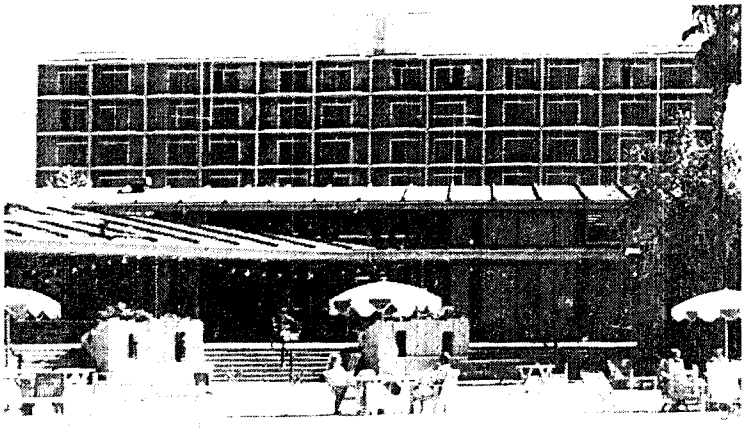
SAN DIEGO

NATIONAL ASSOCIATION OF REGIONAL MEDICAL PROGRAMS, INC.



MEETING HIGHLIGHTS September 1975

SAN DIEGO

INTRODUCTION

The primary purpose of the National Association of Regional Medical Programs is to provide information and educational opportunities in areas of pertinence to the members. The format of the assembly in San Diego was, therefore, designed to provide a spectrum of informational interchanges related to the theme of the development of a health system for the community.

The program began with current perspectives regarding the National Health Planning and Resources Development Act of 1974 (P. L. 93-641) as viewed from state government, the federal administration, health care and institutional professionals. It proceeded to the presentations and discussions of successful programs in high priority areas such as access, manpower, regionalization, quality assurance, and implementation and regulation concerning current legislation. There were special programs on health cultural awareness, RMPs in transition, hypertension, and technical assistance centers. The conference culminated with provocative presentations and discussion of implementations for the future.

Many individuals, both NARMP members and non-members, prepared materials and made important presentations to the assembly and we are most grateful for their very significant contributions. However, the real measure of success of any such program relates to the worth placed upon it by all participants. The members of the Program Committee endeavored to design the conference so that there would be much of value, both in information exchanged and in thought provoking stimuli. We sincerely hope that there was reasonable attainment of this objective.

J. S. REINSCHMIDT, M.D.
Chairman, NARMP Program Committee

MEETING HIGHLIGHTS

The atmosphere of high resolve to overcome problems posed by Public Law 93-641, present at the opening of the second annual meeting of the National Association of Regional Medical Programs, persisted to the very end of the three-day session---with one change. At the end, resolve was coupled with a clear picture of what must be done to make the law work, the result of concentrated attention to an explanation of the law's anticipated impact on the health care delivery system.

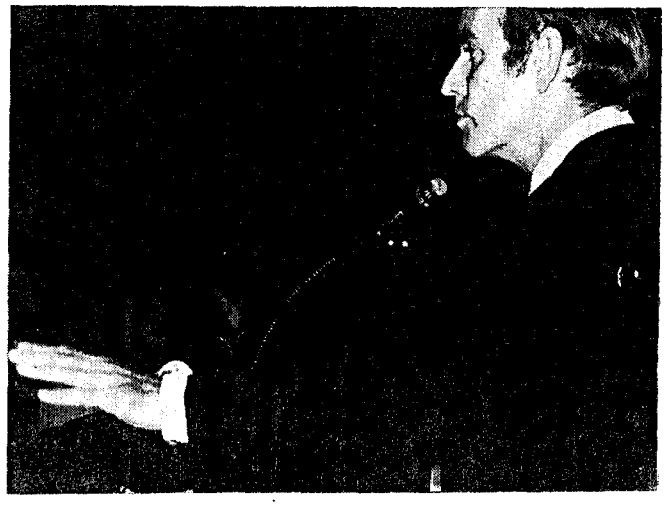
FIRST PLENARY SESSION

The meeting, particularly in the two plenary sessions, provided a forum for expression of opinions and concerns. To the first session came representatives of government, practicing physicians, hospital administrators, medical schools and other health interests.

Few faulted the law's basic concept-access to quality health care for all at reasonable cost. The concern was with the way the law proposed to achieve this, the Health Systems Agency organization mechanism, its operation, impact on various segments of the health care delivery system, accountability and responsibility both as to location and geographic scope.

STATE GOVERNMENT

Robert D. Ray, Governor of Iowa and Chairman of the National Conference of Governors, reminded the assembly that the mid-western governors at their recent conference voted to have P.L. 93-641 repealed in its entirety. The conference's main objection was to removing health planning from "public officials affected by, accountable and responsible to the people that elect them." Among suggestions for improving the law were provisions for complete care capability in each health service area, relaxation of population limits, permitting governors of rural states with few HSAs to name a reasonable percentage of HSA board members in place of appointing a state coordinating body, and more emphasis on quality of HSA board membership and less on categorical representation.



