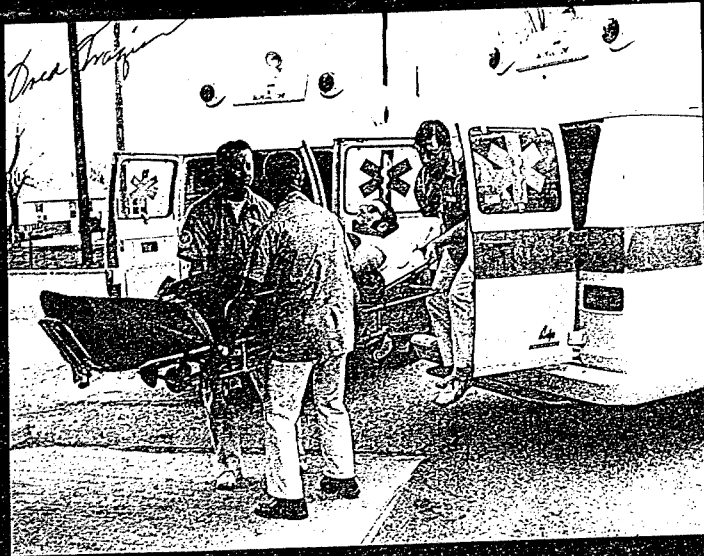




Missouri Regional Medical Program



Health Plans in Action

A report to Missouri's



4,676,501	Consumers
7,099	Physicians
2,239	Dentists
23,307	Registered Nurses
15,000	Licensed Practical Nurses
10,000	Other Health Professionals
183	Hospitals
5	Medical Schools
1	State Division of Health
95	County Health Departments and Nursing Services
2	U. S. Senators
10	U. S. Representatives
34	State Senators
163	State Representatives
180	HSA Governing Body Members

from the Missouri Regional Medical Program



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Our mission

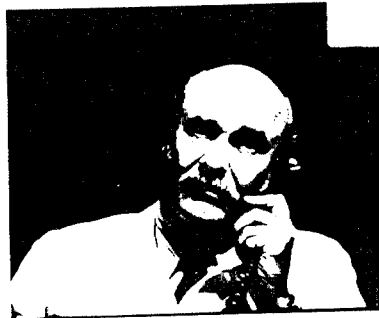
On one end of the scale are doctors, nurses, technicians, health institutions and agencies who have the talents and resources for providing health care. On the other end of the scale are the people of Missouri who need this care. At the scale's fulcrum for the past ten years has been MoRMP, encouraging formation of cooperative arrangements in the health field to bring the best possible health care to Missourians at the lowest cost.

When P.L. 89-239 was signed into law in 1965, regional medical programs were dedicated to education, research, training and demonstration in heart disease, cancer, stroke and related diseases. Over the last 10 years, the federal government has altered RMP orientation, directing the programs to approach health problems common to the treatment of all these diseases.

Through grants and contracts, MoRMP has supported demonstration models and innovative projects designed to improve the organization and delivery of patient services and the productivity and distribution of health manpower. Along the way, MoRMP has had many successes and a few failures. But a great deal about implementing health care plans has been learned.

In this brief brochure, MoRMP hopes to share some of this hard-earned knowledge.





Our process

Bringing consumers and providers together to translate health care plans into action is the rationale behind the MoRMP process.

At the heart of this process is our Regional Advisory Group. Composed of up to 60 representatives of both consumer and provider interests, this volunteer group annually consults state health planners, volunteer health agencies and interested consumers to assess Missouri's health needs. This democratic process produces a set of priorities which forms the framework for MoRMP activities.

The MoRMP process is not a "one-way street." Adhering to Regional Advisory Group priorities, we may solicit program proposals from health professionals designed to improve local health services. For example, if it has been determined that some of Missouri's rural health facilities are unevenly distributed, we may contact and work with local hospitals to help them share resources. Or health providers may approach us with program ideas. Because Regional Advisory Group members and consultants live in all areas of the state, there is ample opportunity for communication between MoRMP and health personnel and consumers.

No matter who approaches whom, MoRMP works closely with health providers to create and implement effective local health programs.

To date, we have been involved with 167 such programs. Each of these has been carefully monitored by our staff and technical advisers to make sure original goals are being met and that Missouri's health needs are being satisfied.

The MoRMP process of review, selection, implementation and evaluation unites providers, consumers and administrators to make health programs responsive to the people of Missouri. Behind the scenes of each of our cooperative health programs described on the following pages lies this time-tested process.





Access: Where to go for help

The three-room apartment in metropolitan Kansas City is small and dark. On the TV set in the crowded living room stand photos of grandchildren, some religious pictures and a collection of knickknacks. This is the home of Flossye Carter, 54, and her beloved cat, Tom Dooley.

