fillmore and Piru, the nurses didn't know who I was and couldn't take time to listen to what I was telling them.

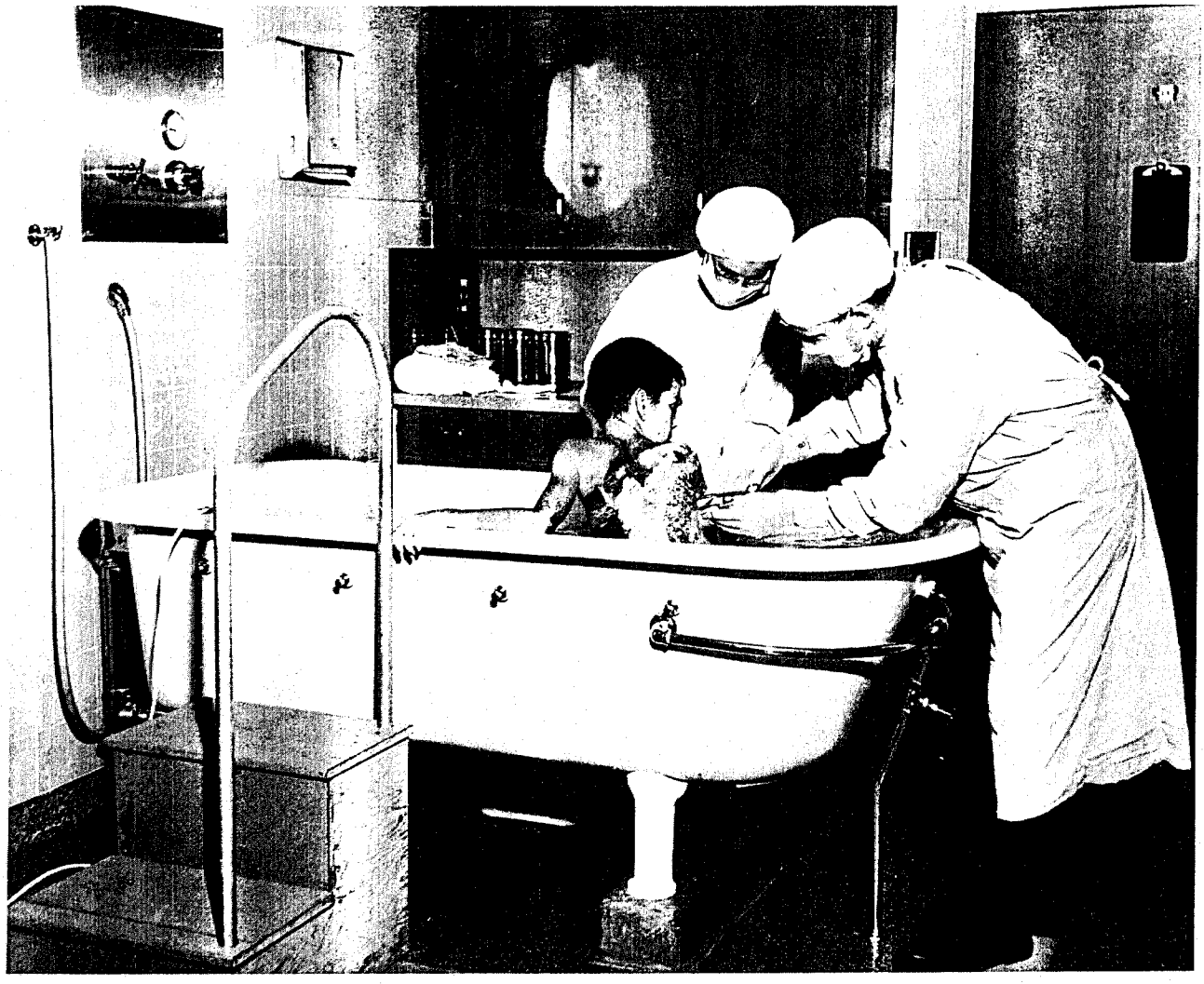
"It took me all day to get my clients through there. The next time I wore my pin, we zipped in and out of that hospital in no time at all. I've learned my lesson, you can believe, I never forget my pin now!" laughs Gloria.

Gloria Rico is one of forty-three women from neighborhoods in Santa Paula, Fillmore and Piru who were trained with California Regional Medical Program help in special sessions to spot and solve potential health problems or problems which eventually may affect good health. For the most part their work includes helping to solve client's health problems by providing elementary health education, transportation and translation by using the Center's resources to plug into existing community or county services.

