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the exchange of news,  
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MEDICAL ECONOMICS FEATURE: "What  
Regional Care Can Mean To You"

July 23, 1968

The May 27, 1968 issue of Medical Economics carried a story on Regional Medical Programs which has produced a good deal of favorable reaction as an accurate report of how operational activities are beginning to make a difference to patients. This feature is reproduced in this issue for those who would not otherwise have the opportunity to see it.

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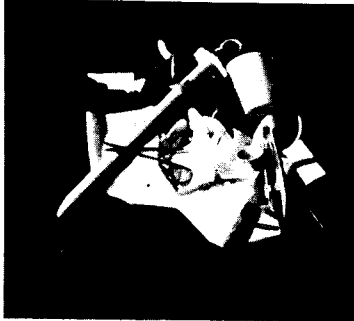
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# Medical Economics

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# What regional care can mean to you

By John H. Lavin

Senior associate editor, MEDICAL ECONOMICS

*Those regional medical programs for research into heart disease, cancer, and stroke, so hotly debated in Congress a few years ago, are now showing up in action. Results of the program in one Missouri town show how these programs can directly aid grass-roots physicians without infringing on their professional freedom.*

Smithville, Mo., about 20 miles north of Kansas City, isn't much more than a wide spot in the road. It has a few service stations, a car wash, automatic laundries, a small assortment of faded retail stores, and a two-story red brick bank, where the interest rate on savings deposits is a conservative 4 per cent. About a mile out of town, in farm country that's slowly giving way to suburbia, is Smithville's 75-bed hospital—the only medical facility within a radius of 15 miles. It serves an area population of about 75,000. Its 20-man active staff includes 10 G.P.s, an internist, an OBG specialist, a pathologist, a radiologist, a surgeon—and five specialists from the University of Missouri.

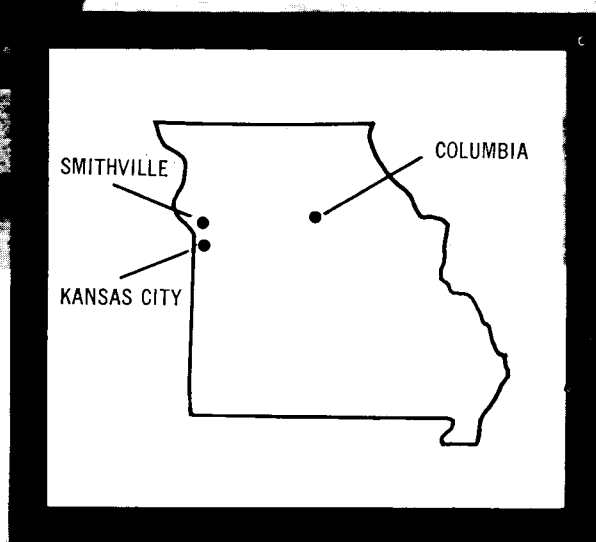
What are five specialists from the University of Missouri doing on the staff of a small-town hospital 150 miles from their campus? The answer lies in the grass-roots story of the Regional Medical Programs.

The programs were legislated into existence in 1965. The idea started off, you'll recall, as a proposal to establish "centers of medical excellence" throughout the nation that would be linked with satellite centers at community hospitals. These centers would be designed to take over on a regional basis much of the care of heart disease, cancer, and stroke victims. That concept, however, was considered a threat to private practice by many physicians. They felt they would be reduced to acting as nursemaids for minor ailments and referral mechanisms for the medical centers. When the Government got all those centers built, the critics asked, where would the staff doctors and other health personnel come from?

Mostly as a result of this criticism, the "centers" became "programs" for the promotion of research, demonstration, and training in heart



**THIS QUIET SMALL-TOWN STREET** in Smithville, Mo., is now as much a part of the mainstream of care as the avenues that lead to major medical centers. Private practitioners here have put to work the advances and consultants from the medical center at Columbia, as you'll see in the pictures and text that follow.



disease, cancer, stroke, and related diseases. The programs would establish cooperative arrangements among all health-field elements in a region. What have been the results so far of these high-sounding projects?