"I talk to Tom Dooley. That's why he's as smart as he is. It's just me and Tom Dooley."

Seven years ago, Ms. Carter visited the federally-subsidized Wayne Miner Neighborhood Health Center. A staff doctor discovered that Ms. Carter had hypertension, a condition in which higher than normal pressure is exerted against the blood vessel's inner walls. Medication now stabilizes her blood pressure.

"I don't think I would be here if it weren't for the Wayne Miner people and Project Hi-Blood," Ms. Carter says. Undetected hypertension can lead to heart attack, stroke and related diseases.

In the late 1960's, medical researchers were expressing concern over the high incidence of hypertension in the black population. In 1968, Wayne Miner staff members, who serve a predominantly black neighborhood, worked with MoRMP to develop a blood pressure screening and treatment program for area residents. The project began in 1969.

Since most blacks were unaware of the potential problems of high blood pressure, the project staff's problem was one of communication. Their solution - personalized home visits by trained neighborhood personnel.

Since 1969, Project Hi-Blood has screened over 40,000 persons for high blood pressure through home, church and school visits, neighborhood mobile units or the Wayne Miner clinic itself. Of those screened to date, approximately 25 per cent were found to be hypertensive. Follow-up screenings and home visits by staff members make certain these patients consult their physicians regularly and follow prescribed treatment.



Project Hi-Blood provides hypertensive patients access to preventive medical care. Making health care accessible, responsive and affordable to people in Kansas City and to all Missourians has been a major MoRMP concern. Because the medical field is highly technological and its services expensive, health resources are necessarily limited and unevenly distributed. Communities, especially those in rural areas, can attract and support only so many health professionals, clinics and hospitals. But local residents may not know what services are available and how to use them. Here are four MoRMP-supported programs that have brought health services and patients together.

• **In Sedalia**, the Missouri Chapter of the American Academy of Pediatrics supports a traveling clinic for children. Some rural Missouri patients, who find medical expenses steep and health care facilities inaccessible, fail to seek preventive medical help for their children. Some of these children reach school age without being properly immunized or receiving periodic medical examinations. To overcome this problem, a medical staff visits churches, town halls, schools, or other public buildings in a 13-county area and offers its services for a minimal fee, based on the family's ability to pay. For two years, MoRMP worked with the clinic to provide "out-reach" workers who maintain follow-up communication with the families to make sure children continue visits and receive prescribed treatment.



• The Sedalia-centered program brings preventive health care to rural families. Another program in **Boone County**, sponsored by Older Americans Transportation Service (OATS) provides transportation for the elderly to medical facilities. Cooperation between OATS and MoRMP extended the service to the handicapped. A small fleet of vans now provides a transportation service for nearly 5,000 handicapped and elderly area residents. For a small fee, passengers can ride to and from doctor's offices, hospitals and clinics.

• **In Dunklin County**, strong community support and assistance from MoRMP led to the establishment of a volunteer blood bank. Thirteen hundred and twenty-five residents' blood types are recorded, and donors are called when the need arises. Before



the bank was organized, Dunklin County Memorial Hospital had to purchase expensive blood from commercial agencies. Hospital statistics showed that blood from volunteer donors is less apt to cause hepatitis than blood purchased from commercial agencies.

• **Problems of accessing health care** are not always physical in nature. They can be problems of communication. Two MoRMP-supported programs at Kansas City General Hospital led to a highly successful consumer advocacy service. Many patients were bewildered by medical terminology, dissatisfied with services and confused about prescribed treatment. Busy hospital staff members were unable to devote enough time to patient communication.

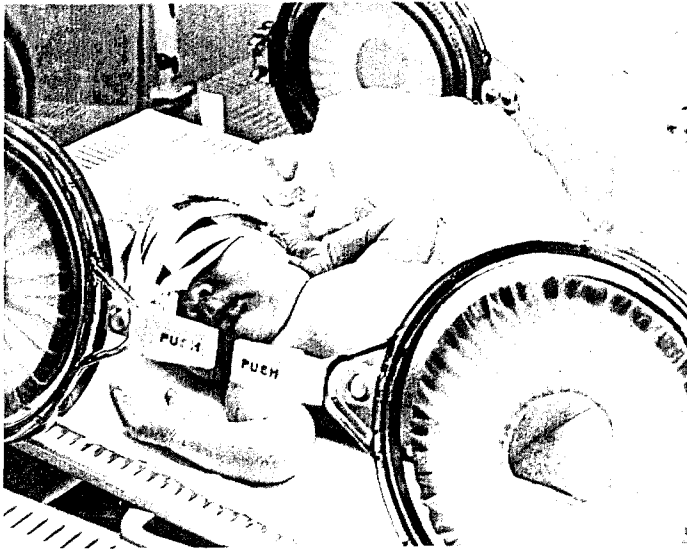
Several nonprofessional community residents, with whom patients could easily identify, were trained to interview patients and provide liaison between them and hospital staff. The program has helped patients understand what services are available to them and how best to use these services. The hospital has benefited by smoother relations between staff and patients.