Although Santa Paula and its neighboring communities may not have changed much in the past decade or two, the Health Care Referral Staff and its contingency of voluntary block leaders insures that a full spectrum of up-to-date health services is widely available to their friends and neighbors.

Karen Johnston

Good Care For Patients



Doctors in California are beginning to develop a contagious enthusiasm for patient care appraisal procedures once regarded in some quarters of the medical profession as just this side of heresy.

The reasons for their enthusiasm are solidly grounded: the system is voluntary, fits in with health care providers' needs to continually improve their skills and, best of all, gives patients better care.

Is Dr. Smith confident enough to sit down with Nurse Jones and other allied health professionals on a hospital medical audit team to see how well they work together? Well, it turns out that yes, Dr. Smith *is*, more and more, likely to accept such a review.

Medical audit teams are developing rapidly in California, spurred by early and exciting results in projects supported by the California Regional Medical Program.

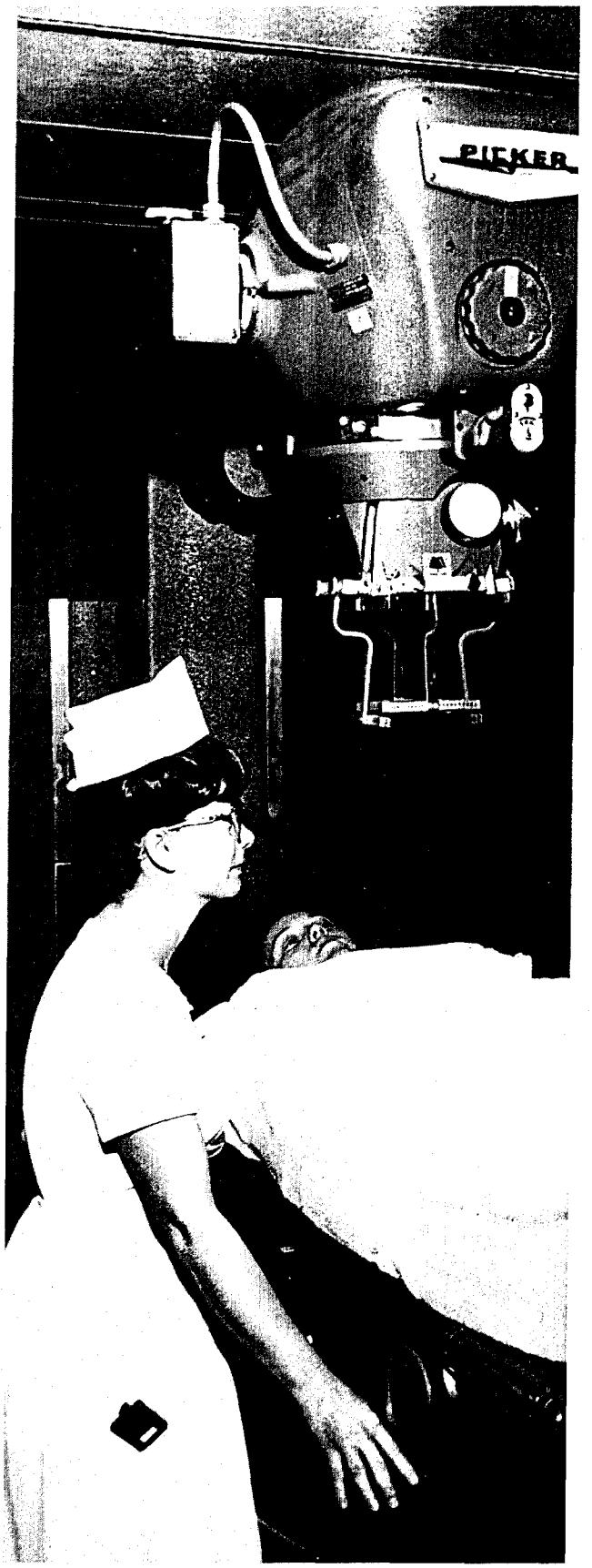
At Pacific Medical Center in San Francisco, for example, the impact on patient care has been dramatic.

"We did an audit on hospitalized patients with adult-onset diabetes," a spokesman explained, "and we found that although our controls were okay a substantial number of patients each month were trapped in a revolving door syndrome. They were in and out of the hospital fairly regularly."