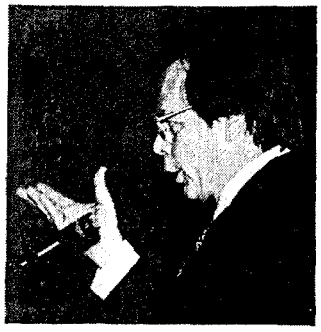
FEDERAL GOVERNMENT

Kenneth Endicott, M.D., Director of the Health Resources Administration, voicing need for rapid communication during transition, announced formation of an RMP multi-regional coordinators group to act as a special liaison committee between RMPs and the Department of Health, Education and Welfare. Relating to Dr. Endicott through Dr. Margulies, the committee is to function in an advisory capacity, identifying, collating and classifying problems and issues.

Harold Margulies, M.D., former Director of the Division of Regional Medical Programs, now Deputy Director of the Health Resources Administration, said more attention should be paid to what will work than to the precise wording of the law. Cautioning against erosion of expectations such as has occured in the past, he pleaded for their reduction so that the law has a fair chance to work. He predicted HSA funding will be low and urged preservation of successful RMP projects through outside funding rather than hope forlornly for continuation through HSAs.

Eugene Rubel, Acting Director, Bureau of Health Planning and Resources Development, stated that the primary concern of HEW with regard to the new HSAs is the "caliber of governing board members and the staff." He granted that technical changes in the law were needed but added that changes could not be expected until after the law is implemented and a number of HSAs established.

PHYSICIAN IN PRIVATE PRACTICE



Joseph F. Boyle, M.D., in private practice in Los Angeles, American Medical Association trustee and speaker of the California Medical Association house of delegates, attributed lack of success in past community health planning partially to provider non-participation, and made a strong plea for providers to avoid repetition of this past mistake. "It is rational that those who have the experience and educational background participate as fully as possible. It is also equally sensible that the people for whom this care is being planned . . .participate so that they receive what they perceive as an answer to their needs and not an answer to the needs as perceived by someone who may never have been there themselves."

Referring to the greater federal expectations from the new law to be achieved seemingly with lower funding, Boyle warned of an apparent "impossible task" for the community to undertake. He urged best efforts to make the law work because "if you fail in an impossible task, we may have to write some other kind of legislation to take care of it again in the future."

HOSPITAL ADMINISTRATION

Stephen M. Morris, past president of the American Hospital Association and President of Samaritan Health Service, Phoenix, Arizona, reiterated the almost universal concern over the discretionary power vested in HEW and the shift in health care planning from the local to the state and federal arena. He added that "federal leadership and direction are necessary to solve the health service problems that we face, and the regulation that follows is inevitable. We in the profession have a duty to make sure that this regulation is a good regulation and that it does what it is designed to do."

He foresaw, as a rational development, the possibility of dividing the HSA planning and regulatory functions with regard to hospitals, with a consortium of hospitals doing cooperative planning.

MEDICAL SCHOOLS

Donald Brayton, M.D., medical director, Kern Medical Center, Bakersfield, California, spelled out an extensive list of recommendations from the Association of American Medical Colleges for inclusion in the federal guidelines. These recommendations dealt with the certificate of need process and federal use of funds, which he described as areas of primary concern to medical schools. The guidelines include requirements for consideration of educational goals of teaching institutions in the conduct of HSA review, criteria development, timeliness of review, project renewal and continuation.

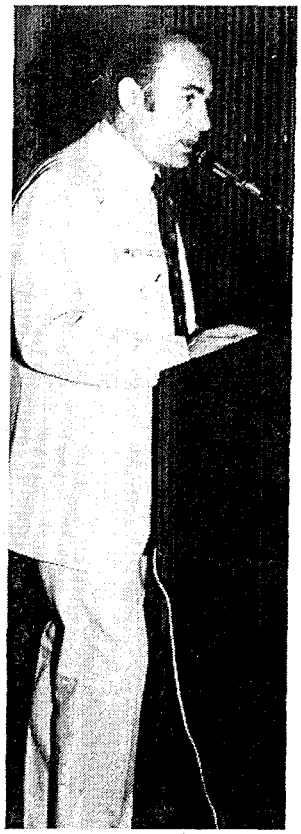
"There could be no doubt but that P.L. 93-641 is possibly the most intricate piece of legislation ever developed. It's guidelines and recommendations must of necessity be intricate. Our exchanges here will perhaps lead to more workable regulations and thereby may ultimately enhance the law's effectiveness."

SECOND PLENARY SESSION

The second of the plenary sessions dealt mainly with in-house matters, with emphasis on the future of successful RMP projects and future leadership in health matters.

