E00046

February 18, 1970

To: Senate Subcommittee on Health
Senator Ralph Yarborough,
Chairman

Statement by Paul D. Ward
Executive Director,
California Committee on
Regional Medical Programs

Re: S. 3355; a bill to amend and extend Title IX of the Public Health Service Act as it pertains to Regional Medical Programs

We are pleased to appear in support of S. 3355 by Senator Yarborough and others, which would amend and extend the current legislative authorization for Regional Medical Programs. I serve as Executive Director of the California Committee on Regional Medical Programs, which is a non-profit corporation founded principally to manage the overall programs in the California Region. In terms of population, our region is the largest of the fifty-five existing regions. Its distribution of resources - both manpower and facilities - as well as its variety of approaches to medical care and its diversity of problems, make this region an interesting point of observation for judging the possibilities of obtaining the objectives and original legislative intent of the program.

The program, thus far, has enjoyed broad support from the health-related professions, the leadership of health facilities and the public. While pursuing its objectives, relatively little adverse reaction has been generated. Additionally, there has been a greater involvement of people on a voluntary basis than in any other program of recent vintage. It is with these considerations in mind that the following comments on

S. 3355 are made.

One of the major contributing factors to the success of RMP in California has been the emphasis on categorical diseases. We support the broadening of the categorical approach as expressed in S. 3355 and we would emphasize that we believe any actions to eliminate the categorical approach would cause irreparable harm to the progress that has been made.

Although ideally it may be more desirable to view comprehensively the health of man and his community, from a practical point individuals become involved and committed to goals because of their interest in specific matters. RMP has been built on the specialist helping the less specialized; it has attracted people, both lay and professional, because of their interest in specific pursuits, yet it has been able to bring them all together at certain points which produce benefits over and above the specific categories concerned.

Lay people have become involved because of their interest in specific areas and they can identify with a specific category. Specialists from the medical schools and medical centers become involved because they can relate to specific objectives. Facilities usually seek aid from the program because their services are weak in a given disease area. Further, patients are usually treated for problems that are categorical, and hopefully, not many patients are ill comprehensively.

This program has been built on beginning with specific problems to which people can relate their specific interests and abilities and then building toward the overall improvement in the organization and

delivery of health care. To completely eliminate the categorical approach at this time would be to destroy much of the foundation on which the program has been built. Significant numbers of people now voluntarily involved would believe that the program no longer concerns them and would be inclined to adopt the attitude of "letting the other guy do it."

On the other side, we have not witnessed any serious curtailment of the program because of the categorical approach. Some regional advisory groups have pondered the exact parameters of the program, but the real limitation on the program has been the available dollars once the planning gained momentum, not the authority to engage in an unlimited pursuit of the problems of health care.

We believe that the sums set forth in S. 3355 as authorized amounts are realistic, although more conservative than the early planning and development efforts had been geared for. The plateauing of funds now in effect and the enforced carryover of funds has been disastrous to some of our best planning, but our planning could be regeared appropriately to meet the levels set forth. I mention this because the program uses voluntary cooperative arrangements as its major means of gaining improvements. The arrangements have proven perishable if held in abeyance for long periods of time awaiting funding. They essentially are agreements between people, facilities, local government and others to perform in a given way together. If the agreements are slow to be put into effect, people either move on to other concerns or

they forget what they agreed to. The planning then has to be commenced anew and the original planning dollars may have been wasted.

Some of the concerns can be seen from the following brief descriptions of certain of our programs.

The California RMP has initiated a confederation of coronary care units. The confederation has trained 1,250 nurses, 105 physicians and has provided consultation to hospitals on equipment and construction needs for CCU's. Physicians from throughout the region meet regularly to coordinate planning for CCU's to assure adequate distribution of care throughout the region without developing more than will be properly utilized.

Activities within the confederation have, in the first year, increased the pool of available trained CCU nurses by 57% in the Los Angeles area. Even so, the training programs we have are producing fewer than half the numbers of nurses we need in the region.