The PMC staff very carefully examined its criteria for acceptable management of diabetes "and we found that although there was a systematic discharge and home treatment program no one was following up on it. As a result we devised a new patient care education program and the revolving door syndrome stopped abruptly."

PATIENT CARE EVALUATION

Pacific Medical Center—PMC—was one of the first institutions in California to adopt new patient care appraisal techniques. The system has several terms —medical audit, quality care evaluation, patient care



appraisal—each with its subtly different shade of meaning.

Although related to peer review medical audit is not the same. Peer review has traditionally involved the review of one individual physician's credentials, ethics, training and experience by another individual of similar training and experience. Medical audit involves interdisciplinary deliberations, interdisciplinary setting of appropriate patient-care standards, interdisciplinary review of the health care given the patient and interdisciplinary action to search for and remove deficiencies. Once established as a regular procedure in the hospital medical audit also permits documentation of trends or cycles in patient care.

A medical audit workshop was co-sponsored in the Fall of 1971 by the California Medical Association, and the California Regional Medical Program.

This workshop, perhaps a watershed for improved continuing medical education and patient care evaluation, was conducted by Dr. Clement Brown, Jr., of Philadelphia. His medical audit procedures were impressive. They offered a way to learn more accurately what a patient may need to recover from illness, and they place the center for that learning in the local community hospital.

SEMINARS AND WORKSHOPS

Several other California seminars were conducted following the highly successful joint CMA-RMP effort in San Francisco. Meanwhile the CMA committee on accreditation formally adopted medical audit as the basis for accrediting hospital continuing education programs.

More workshops were needed than Dr. Brown and his colleagues from Philadelphia's Chestnut Hill Hospital could conduct. Plans were made to develop skilled California-based faculty leaders and consultants to help make medical audit a widely used process in California's community hospitals.

The CMA planned and conducted more workshops, and with RMP co-sponsorship, carried out a one-year project that involved 24 hospitals in Northern California in the workshop experience, under the direction of Drs. Rodger M. Shepherd and Samuel R. Sherman.

Meanwhile Dr. Richard Opfell and Dr. Martin D. Shickman were reaching several hospitals in Southern California.

The medical audit workshops are essentially an intensive training session with hospital teams (ideally consisting of at least three physicians, one nurse, one administrator, one board member and the medical records administrator) going through all the steps involved in the medical audit of two diseases. This process, taking three days in the workshop, might normally take months in a hospital.

The learning process can't stop with the workshop, but continues with a follow-up in each hospital—

and the realities of medical audit begin to be appreciated, or resisted, by staff members—followed, still later, by evaluation of what has been accomplished.


Arthur Jost

Medical audit teams are taught to pick diagnostic categories and to develop criteria showing what services, procedures or outcomes of care should be entered in patient charts to document whether acceptable care was administered in the hospital. Persuading some members of the audit team to agree on the criteria often takes a lot of energy. As one physician put it: "Getting it together back home is really something else."

TAILORED REMEDIES

If deficiencies in care appear—and they do, as in the PMC case of adult-onset diabetes—then remedies are proposed. A medical education program is frequently called for, with the results evaluated, critically, months later.

There are legal and developing professional standards calling for medical care appraisal. Such programs, according to Attorney Ross E. Stromberg, of Hanson, Bridgett, Marcus & Jenkins, "are here to stay and must be carried out effectively." While some physicians may express fear over possible adverse legal consequences for taking part in medical audit programs "the law has recognized these fears and has provided adequate protection for members of the hospital's medical staff, administration and governing body," he says.

But medical audit is becoming more and more attractive to both doctors and hospitals as a means of helping to assure that quality care has been given the patient and as a particularly excellent means of improving health care skills and institutional procedures, all tied intimately to the real needs of the patient.

"BEST FOR PATIENTS"

Says Dr. Thomas Elmendorf, Willows general practitioner and president of the California Medical Association: "I really think patient care appraisal is probably the most important thing we can do for the patients we serve. It will give us a more objective way of self-determination as to quality of care. It will identify problems not only in perfecting medical practice but the educational needs in the whole sphere of interrelationships between patient and physician. It is a truly helpful way for physicians to determine the milieu of the medium in which they practice. We're never going to be perfect but this gives us a method of improving; it will give us a handle to demonstrate that we are competent, continuing our competency and acting in the best interests of people."