The problems of accessing health care are two-fold. Missouri's health resources are concentrated in larger population centers. People who live in smaller communities or those who have economic or physical limitations may find it difficult to reach health facilities that can give them the best care. Even if health resources are within reach, people may not know how to access them.

Neighborhood hypertension screenings, traveling child health clinics, community blood banks, transportation services for the elderly and handicapped and consumer advocacy programs are only a few of the ways in which MoRMP has cooperated with local agencies to bring health resources and people together. MoRMP believes that using health resources to their full advantage prevents waste in manpower and facilities, lowers medical costs and brings better health care to more people.



Education: Beyond the classroom



Julia Smith bends over baby Joshua's crib to stroke his tiny back. As he sleeps peacefully, Mrs. Smith reflects on the struggle, only a month earlier, to save his life.

Joshua was born prematurely in January 1976 at St. Elizabeth's Hospital in Hannibal. Only hours after his birth, doctors diagnosed hyaline membrane disease, a frequent lung malfunction in premature babies. When Joshua experienced total respiratory failure, he was immediately placed on a respirator and administered life-support treatment. In 12 hours, Joshua was pronounced stable. In 16 days, he was sleeping in his own crib at home.

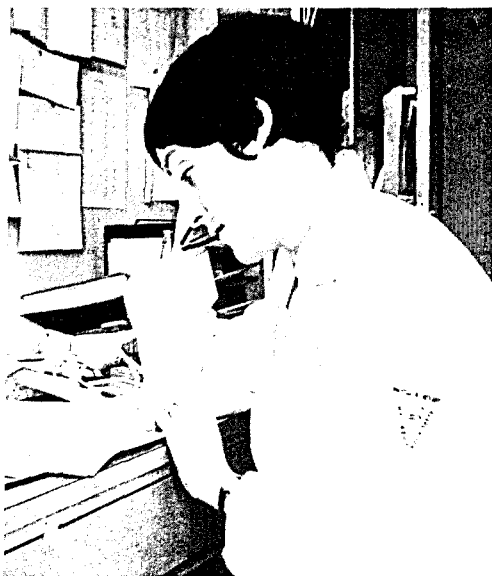
"We were so helpless. If it hadn't been for the marvelous staff at the hospital and the Lord's guidance, we wouldn't have our priceless babies," Mrs. Smith says. The Smith's daughter, Joy, was born prematurely with hyaline membrane disease at St. Elizabeth's only 14 months earlier. Both Smith babies owe their lives to the development of a middle risk infant nursery at the Hannibal Hospital.



Many premature babies born in Missouri's smaller rural hospitals cannot get the specialized care they need unless transported to a medical center, a risky process. It was the dream of the obstetrics and pediatrics staff at St. Elizabeth's to improve their capacity to care locally for problem newborns.

The hospital purchased expensive life-saving equipment and altered their facilities for an intensive care nursery. MoRMP worked with the staff to develop a middle risk education program for St. Elizabeth's staff and interested regional health care personnel.

Since 1974, a contagious dedication to education has spread through the entire hospital, and the im-



proved staff skills has significantly reduced St. Elizabeth's infant morbidity rate. But the hospital's success story reaches beyond its own walls. Health care professionals travel as far as 90 miles to visit the model nursery, attend classes and share new information.

With the mass of medical knowledge doubling every ten years, health professionals are faced with the challenge of keeping abreast of new technology. This is a particular problem for health professionals practicing in isolated rural areas.

Helping to bridge this information gap and bring the benefits of new medical knowledge to all Missourians is one of MoRMP's primary functions. Over the past five years, MoRMP has served as a catalyst for more than a hundred health manpower education programs, like the one in Hannibal, which have improved services in Missouri's hospitals, nursing homes, pharmacies and laboratories.

Bringing the classroom to the student is the concept behind hospital education programs. More than a thousand health care professionals have completed training sessions in intensive care, emergency services, hospital administration and other skills in MoRMP-coordinated programs in local hospitals



or nearby colleges. Without these programs, many professionals would have had to leave their jobs and patients to receive training at distant educational institutions.

MoRMP efforts to improve professional skills extend beyond individual classrooms. Fulfilling its role as an implementer of health plans, MoRMP recognized the value of state-wide efforts to equalize and standardize health education opportunities.

- **To help all Missouri nurses** maintain and update their skills, MoRMP worked with the Missouri Nurses Association to develop a state-wide continuing education program.