Government reports, published frequently in newspapers and periodicals, will tell you that early May, grants totaling more than \$50,000,000 had been awarded to 53 of 54 regions that cover the nation. Program coordinators

will tell you that twelve of those regions—Albany (N.Y.), Intermountain (Utah and parts of five adjoining states), Kansas, Metropolitan District of Columbia, Missouri, Mountain States, North Carolina, Oregon, Tennessee Midsouth, Washington-Alaska, Western New York, and Wisconsin—have already moved into operation. Medical school deans, hospital administrators, voluntary agency officials, and Government aides elaborate on these progress

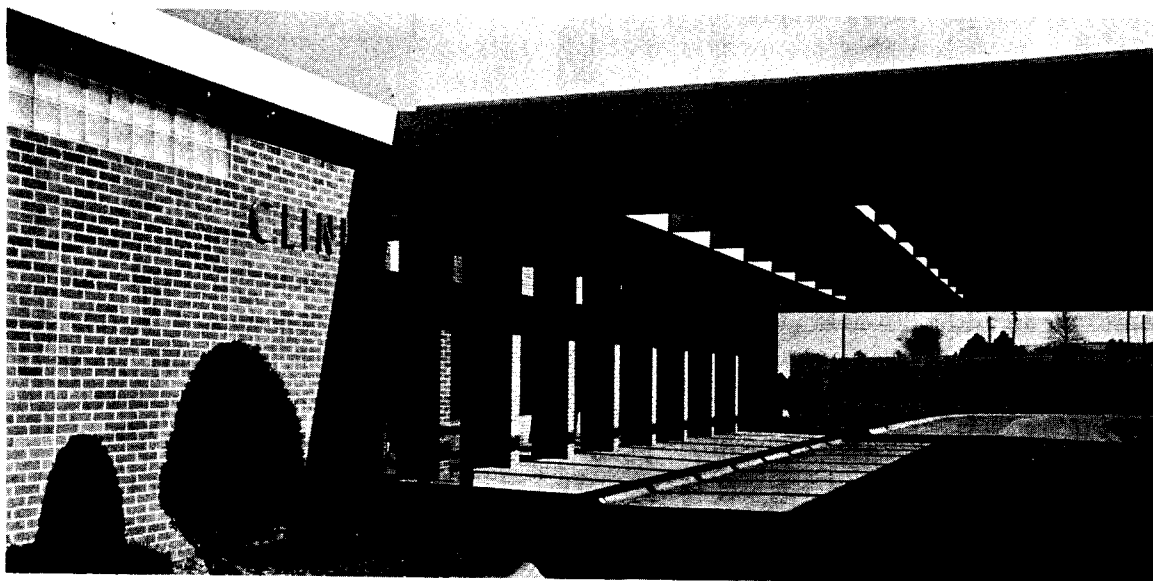
reports. They talk of such sophisticated projects as closed-circuit TV between medical centers and hospitals, facilities for telephone transmission of ECGs, and computer-data centers for storage of patient information.

That's how the Regional Medical Programs look as viewed from the top. They represent a vast, complex, and very serious attempt to develop and correlate medical information to help physicians treat heart disease, cancer, and stroke patients. The view from ground level shows that the programs are well on the way to accomplishing their high-minded goals. Smithville doctors certainly endorse the program, though in the strictest sense they're not out to make a Government program succeed. They say they just want to practice better medicine.

Smithville doctors tell you that the Missouri Regional Medical Program lets them improve direct patient care by bringing them the facilities *they* want and the consultants *they* ask for. It's enabling them to keep *their* patients in *their* hospital, rather than referring these patients to the bigger, more broadly staffed hospitals in Kansas City or trying to get them admitted to the university medical center. It's giving them the nurses and ancillary personnel for rehabilitation services. Such personnel also relieve them of much of the posthospital routine care and, at the same time, assure them that they'll be kept aware of their patients' condition, medication, diet, and of any changes even in the home environment that might affect recovery. Regional Medical Program? That's a label