Dr. Elmendorf places the practice of medicine among the societal changes that lead to increasing requirements for public accountability, and he thinks medical audit programs will help.

Arthur Jost, executive director of the Kings View corporation in Reedley and president of the California Hospital Association, agrees.

"Medical audit is terribly important," he says. "It's going to take a long long time to educate the public, to help them to feel confident, as we would wish them to feel, that they're getting their money's worth."

Adds Gordon Cumming, director of research for the CHA: "Government and the consuming public are interested in good quality and good values in health services. Doctors and hospitals have a community of interests in encouraging the development of solid factual information on hospital services and their costs, to satisfy this demand."

MEDICAL SCHOOL RELEVANCE

Dr. Opfell, a Tustin internist/hematologist, associate clinical professor of medicine at the University of California at Irvine, and chairman of the California Medical Association's committee on accreditation of continuing medical education, was one of the first of the CMA leaders to delve into medical audit.

Traditional continuing medical education programs, he felt, were often laced with a feeling on the part of the medical schools "that they were adversaries to the practitioners in the medical profession, and that 'only 10 percent of practicing physicians really participate in continuing medical education.'


Thomas Elmendorf, M.D.

"It became apparent to me that something ought to be done to bring the two together. My own impression was that MDs were doing a hell of a lot more, but that they were disappointed in the medical schools' offerings and relevance and found it difficult to weave what they were being taught into their everyday practice."

As a practitioner who teaches, Dr. Opfell often asks himself what a physician needs, and the answer "soon comes down to patient-care needs. That was how I learned and the information I gathered stuck. I can remember Mrs. W. who had a pheochro-

mocytoma, for example. So it became my policy as a way to make medical education programs more meaningful to relate them to patient care needs."

Too often medical schools, he feels, do "a lousy job of evaluating whether what they are offering is useful, and they have had no evaluation in terms of patient care. The whole concept of how new knowledge fits in to the practice of medicine is often out of context with real needs of patient care. The usual course lecture is probably the least effective but probably the most utilized. But physicians learn by doing and by problem-solving."

COMMUNITY HOSPITAL TEACHING SITES

In 1967 the California Medical Association and the California Regional Medical Program co-sponsored a planning and goals conference at which it was recommended that the primary teaching site for continuing medical education be in community hospitals. There were several reasons, Dr. Opfell said. "We could determine what the educational needs are, we could evaluate what we were doing, and we could more closely weave continuing medical education into the day-to-day practice of medicine. With community hospitals we could use modern teaching in small groups and we could have more participation of practitioners."

As this concept matured the CMA recommended that a continuing medical education accreditation program be established, and the CMA and the American Medical Association established reciprocity for accreditation principles. Dr. Brown's medical evaluation techniques, modified for local needs, followed.

Dr. Opfell directed a small project to introduce the medical audit process in four Orange County Hospitals—they are now evaluating their work—and has undertaken an experimental medical audit of office practice of family practitioners. There are about a dozen local practitioners actively involved, some are quite enthusiastic and they all feel it is "worthy of further exploration."

ENTHUSIASTIC RESPONSE

Dr. Shickman, a cardiologist and associate director for continuing education in health sciences at UCLA, also had a small grant from the California RMP, to introduce medical audit to a local community hospital and to a large medical center.

The process has been started at the community hospital, and really caught on—to a "total hospital level"—at the medical center. "What was meant to be a little pilot," he said, "has become a massive highly enthusiastic program. The continuing education authorities have taken the position that medical conferences, staff conferences and grand rounds, rather than being some exotic case of pathology brought in by the resident, will now relate themselves to patient care needs in the hospital. Conceptually I think they've got all the nails hit on the head."

Dr. Shepherd, a pediatric cardiologist who is now associate director of continuing education at Pacific Medical Center, was the director for an RMP-funded project that exceeded most of its objectives.

At the end of a year 5 medical audit workshops had been conducted, involving 24 hospitals, 14 audit teams were active (meeting at least each month and working on a problem), 11 hospitals had completed one audit cycle, 20 health professionals had been trained to be consultants to new audit teams. Several hospitals intend to expand their medical audit procedures.