Nathaniel Polster, NARMP Washington representative, expressed belief that if RMPs would focus on programs of Congressional priority and demonstrate effectiveness they would not only be likely to find funds for continuation of successful RMP projects but also would establish the kind of impressive record that results in leadership in re-writing P.L. 93-641 when the time comes.

Paul D. Ward, Executive Director of the California Regional Medical Program stated his belief that we may be at the low end of the Congressional funding curve for health now and must be ready to provide leadership when the upturn occurs. He urged RMPs, as the only group which understands the needs of consumers and providers and which demonstrates a comprehensive approach to health care, to continue the information flow to the legislative and administrative branches of federal government, to see that health dollars get appropriate priority, to use the multi-regional liaison committee to look for opportunities to provide information for appropriations committee hearings, to develop public accountability reports so that they are useful at the congressional and HEW levels and to work together to develop a stance regarding extension legislation.



PLENARY AND LUNCHEON SPEAKERS

P.L. 93-641 - As Viewed by a Governor

The Honorable Robert D. Ray, Governor of Iowa and Chairman, National Conference of Governors, State Capitol, Des Moines, Iowa 50319

P.L. 93-641 - Expectations of the Federal Administration

Kenneth Endicott, M.D., Director, Health Resources Administration, 5600 Fishers Lane, Rockville, Maryland 20852

P.L. 93-641 - As Seen by a Practicing Physician

Joseph F. Boyle, M.D., California Medical Association, 731 Market Street, San Francisco, California 94103

P.L. 93-641 - From the View of a Hospital Administrator

Stephen M. Morris, Past President, American Hospital Association; President Samaritan Health Service, 1410 North Third Street, Phoenix, Arizona 85002

P.L. 93-641 - Impact on Medical Schools

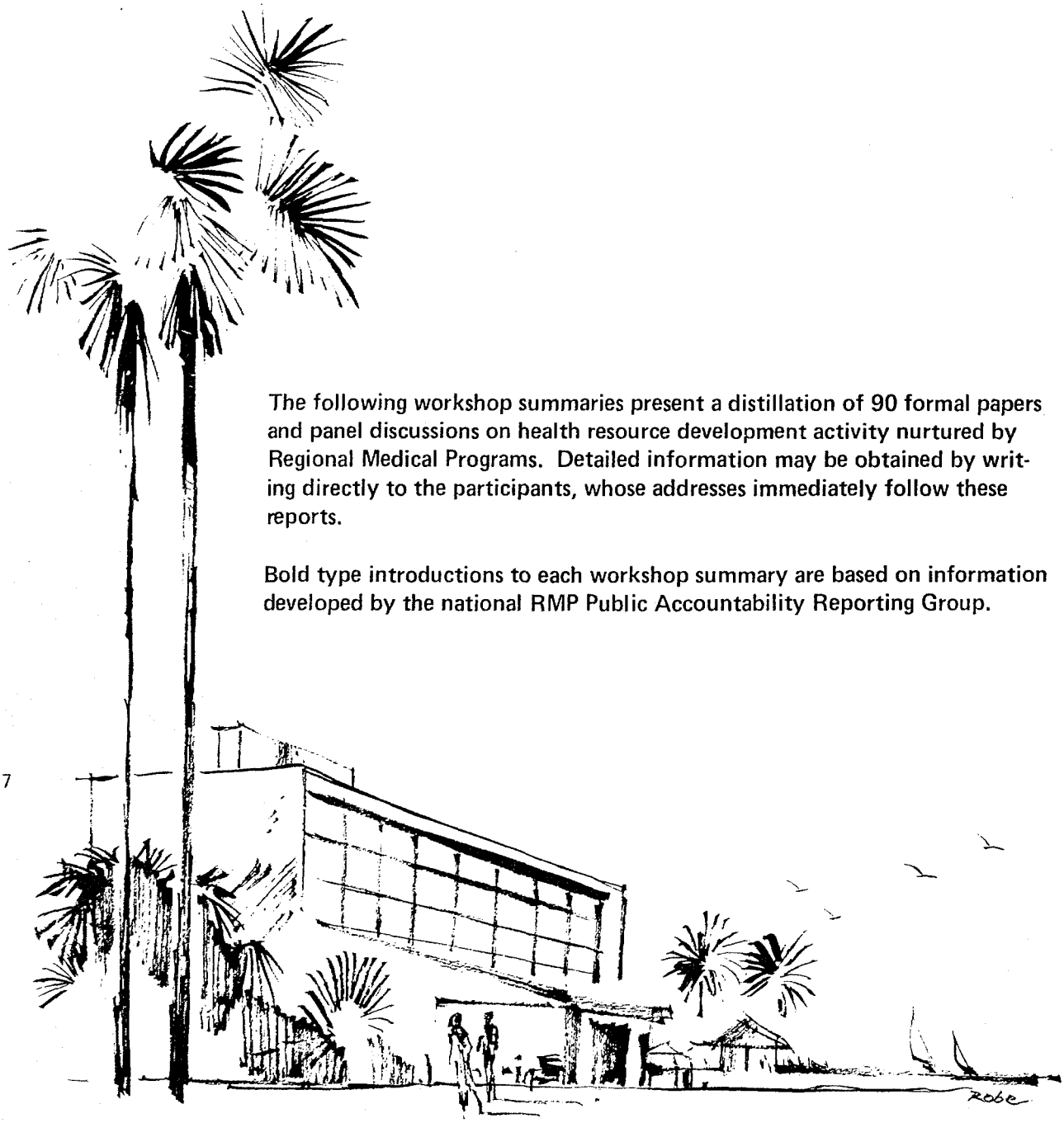
Donald O. Brayton, M.D., Medical Director, Kern Medical Center, 1830 Flower Street, Bakersfield, California 93305