- **In conjunction with the Missouri Nursing Home Association**, the Missouri Department of Education and six state universities, MoRMP tackled the problem of improving the quality of nursing home care. Through this program, over 100 persons have been trained as food handling supervisors. And administration has been made easier by state-wide instruction for medical records personnel.

- **To relieve manpower shortage** in rural Missouri, MoRMP, in conjunction with the Missouri Hospital Association, supported a high school health career recruitment program designed to locally train and employ health care professionals. A direct "hot line" to over 3,000 high school counselors brings health career information to thousands of potential doctors, nurses and technicians.

- **To update and standardize services** in rural pharmacies, MoRMP worked with the School of Pharmacy at the University of Missouri-Kansas City to develop an operating manual. The manual is now being tested in several rural hospital pharmacies and will soon be distributed throughout the state.

- **To overcome the lack of formal training** of many laboratory technicians, MoRMP sponsored a primary education program in urban and rural areas. To date, over 59 technicians have received training.

These are just a few examples of MoRMP's many efforts to increase the number and effectiveness of health manpower in Missouri. Only through continued education, can doctors, nurses and technicians give patients like Joshua and Joy Smith the immediate, specialized care they deserve. Knowledge means progress and progress means life.

Mrs. Smith says it best. "In the 14 months between the time Joy and Joshua were born, I could tell that the nursery staff was even better prepared. They knew more. Why, Joshua was more ill than Joy, but his recovery was speedier. There isn't enough I can say about the doctors and nurses at St. Elizabeth's."



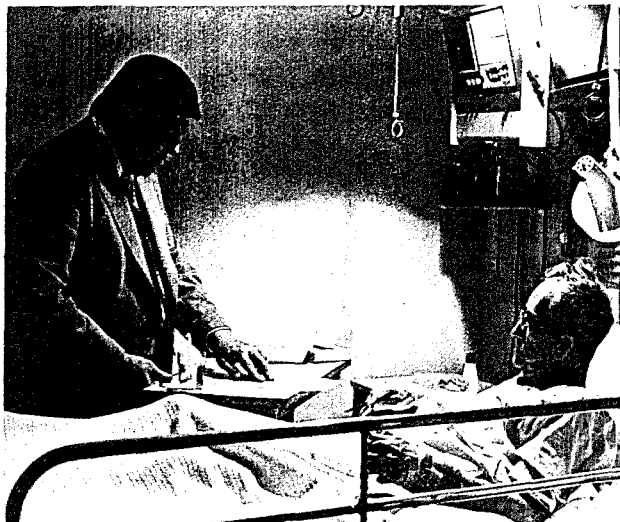
Resources: *The spirit of cooperation*

"There's that Dr. Cofer!" beams the nurse. Dr. Cofer smiles and waves acknowledgement as he breezes from the corridor into his Chillicothe office.

"What have we got here?" Appointment book in hand, the receptionist explains that he is scheduled to perform an electrocardiogram. Dr. Cofer recognizes his patient and calls him by name into the examining room. The door closes. A co-worker pokes her head into the office to confirm a speaking engagement. Yes, Dr. Cofer will speak on drug abuse to a sixth grade class next week.

The examination is over. Dr. Cofer explains he must be at Hedrick Medical Center ("Gotta blast!") and hops into the family car. His large frame and good natured disposition fit comfortably into the station wagon littered with children's school drawings.

Dr. Cofer is a busy man. But he likes his work, the town of Chillicothe and its people. His exuberance is infectious.



At Hedrick Medical Center, Dr. Cofer parks the car and winds his way through hospital corridors to the coronary unit. He is here to visit 71-year-old Delbert Stephenson, a Waverly farmer, for whom he installed a pacemaker the week before.

Dr. Cofer is an internist and cardiologist. In addition to his private practice, he serves five of the 12 member hospitals of the Green Hills Cooperative, a non-profit corporation formed in 1972 to share health services, education and personnel.

Before Dr. Cofer came to the cooperative, most area heart patients who needed pacemakers had to travel to Kansas City for the operation, a hardship for a patient like Delbert Stephenson.

Dr. Cofer says he thinks the Green Hills Cooperative is a good concept. It attracts specialty services, like the one he provides, lowers medical costs to patients and facilitates hospital administration.

MoRMP was instrumental in initiating the Green Hills Cooperative and has given it support over the last four years. The member hospitals have pooled resources to sponsor in-service training and continuing health education programs, to cut supply costs through a group purchasing plan, to alleviate nurse recruitment problems by establishing a school of nursing at Trenton Junior College, to form an inter-hospital communications system and to share personnel.

Sharing health resources has brought better health care to the people of the rural Green Hills area whose hospitals were plagued by rising costs and health manpower shortages. MoRMP has worked with many health agencies to build similar cooperative efforts in other areas of the state. The following three programs are good examples.