## What regional care means to Smithville

Overlooking Missouri's starkly rural Little Platte River Valley is the startlingly modern 75-bed Smithville Community Hospital with its adjacent medical clinic (below). Serving an area population of 75,000, hospital and clinic have become the focal point of Missouri's Regional Medical Program for treating heart, cancer, and stroke patients in the area. In a reversal of the usual from-the-top control of government programs, local doctors are getting help in improving direct patient care through facilities *they* want and consultants *they* ask for.



tagged on in Washington, and if Smithville doctors are "just practicing medicine," they're doing it with this difference: They now have the kind of help they want, when they want it, and in an area where it was tough to get help before.

Smithville is a prime example of how the program can directly aid the private practitioner in his daily work without infringing on his professional freedom. Significantly, the Smithville project wasn't suggested by the regional program planners, but by the local physicians themselves. The Missouri program simply gave them a framework in which to work.

"The premise on which the Missouri program was founded," says Dr. Vernon E. Wilson, program coordinator and former dean of the Uni-

versity of Missouri School of Medicine, "was that it would deal with patients' needs and patients' desires without any regard for the organizations or institutions within the region. Our theory was that we could pick any spot in the state, say a community of 1,000, and we'd find people going to as many as seven or eight medical institutions. For that reason we reversed the 'center of medical excellence' concept. Instead of trying to base the program on a single institution, we decided to help the people—through their physicians—to get the care they needed at the institutions of their choice. That meant trying to give them access to the best health care without having them travel far from home to get it."

Dr. Wilson may well have been thinking of



**TIED TO THE HOSPITAL** by the corridor at left, the Smithville Clinic links the patient to much more than hospital care. It brings him a team of needed specialists whom his doctor has obtained through the auspices of the Regional Medical Program. In this area of rural Missouri, patients are becoming accustomed to their doctors' calling on specialists from Columbia, 147 miles away, to help them. The arrangement keeps patients from making a trip to "the big city" for consultation.

Smithville when he made that statement. Though the Missouri Regional Medical Program does have more sophisticated projects in prospect—use of a computer and closed-circuit TV, for example—Smithville, with its population of 1,500, nevertheless represents a major effort to bring university advances out to the grass-roots physician.

The town's project was first proposed by Dr. Archibald E. Spelman, the head of a four-man medical group, who died shortly after seeing his plan move into operation. The Smithville area, he told Dr. Wilson, was going to double or triple in population because new industry, a state dam, and recreation projects were planned for it. Yet the area was still medically isolated and extremely short of specialists. For Smithville doctors, population growth would simply mean more referrals to Kansas City. It would mean, too, that many newcomers would bypass local physicians for all but the most routine care and seek medical excellence in the big city. Dr. Spelman proposed that the Smithville area be turned into a pilot project for early comprehensive care of heart disease, cancer, and stroke patients.

"The basic idea," says Dr. H. M. Hardwicke, the University of Missouri consultant who went to Smithville to work with Dr. Spelman, "was to find out what the area needed to combat these diseases, what it wanted, and what it could adequately utilize. If we learned those things, we'd have the plans for a model project that could be adapted for other areas." Dr. Spelman's four-man clinic, with its offices adjacent to the hospital, became the nucleus of the project early last year.

These four doctors, working with about 10 other area physicians, came up with what they

## In Smithville the consultant goes to the local doctor and his patient

**THE PRIVATE PRACTITIONER IS BOSS** at the Smithville Clinic, but local doctors have learned to draw on the visiting specialists' knowledge. Here Drs. David R. Chiles, Paul W. Purcell, and John E. Dernoncourt (left to right), three members of the four-man clinic, consult with visiting University of Missouri Medical Center internist Nathan C. Galloway.



**BETTER REHABILITATION** for stroke patients has been one result of the program. Walt Gault (at rear), a visiting physical therapy consultant, spends one day a week at the hospital.