Eugene J. Rubel, Acting Director, Bureau of Health Planning and Resources Development, Health Resources Administration, 5600 Fishers Lane, Rockville, Maryland 20852.

Harold Margulies, M.D., Deputy Director, Health Resources Administration, 5600 Fishers Lane, Rockville, Maryland 20852.

Nathaniel Polster, NARMP Washington Representative, 2128 Wyoming Avenue, N.W., Washington, D.C. 20008.

Paul D. Ward, Executive Director, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621.



The following workshop summaries present a distillation of 90 formal papers and panel discussions on health resource development activity nurtured by Regional Medical Programs. Detailed information may be obtained by writing directly to the participants, whose addresses immediately follow these reports.

Bold type introductions to each workshop summary are based on information developed by the national RMP Public Accountability Reporting Group.

ACKNOWLEDGMENT

Preparation of this San Diego meeting report was made possible with the generous help of the following individuals: Roger L. Beck, Virginia Regional Medical Program; June Estes, Mississippi Regional Medical Program; Patricia Estes, Tennessee Mid-South Regional Medical Program; J. R. Gallagher, Iowa Regional Medical Program; Katherine Herzog, Arkansas Regional Medical Program; Robert C. Hunt, South Dakota Regional Medical Program; Linda R. Johnston, Texas Regional Medical Program; Steve F. McCourtie, Michigan Regional Medical Program; Kay Page, North Carolina Regional Medical Program; Virginia Rodgers, Memphis Regional Medical Program; J. P. Smith, Colorado-Wyoming Regional Medical Program; Ellen Soo Hoo, Illinois Regional Medical Program; Jerold G. Sorensen, Intermountain Regional Medical Program; Carol Sympson, Ohio Valley Regional Medical Program; and Linda Wenze, Nassau-Suffolk Regional Medical Program.

WORKSHOP 1

ACCESS TO PRIMARY CARE

The provision of primary care services for medically underserved populations is first among ten priorities mandated for action under the provisions of Public Law 93-641. During the year which ended June 30, 1975, Regional Medical Programs wholly or partially funded some 550 new health service activities in the development of primary care services in rural and medically underserved areas.

Workshop participants discussed problems concerned with access to primary care in urban and rural areas, with the effectiveness of nurse clinicians and community health workers, with the role of the university in primary care manpower production and education, and with the problems facing the newly emerging Health Systems Agencies in dealing with ease of access and availability of health services.

Some of the findings:

Urban Programs

An example of an RMP function in an urban area was presented. One RMP effectively worked with Model Cities programs, using hospital-based resources, to establish and expand community ambulatory care centers. In this example, a dollar-for-dollar local match was required. These centers were rapidly accepted and continue their operations without RMP funds. The use of hospital-based resources provided several advantages:

> Hospitals were already located in each of the underserved areas. Use of these existing facilities avoided the necessity for costly development of new facilities or services;
>
> Physicians preferred delivering outpatient services in the hospital setting, which offered appropriate facilities and services, including established administrative systems.

In another example, an RMP incorporated a hypertension screening program sponsored by an inner city neighborhood health center as a means of stressing the importance of a specific disease process in an ambulant, black population. The intent was to develop or modify patterns of utilization of available resources. Through a successful program of detection, treatment, and improved compliance, the hypertension orientation augmented the comprehensive health care services offered by the center. Indigenous personnel were trained and used as outreach workers in the project.

Rural Programs

Use of technical and financial support to establish 12 rural community health centers was cited as an example of RMP efforts to improve primary care access in rural areas. Features of the program included: development of fixed sites for services; commitment of local funds or services; provision of varied types of health services; and establishment of minimums for times and types of services offered. A statewide committee on primary care has guided implementation of the project, and will aid in evaluation.

Manpower

An example of the evaluation of one type of physician extender has produced preliminary evidence that use of a nurse clinician in a rural solo practice can increase productivity by 20-30 percent. It would appear that increased use of such personnel might have a significant effect on the overall availability of primary care.