- **More than 10 small rural hospitals** in the state's southwest region are sharing the services of two physical therapists. Visiting hospitals, nursing homes and patients' homes, the therapists administer direct patient care and conduct training sessions



for nursing staffs. MoRMP served as the catalyst for this cooperative effort.

- **At the Kirksville College of Osteopathic Medicine** a cooperative regional pathology laboratory was established among five area hospitals. None of these rural hospitals could have borne alone the burden of supporting a well-equipped laboratory and trained pathologists. In about one and a half years, this regional laboratory performed over 64,000 valuable tests. MoRMP paid a portion of the laboratory's personnel and travel costs for over a year. With MoRMP funding ended, the laboratory continues to serve the area, its costs shared by member hospitals.

- **For the past two years**, MoRMP has helped the city of Independence conduct a health survey. House-to-house volunteers are making local citizens aware of available health care resources and are collecting information needed to plan future area health services. Preliminary results of the survey are being submitted to the city of Independence for review and action. The local health department was so impressed with the survey that they decided to contribute support to its completion. Two-thirds of the city had been canvassed by December 1975.

Cooperation is the key to sharing health resources. It was only through the cooperation of health institutions and professionals that these valuable services, at reduced costs, were made available in these Missouri regions. But many Missourians, especially those living in rural areas, still lack the services of a cardiologist like Dr. Cofer, the skills of a physical therapist or the advantages of having a sophisticated laboratory close at hand.

Health resources are not evenly distributed over Missouri's cities and countryside. Through regional health surveys, like the one in Independence, Missourians can find out just what health services are and are not locally available. And through the MoRMP-tested concept of regional health resource sharing, they can overcome service shortages by sharing health personnel, facilities and equipment. MoRMP demonstration models prove that cooperation in health care works.

Services: Emergency!



Shortly before 9 a.m. on a Saturday in early January, James Crossgrove, 19, left his home near Kirksville to return to college in Oklahoma. Minutes later, he lost control of his car and drove into a bridge abutment. The car left the road, crashed into a ravine, and James was pinned inside, the motor pressed against his legs.

In exactly six minutes after the Kirksville Hospital of Osteopathic Medicine was notified of the accident, two Emergency Medical Technicians (EMTs) were on the scene. Charles Gulley climbed into the back seat of the Crossgrove car and put traction on James' neck. He kept the air passage clear while encouraging his patient to talk to prevent blood from getting into the lungs. James' palette was split, and he had a fractured jaw and multiple facial injuries. One lung had collapsed, and his spleen was lacerated.

While Gulley tended his patient, Mike McKim began to pry the motor loose from James' legs. A wrecker could not make it down into the ravine, so McKim radioed the hospital for two more EMTs, Randy Lewis and Jay McClintock. With the help of three Missouri State Highway Patrolmen and passers-by, the four EMTs managed to free James from the car. They placed him on a back board, put his leg in a splint and continued suctioning blood out of his mouth.

At exactly 9:35, only 37 minutes after they had arrived, the EMTs were in the ambulance with their patient, headed for the hospital. But their job did not end at the hospital doors. All four EMTs continued to tend James in the emergency room for an hour and a half until he went into surgery.

Five weeks later, James Crossgrove was released from the hospital. He cannot remember his accident or the care he received from the four EMTs at the accident site, but, according to his physician Dr. Edward Herrmann, he owes his life to their skill and composure. "If James had not received the expedient treatment he had at the site of the accident, his injuries would have been more difficult to treat, if not fatal."

James Crossgrove was fortunate to be attended by trained EMTs who were backed up by direct radio hospital communication and a well-equipped ambulance. If he had had his accident three years earlier, he might not have been so lucky.

Before 1974, most emergency patients, especially those in rural areas, were transported to hospitals in funeral hearses or private cars. These vehicles were not staffed by trained emergency medical personnel, had no emergency equipment and no radio communication. A farmer, injured in a chain saw accident, might have had to ride to a distant hospital in the bed of a pickup truck. Although most city residents enjoyed the service of ambulances and attendants, no law existed to regulate their operation.

In 1974, the state legislature passed Senate Bill 57, and Missouri emerged from the "dark ages" of emergency medical care. Senate Bill 57 requires all



ambulances to be licensed, specially equipped and staffed by certified, trained EMTs.

To help communities comply with the new law, MoRMP helped organize 18 EMT training courses, procure emergency ambulances and equipment and establish locally-integrated emergency systems.