**ONE OF FIVE SPECIALISTS** who come to Smithville regularly from the medical center at Columbia, Dr. Henry M. Hardwicke spends two days a week at the clinic. When this 14-year-old became paralyzed, Dr. Hardwicke, a physical-medicine specialist, helped local doctors form a team to put the boy back on his feet. Though the program was designed basically to treat heart, cancer, and stroke victims, consultants in other fields are also available.





**WORKING CLOSELY TOGETHER,** *visiting consultant Nathan Galloway and local nurse Virginia Halliburton discuss a patient's condition in the newly opened cardiac intensive-care unit. Mrs. Halliburton, selected by local physicians, was trained to take charge of the unit.*

## Better patient care is one result of the program

**CORRIDOR CONSULTATIONS** are common between a visiting specialist like Dr. Hardwicke (left) and local physicians Robert D. Williams (center) and John E. Dernoncourt (second from left). Smithville doctors now have the kind of help they want, when they want it, in areas of medicine where it was difficult to get help before.



**DOUBLING AS A COMMUNITY ROOM**, the hospital's physical therapy center also serves as a dining and rest area for rehabilitation patients. During the lunch period card tables are set up, and patients are encouraged by visiting therapists and staff nursing personnel to feed themselves and chat with one another.

**NURSES' AIDES SERVE SPECIAL DIETS** prepared under the supervision of university-trained home economists working with the regular hospital staff.





**SAFER SURGERY**, medical excellence, and the best are possible without making the patient travel long distances to get it are benefits of Smithville's participation in the Regional Medical Program.

felt Smithville needed and what *they* wanted: (1) a cardiac intensive-care unit and trained personnel to operate it; (2) rehabilitation facilities in the hospital for stroke patients and physical therapists to work with them; (3) home-care nurses and allied health workers who could bring posthospital care out to the farm and bring progress reports back to the private physician; (4) terminal-care facilities in the hospital for those cancer patients who belonged neither in their own homes nor in the hospital proper; and (5) university cardiac and physical medicine specialists to be available for consultation regularly in Smithville.

The physicians wanted the project to run two years. Then it would be determined how much use they and their colleagues had made of all that had been made available, how their patients and the growing population had reacted to the new services, and whether the individual activities of the program could be continued on a self-sustaining basis.

"What these physicians proposed," says Dr. Hardwicke, "was simply a speedup in the timetable of medical advances for Smithville. They would ultimately have gotten most of the things they proposed through their own efforts alone. But the Regional Medical Program enabled them to get these advantages 15 years sooner."

The Smithville doctors got what they wanted. The project began in June, 1967, and will operate for at least two years. The hospital, which had already done some pioneering in rehabilitation and social service work, set off a wing of 15 beds and one large rehabilitation room for stroke patients and four beds for terminal-care cancer patients. Such simple equipment as parallel bars, steps, and examining tables were added to the hospital's rehabilitation equip-

## ... What regional care can mean to you

ment. The large rehabilitation room doubled as a community room, where doctors lectured to P.T.A.s and other groups on health matters. The hospital also hired physical therapy and nursing personnel, arranged for visiting nurse service and the use of home economists, medical-social workers, and other university experts. Three university physical medicine specialists and two internist-cardiologists were added to the staff as consultants. Each of them put in a day or more a week in Smithville.

Nurses, selected by physicians, began training to operate the cardiac intensive-care unit. And three local physicians, all G.P.s, prepared to return to the university for from several days to a month, one of them to work in cardiology, another to work in post-trauma and postsurgical rehabilitation.

The program, however, didn't bring in a lot of expensive hardware to Smithville. Of its first-year grant of \$257,000, only \$35,000 has gone for equipment, compared with \$117,000 for salaries of M.D.-specialists and other health personnel. These specialty personnel were brought in at no cost to the hospital for the first year. In the second year the hospital will pick up 50 per cent of the bill for their services, then, if a third year is feasible, 75 per cent, and finally, if the program becomes self-sustaining, full cost. To help determine whether the program can become self-sustaining, a five-member research team is going into the homes to find out what the people feel the community needs in the way of medical care.