Those hospitals which are too small to justify a unit for coronary patients exclusively are being encouraged to include specialized coronary care equipment within intensive care units. A program operated through Pacific Medical Center in San Francisco has provided a training program for physicians in small hospitals to learn ICU techniques. This program provides in-residence training at the San Francisco hospital for practicing physicians, followed by consultation visits from PMC staff to the local hospitals. The support for this program has been overwhelming. Many rewarding comments have been made publicly about it. Dr. John W. Derbyshire, of Palm Drive Hospital in Sebastopol,

California, stated that before the program began, several of the ICU procedures were not used or were infrequently used because of lack of confident understanding of their applicability. Now, daily application of electrocardiographic monitoring is done. External pacing, he has said, has saved the lives of at least two patients. Because funds have been cut back, the program has not been able to meet the demands from the community hospitals for the training offered. Seventy physicians are currently on the waiting list. Included are doctors from the hospital at Garberville, California, which is 60 miles from another hospital. It has ICU equipment which is not being properly utilized because the staff does not feel qualified to do so. The hospital is eager to have its staff participate in the project, but because of a long waiting list and reduced program funds, these doctors must wait until October to participate, and there is no assurance that there will be enough funds for the project to continue that long.

The accomplishments of the coronary care programs are that we have developed a group of people who understand CCU's and who are working together on their planning. We have learned much about how best to train the doctors and nurses needed to work in and manage these units. We have trained many people who have the capability of training others. Now that we have reached the point where we can do much in the region, we fear that efforts to date will be lost because funds are not available to go on.

Our cancer program was not begun as early as that concerned with

coronary care. We are only beginning to see improvements actually reach the patient. The proper management of cancer patients requires highly trained and experienced specialists working in close cooperation. Just this kind of cooperation and the needed specialists are making available in Northern California many of the refinements in cancer therapy that tend to be concentrated in metropolitan cancer centers. By the end of the first year of operation, this project will involve 20 institutions, 200 health providers will receive training, and at least 500 cancer victims will benefit from the program.

Included in the program are cancer consultation services, radiation physics support, a computerized data retrieval system, and educational activities for physicians, nurses and other allied health professionals. Under the consultation services program, specialists from the cancer centers at the University of California and Mount Zion Hospitals in San Francisco visit the participating hospitals - as much as 300 miles away - to share with other doctors their expertise in radiation therapy, chemotherapy, and cancer surgery. Each community will be encouraged to develop its own cancer management team, and assistance will be available as needed in the planning of cancer treatment facilities. A computerized data retrieval service will serve as a memory bank of information about individual patients. It will offer participating hospitals the basis for evaluating their performance in cancer treatment, and will assist in the evaluation of the program as a whole.

A unique feature of the program is the telecommunications link

between San Francisco and community hospitals. The hookup transmits the patient's diagrammatic contour and clinical findings by teleprinter to the center in a few minutes. The displayed information is examined by experts in determining how radiation can be applied most beneficially to a patient. A detailed treatment plan is calculated and transmitted back to the community hospital. During this time the physician also can discuss by telephone such matters as the amount of radiation dosage the patient should receive and the best angle for administering radiation into the patient. This communications system enables cancer victims to stay in their home communities and receive benefits of the best modern treatment methods, no matter how far they are away from the major medical centers. As this program is refined, it eventually can be blended into the normal funding mechanisms for patient care.

Planning programs for the care of stroke patients has been a slow and laborious process due largely to the once widely held belief that nothing much could be done for these patients. The massive crippling effects of the disease, and the multiplicity of medical and allied health personnel required to carry out the time consuming process of rehabilitation caused many communities to virtually ignore the problem. However, in California four farsighted projects have been processed through the planning stage and one has had initial funding.

After less than six months of operation, our one funded project has already begun to show promising results. Fifty-five physicians have received specialized training in the care of the stroke patient

and have returned to their community general hospitals and local practices with an awareness that the stroke patient is not hopeless and with knowledge of what can be done for him. Eleven speech therapists are now in training in the project, gaining specialized knowledge on stroke rehabilitation.

One of the most significant effects of this project has been the new, enthusiastic, almost evangelical, attitude of the community physicians who have been through the training program. They no longer file their own stroke patients away in a nursing home for living storage until death. Instead, they are insisting that their patients be placed in extended care facilities which have personnel knowledgeable in stroke rehabilitation. Such facilities are extremely rare, but they hopefully will become more abundant as the project itself achieves its objective of training skilled stroke rehabilitation teams from the local extended care facilities and hospitals. Thus, it is imperative that full future funding of this project be assured.