- **Project RESQU**, covering 33 counties in southwestern Missouri, offers the 81-hour Department of Transportation EMT course. MoRMP provides training equipment and instructor compensation. Over 543 EMTs have successfully completed this course and are certified by the Missouri Bureau of Emergency Medical Services. In response to requests from local communities, RESQU also helped organize 13 area tax-supported ambulance districts. These districts and commercial and hospital services now provide the southwest area with 75 ambulances. With MoRMP aid, RESQU helps many of these ambulance services procure equipment and vehicles.

- **In northeast and north central Missouri**, the College of Osteopathic Medicine sponsors an MoRMP-supported emergency medical services program. In 1971, according to the Emergency Medical Services Plan for the State of Missouri (1973) quality emergency medical service was virtually unavailable in this predominantly rural region. The 10-county area was served by only four qualified ambulances and 26 trained personnel. Only one of the seven surrounding hospitals had communication facilities besides the telephone.

Today, with MoRMP help, a total of 18 licensed ambulances serve the area with the aid of a new communication system. And over 255 persons have completed the 81-hour EMT course. MoRMP also helped design a regional EMS plan.

- **In Missouri's southeastern Bootheel region**, there were no ambulances before 1974. Emergency patients were transported to one of the six area hospitals, a distance of up to 35 miles, in funeral hearses. There were no qualified EMTs. Now over 200 EMTs, trained through an MoRMP project, are qualified for emergency service, and local communities are establishing ambulance districts and services.

Missouri's emergency morbidity rate has been greatly reduced in just the last two years. If an emergency victim is quickly treated by a qualified attendant and transported to a medical facility in a well-

equipped ambulance with a communication system, chances for his survival are much greater than if he makes the same trip in a funeral hearse or private vehicle. Helping communities make the costly transition from minimal emergency service to a state-licensed service has been an important MoRMP goal. But the task has only begun. More ambulances and more EMTs are needed. And, most importantly, public and professional awareness of the emerging ambulance services and their cooperation with trained EMTs is needed to coordinate local efforts into a state-wide emergency medical system.



Gift of life: Timmy and "Herbie"

Who is Timmy? Timmy Kissel is a tow-headed seven-year-old in the first grade at Maddox Elementary School in St. Louis who can't wait for the Little League baseball season to start.

Who is "Herbie"? "Herbie" is Timmy's name for his new kidney, the gift of life that allows him to attend school, play with his friends and lead the active life of a healthy child.

Timmy and "Herbie" were united in a six-hour transplant operation in September 1975 at Barnes Hospital in St. Louis. The transplant culminated Timmy's struggle with polycystic kidney disease, two years of dialysis at St. Louis Children's Hospital and numerous hospitalizations for treatment related complications. Timmy's successful transplant is also a hallmark in the progress of Missouri's kidney program.

Before 1968, an end stage renal disease (ESRD) patient in Missouri had to rely on private funds or public donation to pay for dialysis on an artificial kidney machine, an expense which runs into thousands of dollars a year. To help ease the financial burden of the ESRD patient and to develop needed dialysis facilities, the Missouri legislature began appropriating funds in March 1968 for a state kidney program.

The legislature, impressed with MoRMP's proven mechanisms for reviewing proposals and monitoring grants, asked MoRMP to develop a state dialysis



program with these funds. Since 1968, MoRMP has administered, at no cost to the state, the more than \$4 million allocated for Missouri's renal program, making all funds available for direct patient care. The number of the state program's dialysis and transplant facilities has risen from the initial two to 10 in 1976. Seventeen patients were treated in 1968; more than 1,200 patients have been treated since then.

With MoRMP help, the state has taken steps over the last seven years to facilitate transplantation. Dialysis can run as high as \$30,000 a year, while the average cost of a transplant is \$15,000. Successful transplants save lives and reduce treatment costs per patient, making more state funds available for the increased patient load. Recently, the federal government extended Medicare to kidney victims, but with certain restrictions. Payment begins only after the patient has been on dialysis three months and then only covers 80 per cent of the costs. Transplant costs are entirely covered.

In 1969, kidney disease was added to the list of categorical diseases for which RMPs had specific directives. Since then, MoRMP has helped establish public and professional education programs, a computer data bank, a laboratory quality control system and the development of a three-state kidney network in cooperation with the Department of Health, Education and Welfare.

Educational programs

Most ESRD patients cannot live indefinitely on dialysis; they need new kidneys. But many obstacles stand between the ESRD patient and the donor kidney that may save his life. Donor kidneys are scarce; people do not know of the desperate need for transplantable kidneys. To overcome lack of public awareness, MoRMP supports educational programs sponsored by two Missouri kidney foundations.

With brochures, films, slide shows, media campaigns, and the distribution of organ donor cards, the kidney foundations reach thousands of Missouri citizens. Through the efforts of these two educational programs, it is estimated that approximately 292 kidneys will be available in 1976-77 for transplantation.