CALIFORNIA REGIONAL PROGRAM

By early January, with the CMA's pioneering efforts and the success of the RMP-funded projects as inspiration, a regional quality of care program, funded by the California RMP, was under way, involving CMA, Pacific Medical Center, the California Hospital Association, the California Nurses' Association, the California Medical Records Administrators, and the State's medical schools and schools of public health. This massive effort will be directed by Dr. Samuel R. Sherman, retired surgeon and former president of the California Medical Association, with the medical and public health school component coordinated by Dr. Donald W. Petit, director of on-campus programs in the department of postgraduate medicine at the USC School of Medicine. Both are among the State's most highly respected physicians. The program is expected to introduce medical audit to all of California's 580 acute general hospitals in five years. One hundred have, thus far, been exposed to the process.

To Dr. Opfell "this is beautiful. The RMP proposal has 10 percent in it for evaluation. This whole concept has caught on in the United States," he said, pointing to a recent AMA statement that the California formula of accreditation and medical audit workshops is, with some modification being adopted in 38 states, the District of Columbia and Puerto Rico.

"What's turning doctors on in California," says the CMA's Dr. Elmendorf, "is that you can't overemphasize the educational aspects of patient care appraisal. Nobody is forcing anybody. Doctors act like it was their idea to begin with. They really like it. The principle of self-determination in education applies here, too. They don't have to have anybody dictating to them. With this technique they can carve their own niche; they can do their own thing."

William Boquist

The Health Manpower Network

Dale Spencer is 52, has always been in good health, and like most people, only visited the doctor when there was something specifically wrong with him. Last year, although he felt fine except for some sluggishness, he joined the CommonHealth Club. He learned that he had high blood sugar and was a borderline diabetic. He was overweight and had high blood pressure. Spencer is now something of a health fanatic: he's lost weight, his blood pressure is down, and his blood sugar level has dropped. He talks to friends about "preventive" health care. What brought about this radical change? The CommonHealth Club in Santa Rosa, a part of the Sonoma Health Services/Education Activities (HS/EA) funded by a grant from the California Regional Medical Program (CRMP).

CommonHealth Club originated last year in Santa Rosa under the aegis of its present coordinator Kenneth Bubb with the guidance of local health professionals and the enthusiastic support of the Sonoma HS/EA's director John C. Wong. Bubb's task was to get the people of Sonoma County interested in learning more about their health, something that too few people care about before a crisis situation arises. He soon realized that traditional health lectures did not interest many people and started toying with the time-tested educational formula of "learning by doing."

The CommonHealth Club involves people personally in health education through a medical testing program. Each member goes through a battery of tests administered by volunteer local health professionals. Medical personnel later explain the purpose and results of each test and give short talks on health problems. No diagnosis is made—if a test indicates some abnormality, the member is urged to see a physician for treatment. The members are given guidance in how to control certain health problems and what they mean to the individual's total health picture. For example, if someone has a high cholesterol level, he or she is taught just what this means and ways it can be corrected. If enough members indicate an interest in say, back problems, a class with an expert lecturer is arranged. Thus consumers, by knowing more about their own personal state of health, are motivated to learn more about various problems. It is this personal involvement that keeps them coming back and 90% of the club's 1150 members (age range 18-94) indicate that they will return for a second screening in a year to see whether their health has improved. Well over 50% show a definite health behavorial change—stopped smoking, lost weight, sought medical attention—due to their participation in the CommonHealth Club.

Coordinator Bubb readily admits that the Club's testing procedure is not the ideal complete annual

check-up, but realistically it serves the purpose of making people aware of potential health difficulties and causes more consumers to seek medical attention. Dale Spencer, thinner and with less chance of becoming diabetic, would concur.

FAMILY HEALTH WORKERS

Language and ethnic barriers, rather than a lack of motivation, can also prevent people from taking advantage of the health care available to them. You are Spanish and don't speak or read English. You've just given birth, and the hospital has instructed you to continue feeding your baby the same pre-mixed formula that they've been using. You go home from the hospital, buy the same formula, pour it into a bottle and try to feed your child. He won't accept it. You contact a Spanish-speaking family health worker in your community and learn that because you couldn't read the English directions on the formula that say "dilute with water" you were feeding your baby a concentrate.

Your doctor, who doesn't speak Spanish, decides you need surgery. He can't explain exactly what the procedure will be, or more important why it's necessary. A family health worker talks with you, answers any questions you may have and serves as an interpretor between the doctor and yourself. Your suspicions and hostility are mollified and you agree to go through with the needed surgical procedure.