Measured by some of the sophisticated projects contemplated under the Regional Medical Programs, Smithville's accomplishment may seem minor-league. But not to its doctors. David R. Chiles, a G.P. who succeeded Dr. Spelman as

head of the four-man clinic, explains it this way: "Before this program went into operation, we did what we could for, say, a cardiac or a stroke patient during the acute phase and then treated him as an outpatient or at home. We had to rely chiefly on the patient and his family to follow up with his care. That cardiac patient will now have a better chance of survival in the acute phase because of the intensive-care unit. The stroke case will get much more active rehabilitation, including speech and hearing therapy if he needs it. He may stay in the hospital longer, with rehabilitation specialists giving him their time and care. Return visits will be cut down, both because patients will be in better physical condition when they're discharged and because we'll have a nurse to visit them at home."

Dr. Chiles cites the case of a 76-year-old stroke patient who lives on an outlying farm with an older brother and two sisters: "The family brought him to the hospital after a stroke recently, his third. He was suffering from aphasia, loss of speech, mental confusion, and he couldn't use his right hand. I evaluated his condition, consulted with the internist from the university who was making his regular visit and with the physiatrist. We decided to anticoagulate him. Within two weeks, we had him started on a physical therapy program. He was taught what he needed to know to take care of himself. Two weeks later he was sent home. A visiting nurse made two calls at his home, in the following weeks, calls that would have taken me half a day each. She determined that he was getting along well at home. It was a month before I had to see him again when I had him come in for laboratory tests."

Robert D. Williams, a surgeon and also a clinic member, tells of a similar case involving a

66-year-old woman, who made a significant recovery after a paralyzing stroke. "Without the help she received through the program," Dr. Williams says, "I doubt that she would have recovered nearly so well. She would have been bedridden and would probably have gotten pneumonia and died." In another case a woman coronary patient was able to be sent home after a medical social worker determined that, though the patient had additional medical problems, her husband and sister who lived with her would be competent to care for her adequately.

The patients, of course, pay for their own care. But they seem to appreciate the additional services that their doctors, in effect, are securing for them. Patients have grown to accept the idea that their family doctors now have a whole team of specialists they can call on for help. Patients also like the idea of a nurse or a home economist coming out to visit them and advising them about their illness, their diet, their medication, and so on. They seem to understand that this service is an extension of their own family doctor's care.

The visiting consultants in cardiology, physical medicine, and other specialized fields on request are usually booked solid from the time they arrive to the time they leave—chiefly because there are so few specialists in the Smithville area. (About 80 per cent of the area's M.D.s are G.P.s.) "The G.P.s here are developing an awareness of consultants that they didn't have before," says Dr. Hardwicke. "That means more referrals to specialists already practicing here." Internist Paul C. Vescovo Jr., an active staff member at the Smithville hospital who lives 20 miles away in Kansas City, agrees. "As I become more aware of what we have here," he

says, "I make more use of local consultants instead of sending my patients into Kansas City." When the program ends and the university men are withdrawn, there's likely to be a demand for more specialists in Smithville—and a medical awareness in the community that will support them.

Smithville still needs the university medical center for practical reasons, according to John E. Dernoncourt, another clinic G.P. "Obviously, a lot of highly expensive equipment couldn't be sufficiently utilized in a rural area," he says. "But we need the university as a 'center of practicality,' not a 'center of excellence.' Our program is putting the excellence where it ought to be—out in the hands of the practicing physician."

As with any program, Smithville's has its statistics. Doctors there can tell you that in the program's first few months of operation, 250 patients went through the stroke rehabilitation unit for evaluation, care, or outpatient care. Occupancy there runs about 90 per cent. Consultations with university men alone in the overall program run about 96 a month. Yet in cardiology, for example, the university consultants are called on to read only 50 per cent of the hospital's electrocardiograms. And the cardiac intensive-care unit is just beginning to get some use.

Statistics aside, Dr. Hardwicke sums up the Smithville program from the physicians' point of view this way: "The private practitioner is boss here. He gets more efficient utilization of his own time, the ability to keep up with the competition from big-city hospitals a short distance away, and the satisfaction of knowing he's got the knowledge and materials available to do the best job he's capable of." **END**