Besides public education, efforts are also made by the foundations to educate professionals to the pressing need for organ donation and the techniques of retrieving cadaver kidneys.

Computer bank and laboratory quality control

Another obstacle that stands between the ESRD patient and a compatible donor kidney is time. A cadaver kidney is only viable a few hours. To speed the process of matching the donor kidney with a suitable recipient, MoRMP supports a computer operated by the Midwest Organ Bank, Inc. of Kansas City that stores the names and relevant medical data

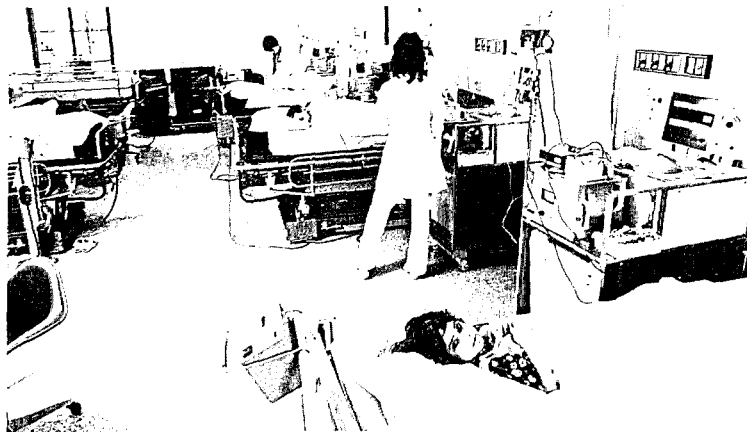
of ESRD patients from Missouri and the surrounding eight-state area. Results of laboratory tests on the donor kidney are quickly and efficiently matched with a compatible recipient by the computer. An MoRMP-supported laboratory quality control system maintains standards for these laboratory tests.

ESRD Network #9

When the Social Security Act was amended to make ESRD patients eligible for Medicare, the federal government made provisions to set up regulatory networks to supervise renal disease care. RMPs were asked to help establish the developing networks until funding applications were approved.

MoRMP has been closely involved with the development of Network #9 which includes all of Kansas and Missouri and part of southern and central Illinois. The network coordinating council, composed of representatives of Medicare-approved health care facilities, will be responsible for ESRD quality control assurance and peer review.

Over the last seven years, MoRMP has been instrumental in helping Missouri become a national leader in the treatment of kidney disease. But the story does not end here. Approximately 835 Missourians will need dialysis and eventual transplantation in 1976. To assure these and future ESRD patients of adequate medical care, no link in the cooperative chain of direct patient care, public and professional education, tissue typing laboratory control and computerized patient registry can be broken.



The Future: Dr. Wyeth Hamlin

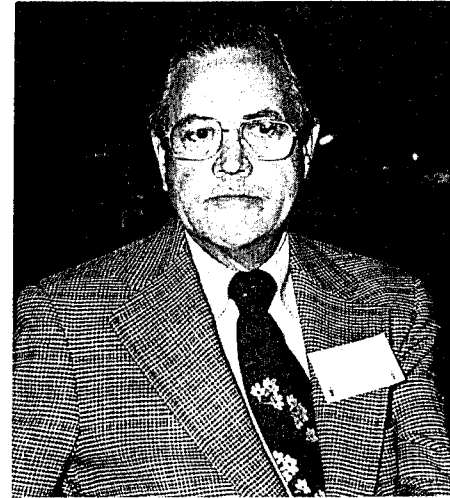
It is satisfying to report that Flossye Carter's hypertension is stabilized, that James Crossgrove is on the road to recovery, that Timmy Kissell has his new kidney, that little Joshua Smith has fully recovered from the sudden illness which threatened his life, and that the heart patients of rural north-west Missouri continue to benefit from the specialized skills of Dr. Tom Cofer. After all, these are some of the hoped-for end results of the Missouri Regional Medical Program process.

Important as these are, they are just the tip of the iceberg. Not so apparent are the thousands of heart disease victims across the state whose lives have been saved in cardiac intensive care units staffed by specially trained personnel, the victims of kidney failure whose lives have been productively extended through an effective dialysis and transplant program, or the countless others who have benefited from any of the 167 programs, all products of cooperative planning and enterprise between the MoRMP and many individuals and institutions intent on improving health services for the people of Missouri.

Recognizing the specific health needs of a community, determining innovative solutions and bringing together human and material resources to implement those solutions are the components of the Missouri Regional Medical Program process.

From the vantage point of observer and participant in that process, as a member of our Regional Advisory Group over the past few years, I have concluded that the MoRMP process has been successful because:

- it has been entirely voluntary,
- it is built on cooperative arrangements between health providers and institutions, and
- it has depended on the direct involvement of



providers who looked beyond their own interests to those of the community.