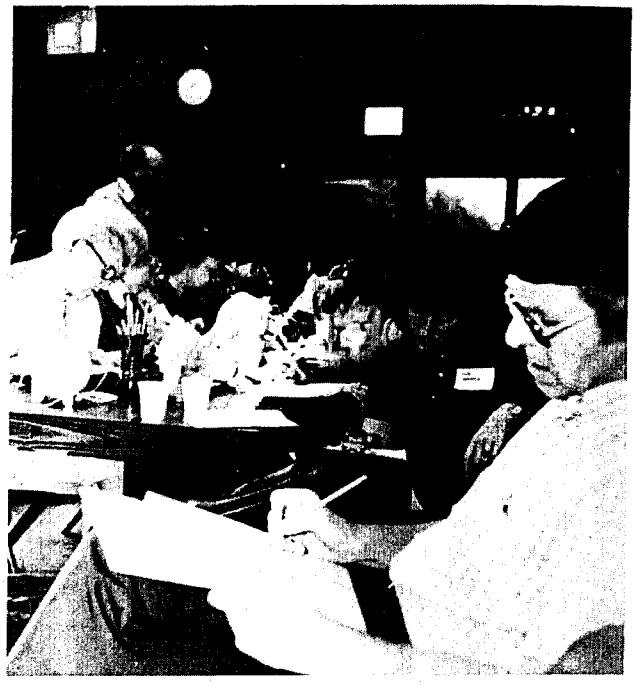
These are just some of the vital services performed by the family health workers of the Northeast Valley Health Corporation, whose training was coordinated by the San Fernando Valley Health Consortium, under a grant from the CRMP. Twenty-six people who had no previous experience in the health field were recruited from the communities to be served. They underwent a six-month training period consisting of a twelve-week nursing assistant course that can be credited toward a twelve-month licensed vocational nursing program, and took fifteen college credits in speech, health science, psychology, sociology and emergency medical procedure.

Because they are already members of the predominately Spanish and Black community, the family health workers help overcome much of the suspicion and hostility that exists toward the bulk of local white health professionals. They serve as one-to-one health educators and have helped to concern the local populace with preventive medicine. They interpret feelings as well as language for the patient, and help the doctor explain medical treatment ranging from diet to how to take prescribed medication to surgery. Thus, a group of people who frequently did not seek medical care, and didn't understand it once they found it, are now better able to take care of themselves.

VARIED PROGRAMS

Both the CommonHealth Club and the family health workers training program are part of a statewide network of eleven consortia engaged in health services and educational activities, with coordination coming from the CRMP Oakland office of Charles White, Ph.D. Each of the eleven HS/EA's is involved in a variety of programs funded by grants from CRMP —the following are some highlights.

In San Diego County there is an ongoing health career education and recruitment program in which minority students are paired with black physicians in a "big brother" program to create an awareness of various health careers. Also in San Diego, health educator Marcia Kerwit has assisted in the establishment of a well-women's clinic. The Santa Clara County consortium, in conjunction with other groups, is helping to educate diabetics to be more responsible for managing their own illness and is supporting a rural health manpower development project. The Los Angeles East Health Manpower Consortium is seeking a strong alliance between providers and consumers to recognize and meet the needs of the largely Chicano community, and has conducted a successful Health Awareness Program to orient Indian and Chicano students about health careers. The San Joaquin Valley HS/EA is assembling a health education directory to assist high school guidance personnel in counseling students about health-related fields. Superior California (the twelve northeastern counties) is working on in-service training coordination for nurses with local hospitals. The new South Central Health Manpower consortium of Los Angeles will rely heavily on a community ombudsman whose expertise in the area will create an effective liaison between the community's needs and the consortium's activities. In Kern County they are in the process of meeting consumer needs in largely rural and isolated areas through education and more effective manpower distribution. The Pomona East San Gabriel HS/EA has conducted a survey of community health beliefs and attitudes and



will be working for more effective interaction between health providers and educators in the establishment of initial and continuing education programs to meet the area's manpower needs. The San Bernardino consortium is at work devising an informational system to promote consumer awareness of existing health resources.

By attracting much-needed manpower into health careers, coordinating continuing education curricula for those already in the health field, and conducting various consumer education activities, the HS/EA network has become an integral part of the health spectrum. For without the trained manpower to implement medical care and without consumer awareness, the greatest advances in medicine, as well as everyday medical care, will be provided for a minority rather than a majority of this country's citizens.

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