In another example, an RMP has a task force studying 44 projects utilizing the Community Health Worker to: describe utilization patterns; standardize methods of training; develop credentialling procedures; and develop third party pay or funding for community health worker services.

Role of the University

Panelists agreed that universities had not taken the lead in improving access to primary care, citing their preoccupation with other activities, and the lack of appropriate encouragement from federal funding sources. However, medical schools are now perceiving primary health care as a desirable avenue for teaching and research. A number of state legislatures, who provide a large portion of medical school budgets, have been urging production of more primary care providers and decentralization of the education process.

Problems for Health Systems Agencies

There is a necessity for HSAs to build on the RMP experience with respect to access to primary care. The following suggestions were offered:

1. Involve public officials in the planning process to facilitate implementation and continuation of health programs.

2. Provide educational programs for people involved in the planning process.

3. Coordinate the effective use of local resources.

Conclusions

Participants in the workshop expressed the following strong concerns:

1. It is vital that the accomplishments of RMPs in implementing programs to improve access and availability of health services be recognized as a basis for continued expansion.

2. There is no central agency in Washington responsible for improving access to primary care, a high priority component of P.L. 93-641. This situation contributes to the slow realization of the solution of this complex problem in health care delivery.

WORKSHOP PARTICIPANTS

ACCESS TO PRIMARY CARE

Moderators:

Robert W. Brown, M.D., Director, Kansas Regional Medical Program, 4125 Rainbow Boulevard, Kansas City, Kansas 66103

Marlene Checel, M.P.H., Director, Access to Primary Care Program, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

John A. Mitchell, M.D., F.A.C.S., Associate Professor, Community and Family Medicine, University of Arizona, 1501 North Camel Avenue, Tucson, Arizona 85724

Panelists:

Improving Access to Primary Care Through Hospital-Based Ambulatory Services in New Jersey
Alvin A. Florin, M.P.H., Coordinator, New Jersey Regional Medical Program, 7 Glenwood Avenue, East Orange, New Jersey 07017

Health Center Development in Arizona
Phyllis Reifurth, Health Systems Specialist, Arizona Regional Medical Program, 5725 East 5th Street, Tucson, Arizona 85711

Problems for the Health Systems Agencies in Access and Availability of Primary Care
John A. Mitchell, M.D.

Role of University in Improving Access to Primary Health Care
John A. Packard, M.D., Associate Dean, University of Alabama, College of Community Health Services, P. O. Box 6291, University, Alabama 35468

Categorical Entry to Primary Care - Project High Blood: Screening and its Aftermath
Samuel U. Rodgers, M.D., M.P.H., Project Director, Wayne Miner Neighborhood Health Center, 825 Euclid, Kansas City, Missouri 64124

The Community Health Worker
Gloria Ellis, Community Health Worker Component, Access to Primary Care, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

A Physician-Extender Study
Geraldine C. Holmes, Ph.D., Planning and Evaluation, Kansas Regional Medical Program, 4125 Rainbow Boulevard, Kansas City, Kansas 66103

Development of Primary Health Care Services in Los Angeles County
Loren G. McKinney, M.D., Assistant to Medical Director, Department of Health Services, 313 North Figueroa Street, Room 805, Los Angeles, California 90012

The Challenge
Teresita Moreno, Program Officer, New Mexico Health Cultural Awareness Program, 2701 Frontier Place, N.E., Albuquerque, New Mexico 87131

WORKSHOP 2

MANPOWER

The number of health professionals trained in new roles by RMP's for an 18-month period extending through June, 1975 has been estimated at 32,456. Categories include nurse practitioners, physicians' assistants, emergency medical technicians, and others. For the corresponding period, it is estimated that 5,120,000 people were served by these RMP-trained new health manpower providers.

The Health Manpower Workshop intended to step outside the day-by-day living and working experiences of health manpower planners, educators, and employees. One half of the program was devoted to identification of key issues and changing priorities with regard to health care delivery/education systems. The second segment examined recent work in the application of social science technology to health manpower planning.

One effective method for assuring balanced health manpower planning from small communities to statewide or regional areas - is through the comprehension and amplification of existing linkage systems. An individual linkage is the connection or relationship between two functions or between two people; a linkage system is the sum of all the individual linkages.

Many different agencies and organizations conduct health manpower planning activities. Seldom does any one group direct its planning at the broad range of health manpower as it is related to the total health care delivery system. A statewide linkage system concept is most useful when combined with a step-by-step planning process. Suggested process steps include: (1) assemble staff, (2) develop a work plan, (3) determine current process, (4) develop linkage mechanism, (5) develop planning process, (6) identify future conditions, (7) determine manpower supply and demand, (8) alternate strategies developed, (9) draft, test and publish a health manpower plan, and (10) develop a data collection system.

The decisions and priorities generated by the health manpower planning process are augmented by health manpower econometric models. It is important that these models be considered as tools for employment in the health manpower planning process.