On June 30, ten years to the day since it received its first grant, MoRMP will cease operations. In keeping with the provisions of Public Law 93-641, responsibility for health services development will then belong to the newly organized Health Systems Agencies (HSAs).

These agencies will be responsible for health planning and regulation in their respective areas. They will face the demanding tasks of agency organization and gaining community participation in the development of comprehensive health plans for their areas. It appears that only minimal resources will be made available to them for these purposes. No funds will be available for health services development before July 1977, at the earliest.

Since 1967, Missouri Regional Medical Program has been responsible for the investment of over \$28 million in federal funds and over \$4 million in state funds to improve health services for the people of Missouri. As MoRMP leaves the scene, we are especially concerned that vital programs which we have fostered may be forced to terminate for lack of appropriate transitional support. We are concerned that the already large investment of time, energy and resources in HSA organization may be eroded through underfunding. And we are concerned that some of the knowledge and skills acquired in ten years of helping communities improve their health services may be overlooked as the new agencies attempt to cope with problems of organization.

Too often, persons involved in organizing agencies must devote most of their energies to developing plans and not enough to carrying out these plans. It is through effective implementation of programs that Flossye Carter's hypertension was detected and James Crossgrove's injuries treated.

We sincerely hope that these concerns are groundless and that early and appropriate action will be taken so that transition from the old to the new can be accomplished without undoing the advances in program and process which have been so hard won.

The lives of future patients like Joshua Smith and Timmy Kissel depend on it.

Dr. Wyeth Hamlin, M.D., Hannibal, Mo., is chairman of the Regional Advisory Group.



Credits

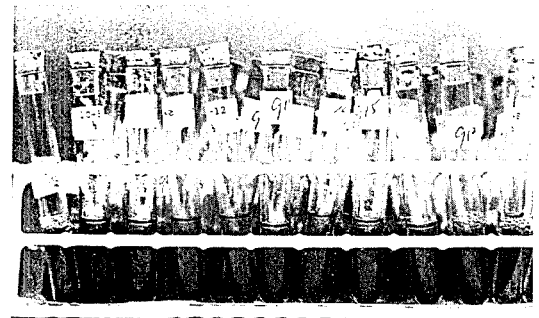
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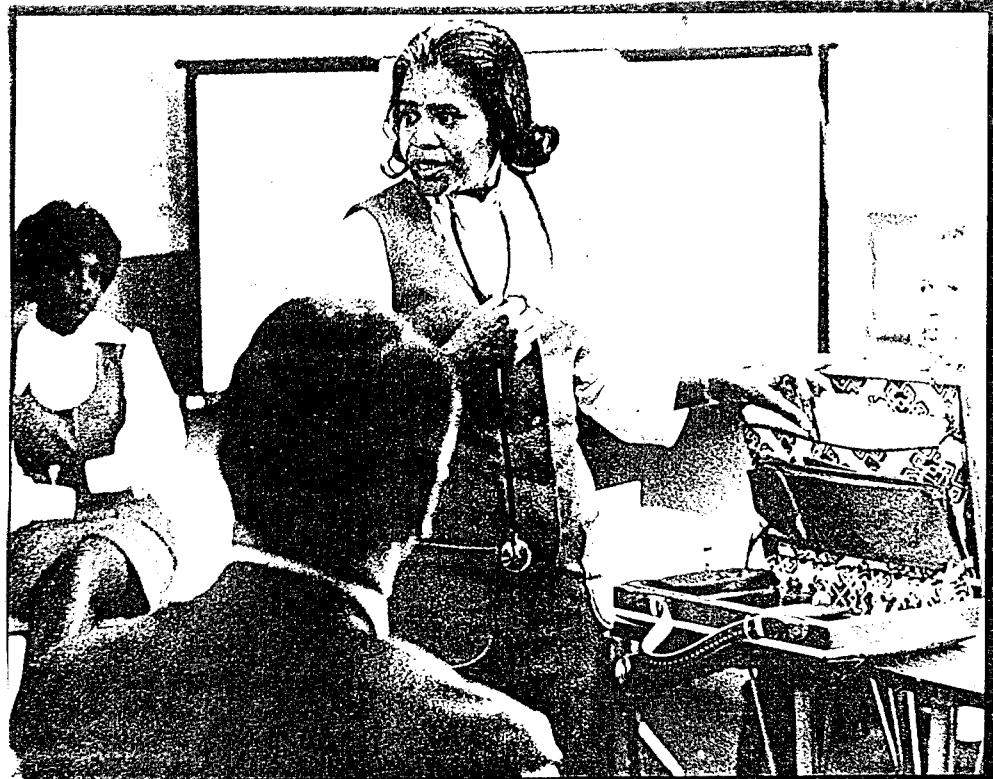
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