Of even greater concern, however, is the need to assure that this one project not be allowed to exist in isolation. Three other projects, in other areas of the state, are in abeyance due to lack of funding. Each has many of the elements of the one funded project, and each has other elements designed to test new and different concepts in stroke care. A Statewide Stroke Task Force has already done all of the necessary groundwork to standardize records among, and elicit comparable data from, these projects. Therefore, if the others could get started

the system exists for comparing one against another, thereby identifying, for the advancement of the future care of all stroke patients, the most effective ways of providing treatment and rehabilitation.

We support the proposed addition of language in S. 3355 which would emphasize the need to improve primary care and to create a bond between it and specialized care. We believe we have made a significant beginning in this regard with the planning in Watts and other lower income areas.

In northeastern San Fernando Valley, in Pacoima and five other contiguous communities which have been without proper health services, a vigorous drive is under way to establish useful transportation, a corps of neighborhood aides, new hospital and clinic services and a highly unusual consortium involving high schools, hospitals, colleges, the medical society and several health agencies in the organization of training programs for the allied health professions.

In the Watts area of Los Angeles an RMP program tied closely to an all-out effort on behalf of county government is deeply involving the community in programs designed to materially improve the levels of medical care for the residents and to greatly increase opportunities for the training of minority group members in medicine and allied health professions. One project will be a "health store," an idea originated and to be implemented by a community youth group with RMP support. The "health store" will provide counselling, referral and a site for screening and other service programs. While areas such as Watts are totally disillusioned by studies conducted by outsiders who visit for

a while and then disappear forever, under RMP they are themselves conducting meaningful studies which will lead to community action programs.

The RMP sponsored Drew Postgraduate School of Medicine will be located within the new Martin Luther King General Hospital being built by the County of Los Angeles and will provide postgraduate training for physicians, faculty for the county's training program for allied health personnel, and medical staff services for the hospitalized patients. The county has made a deep commitment to this effort, both in money and in the assignment of some of its best available personnel. When the hospital opens, the Drew School faculty will be jointly financed by RMP and the county for a period of time until the school becomes fully self-sustaining. Under RMP auspices solely at the present time, a nationwide search and recruitment program is going on to get faculty aboard and do the massive planning necessary to begin operation of a large modern medical center and medical school in the fall of 1971.

When in full operation the Drew School will be overseeing the medical staff of a hospital serving over 500,000 persons who have had only minimal services to date. In addition, a comprehensive ambulatory care program will be conducted in the immediate Watts area for more than 25,000 residents through the hospital out-patient department and satellite centers. The school will eventually turn out in excess of 100 physicians a year with graduate medical training in community medicine, pediatrics, internal medicine and seven other specialties. It will also contribute significant faculty resources to the allied

health personnel training program which will train several hundred nurses, therapists and technicians per year, largely drawn from the unemployed or marginally employed citizens of the area. This immense cooperative effort, involving a community, voluntary agencies, and all levels of government could well serve as a national prototype as an urban ghetto program which simultaneously tackles problems of education, medical care, and employment.

We support the addition of language in S. 3355 which would authorize construction in addition to the present authorization for alteration and renovation. Several of the programs in developing needed facilities for educational purposes, coronary care units and the like have experienced difficulty with the narrow interpretation placed upon alteration and renovation. It should be made clear, however, that construction in thise sense could not mean the creation of entire new facilities and centers, since the level of authorization within the bill is not sufficient to contemplate this type of construction and at the same time support the many other planning and operational efforts now contemplated by the regions.

We concur with the proposal in S. 3355 which would bring the Regional Medical Programs into a closer relationship with Comprehensive Health Planning. We would hope, however, that this relationship could be structured at the B Agency level only.

To date most CHP agencies seem to have taken the limited approach toward health proposals that they have the right of approval or

disapproval of a project proposal or a proposed facility advanced for funding at the time the funding is applied for. Upon further analysis, however, this seems to be both a frustrating and wasteful approach to the problem of coordination. Ideally, if the planning is to be coordinated in the most efficient and least harassing manner, it should be coordinated on a staff level beginning at the inception of a concept until it matures into a completed project or facility proposal. This means that CHP somehow should provide the forum for coordinating the planning from the day it begins until it is a completed proposal, and upon completion, there should be no need for a final review and approval process. Each one of the steps in the planning process should have had the benefit of the coordinating process. A conflict should be resolved at that point in planning when it is first discernable, not after it has been woven into a completed project.