When these tools are designed in cooperation with their users, local planners and decision makers; when these tools are powered by accurate, timely, appropriate data; and when these models are respected as abbreviated representation of reality; then they may be effective methods for determining future manpower supply and demand.

Several "micro" health manpower models were described. The thrust of these econometric efforts is the development of specific information for local level use in reaching health manpower planning decisions.

The sessions also received a detailed technical presentation on a new "micro" health manpower model. Such instruments are designed for use on regional, interregional or even national scales and may provide unique and useful insights into the over-all manpower arena.

The conference shifted from reviewing planning and modelling, to considering finds and conclusions from a number of specific strategies. These projects are aimed at health manpower solutions in the nurse practitioners, physician assistant, and physician extender realms.

The group studied some of the problems of developing, placing and evaluating innovative efforts for health manpower and related health programming strategies.

It was noted that most innovations come as a result of the efforts of a single charismatic person. When he leaves, the innovations vanish.

Innovations in health manpower education were studied. It was stressed that these approaches (AHEC, HS/EA, VA and others) are but one resource in the development of a community health education system. Community health

education efforts continue to be a prime consideration, since, historically, health education programs have done much in shaping the delivery of health care.

The importance of decision makers (gate keepers) in social action programs was stressed. Highlight of the workshop was a description of 40 years of technical work which resulted in the use of such models as the BHSDS, EMCRO, UHDD, and PSRO.

The health manpower workshop ranged through process for (1) developing small community data, to (2) statewide planning and to (3) the federal dilemma in applying national programs to regional requirements.

The challenge may be summed up in the idea that health planners, especially health manpower planners, should be aware of social, political and economic factors; but they should be keenly aware of the differences between what they, as planners, think is needed and what is really needed.

WORKSHOP PARTICIPANTS

MANPOWER

Moderators:

Donald G. Brekke, Director, South Dakota Regional Medical Program, 216 East Clark Street, Vermillion, South Dakota 57069

C. Kenneth Proefrock, Executive Director, Mahoning Shenango Area Health Education Network, 5211 Mahoning Avenue, Youngstown, Ohio 44515

Charles W. White, Ph.D., Program Director, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

Panelists:

Summary Analysis of Health Manpower Models
Timothy C. Doyle, Ph.D., Program Director, Vector Research, Inc., P. O. Box 1506, Ann Arbor, Michigan 48106

Manpower Planning Models and Quality Assurance
Paul Sanazaro, M.D., Director, Private Initiative & Professional Standards Review Organization, 703 Market Street, Suite 535, San Francisco, California 94103

Overview of the AHEC, VA, HS/EA Consortia Models
Lawrence H. Miike, M.D., J.D., Research Director, UC San Francisco Health Policy Program, Washington Study Group, 1828 L. Street, N.W., Suite 700, Washington, D.C. 20036

Some Economic Aspects of Health Manpower Planning
Donald E. Yett, Ph.D., Director, Human Resources Center, University of Southern California, Los Angeles, California 90007

Congressional Viewpoint on Health Manpower
Carl A. Taylor, Health Manpower Manager, Office of Technology Assessment, Congress of the United States, Washington, D.C. 20000

Problems of National and Areawide Planning for Appropriate Distribution of Health Personnel
William Shonick, Ph.D., Associate Professor of Public Health, University of California, Los Angeles, California 90024

Health Manpower Linkage Systems
B. Jerald McClendon, Project Coordinator, Health Manpower Planning and Linkage System, State Department of Health, Pierre, South Dakota 57501

Innovations in Health Manpower Training and Utilization
Charles E. Lewis, M.D., Chief of Division of Internal Medicine and Health Research, University of California, Los Angeles, California 90024

WORKSHOP 3

WORKSHOP III - REGIONALIZATION ACTIVITIES

Regionalization of services has been a major RMP goal from the beginning. During calendar years 1970 through 1974 it has been estimated that 10,962,000 patients received direct health services in demonstration projects having strong regionalization of secondary and tertiary care components. In 1974 alone, 2,276,000 persons received direct health services for heart disease, cancer, stroke, kidney, hypertension, pulmonary disease, arthritis and other disorders. Regionalization system development---statewide kidney transplant and dialysis networks, regional referral and transportation systems for neonatal intensive care, arthritis centers and support networks and other services---received more than $25 million, 22 percent of all RMP 1974-75 awards.

Perinatal - Neonatal

Although the value of perinatal centers has been extensively documented---one center recorded a drop in high risk infant mortality, from 200 per 1,000 to 150 per 1,000---panelists agreed with the sentiment that "if medical care is offered on a per pound basis, then newborns certainly need someone to fight for them."

Outreach education is for many RMP projects the first step toward regionalization of neonatal intensive care. "Mini-fellowships", in which physicians spend up to 10 days at a tertiary center as full members of the NIC unit staff and performing hitherto unfamiliar techniques, have encouraged participants in one project to train their own nurses in NICU techniques back home, starting the nucleus of a perinatal team for comprehensive infant care in the community. This "ripple" method of continuing education has helped to overcome many problems encountered in neontal/perinatal health care delivery; for example, infrequent deliveries in large, but sparsely populated geographic areas, the failure to transport patients appropriately among facilities, and the tendency of a physician to overextend himself by performing delicate techniques in which he is not proficient.

NICU ideal conditions will have been reached when high risk mothers are routinely detected beforehand, and their pregnancies completed in effectively managed centers.

However, such centers require expensive equipment and personnel not likely to be replaced as the RMP structure disappears as the result of Public Law 93-641.

Hypertension

The RMP commitment to community-level management of high blood pressure often linked with the early involvement of the American Heart Association, has spawned a variety of approaches. In one instance, a cardiovascular disease network, established after task forces recommended secondary and tertiary care programs, is now serving more than half the health districts of one state and the remainder are expected to become involved in the coming year.

Other projects dealing with screening and treatment within the existing health care system coupled with effective follow-up were supported in high impact urban settings, emphasizing peer group pressure "on the job." In one, control rate of 82 percent was achieved largely because of easily accessible care. Detection and readily available treatment are an effective team.

Another approach used a statewide council to provide coordination and technical assistance, establish priority activities, target efforts and assure evaluation. As a result, nine service areas around medical centers were established.

Efforts at hypertension control in isolated, small rural communities, hampered by physician shortages and inadequate transportation, has often led to the organization of community groups whose purpose is to deal with high blood pressure services and to seek widespread public utilization. A recently instituted mobile unit seems in one project, to be more successful in attracting large numbers of the public than a stationary clinic.

Emergency Medical Services

The amalgamation of diverse political jurisdictions to build a truly regional EMS system can involve major obstacles to success. Included among them are a lack of contact and communication with top executives of the various jurisdictions, Federal Communications Commission rules changes and radiobroadcast problems. The planning and implementation of improved emergency health care must, however difficult, include at the earliest stages a realistic plan for evaluation of the developing system. Rural EMS systems, panelists were told, suffer from a number of special problems, among them, the absence of even one conforming ambulance, lack of appreciation for the elements desired and the importance of quality EMS, and a geographic territory and population mix that are not in compliance with funding agency requirements.

Other Regionalization Activities

Inadequacies in rural health care delivery were reduced in one region by a project designed to have a large well established group practice clinic coordinate services throughout more than 100 hospitals and clinics. Outreach activities included physician consultation, computer assisted electrocardiography; reference laboratory, blood banking, equipment repair and maintenance, psychiatry, psychology and psychiatric social services, electroencephalographic interpretation, neonatal emergency care, pulmonary function testing and remote continuous cardiac monitoring.

Solutions in one large state with complex geographical and cultural barriers were found by opening many new clinics and generating local support. Supplementary services were developed by recruiting and training interested community members to coordinate and monitor local planning efforts and health programs.

Panelists heard of a 10-year old program that began in a large state as a home health agency. Since RMP involvement, it has added early and periodic screening; diagnosis and treatment, lead poisoning and senior citizen screening, family planning, alcoholic rehabilitation and detoxification, dental education, in-service education for hospital and nursing home staffs and a comprehensive clinic program staffed by physician assistants in three rural communities.

Still a different type of regionalization project by an RMP, concerned itself with adverse drug reactions suffered by patients in 10 participating hospitals. Patients were monitored, reactions recorded and controlled. The additional pharmacy and drug information and poison control data have been shared, and the project provides continuous, easy access to the latest pertinent information through a network serving 450,000 patients per year.

Kidney Disease Control

Necessary components for a successful kidney disease control program are a transplant center, facilities for tissue typing, organ preservation and organ procurement center, limited care services, home and satellite dialysis, and ancillary laboratory facilities. Most of the projects described for panelists were begun five years ago and included statewide kidney disease information systems, nephrology manpower studies, formation of a society of transplant surgeons, training of surgeons in renal transplantation and professional and public education designed to lead to organ procurement.

Traditional physician cooperation to improve care of end-stage renal disease patients has recently been augmented by joint efforts in organ sharing, cooperation in immunology, organization of common transplant recipient pools, more formal referral and organ harvesting networks, and passage of pertinent legislation.

Professional education efforts have been highly successful, with high attendance at training workshops, and dramatically improved viability of harvested organs and organ retrieval rates.

One project concerned with public education funded through the Kidney Foundation found that three out of four persons surveyed expressed positive feelings about medical transplantation, and better than half felt positive about donating specific parts of their own bodies.

Many states have recently passed legislation authorizing organ donor pledges on driver licenses, millions of dollars for hemodialysis, new definitions of death and the easing of restrictions on home dialysis patients.

Arthritis Control

A shortage of physicians specializing in rheumatology, a severe maldistribution of those who practice, and a clear need for continuing education of doctors, nurses, physical therapists, social workers, and allied health care team members hamper this emerging medical specialty. Panelists were told that fewer than 500 physicians are board certified in the nation; most are in California, and those are concentrated in Los Angeles - San Francisco. This occurs in spite of the

fact that patients appear to be evenly distributed throughout the country.

Against this background, innovative solutions are sought. In one project, a rural care model was developed. Local physicians identified as community coordinators were combined with other health personnel to compose a local arthritis care team. Consultative clinics and patient family education were held in local communities with visiting consultants examining, evaluating and prescribing comprehensive treatment that was to be carried out by the referring physicians.

Arthritis centers may focus on development of sub-regional clinics, special problems of children with arthritis, professional and lay education, assistance and regular physician visits to widely dispersed communities, evaluation, follow-up and monitoring of patient progress, and linking all state physicians into a medical information service system by telephone. Another goal is to establish rheumatology as a high-need specialty among physicians, nurses and other health care providers, with special emphasis on those physicians in training for family practice. Not forgotten are the all important policy-making medical institution administrators.

Cost Sharing

Objectives of shared services include the provision of otherwise unavailable services, prevention of loss of autonomy to otherwise stronger forces; i.e., government or competing organizations, through cost reduction, better patient care, reduced inventory, and attempting to satisfy competing demands and consumer criticisms. Cooperation on common problems such as in-service training needs, shortage and turnover of personnel, communication and practical "do it yourself" answers can lead to many benefits and, eventually, to self-sufficiency through cost savings. Sharing of lessons learned in fiscal management and administration, and in developing acceptable peer review systems are other outcomes that lead to additional benefits.

Cancer Control

Regionalization of RMP-funded cancer control projects has resulted in a higher quality of care for cancer patients, more efficient utilization of medical personnel and the ability to centralize certain key services previously handled by disparate organizations.

Panelists were told that successful cancer regionalization activities have several characteristics in common. Usually the project relates to health problems that no single agency can handle alone. Usually the project affects a large geographic area and involves some highly specialized activity or some technology that is new, scarce and expensive. Participating institutions in the regionalization activity include those organizations that were recognized centers of excellence before the project was initiated. Results can build closely-knit networks of major therapy resources, statewide tumor registries, radiation therapy and visiting consultant programs, annual statewide cancer workshops, facility planning and development for new centers, clinical traineeships, shared allied health personnel projects and vastly improved patient care.

WORKSHOP PARTICIPANTS

REGIONALIZATION ACTIVITIES

Perinatal-Neonatal

Moderator:

Sheldon Korones, M.D., Newborn Center, John Gaston Hospital, 860 Madison Avenue, Memphis, Tennessee 38103

Panelists:

A Multi-State Rural System Development Effort in Neonatal Care
Sidney C. Pratt, M.D., Project Director, P. O. Box 2829, Great Falls, Montana 59401

Regionalization of Neonatal and Perinatal Activities
Sheldon Korones, M.D.

The Regionalization of Perinatal Care in Wisconsin
Craig Anderson, M.D., 5721 Odana Road, Madison, Wisconsin 53719

Florida's Perinatal Program
Richard Boothby, M.D., Project Director, Hope Haven Children's Hospital, 5720 Atlantic Boulevard, Jacksonville, Florida 32207

Regionalization of Perinatal Care in the State of Kansas
Howard Fox, M.D., Department of Pediatrics, University of Kansas Medical Center, Rainbow Boulevard at 39th, Kansas City, Kansas 66103

Hypertension

Moderator:

Elliot Rapaport, M.D., President, American Heart Association, 1370 Mission Street, San Francisco, California 94103

Panelists:

Regionalization of Hypertension Services
Morris M. Bradley, 938 Peachtree Street, N.E., Atlanta, Georgia 30309

The Future of Community Hypertension Control Funding Under Recent Federal Legislation
Howard J. Bochnek, M.E., Coordinator of Hypertension Control Program, Metropolitan New York Regional Medical Program, 2 East 103rd Street, New York, New York 10029

Regionalizing High Blood Pressure Control in California
Adelbert L. Campbell, Director, Program Coordination and Development, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

Development of a Statewide Hypertension Registry Program
Robert S. John, Assistant Director of Program Development, Illinois Regional Medical Program, 122 South Michigan, Room 939, Chicago, Illinois 60603

Planning for a Hypertension Control Program in a Rural Area
John L. Isbister, Chief, Bureau of Community Health, Michigan Department of Public Health, 3500 North Logan, Lansing, Michigan 48914

Emergency Medical Services

Moderator:

James O. Page, Project Director, Lakes Area Regional Medical Program, 2929 Main Street, Buffalo, New York 14214

Panelists:

Regionalization of Emergency Medical Services Activities
Vaughan E. Choate, 2007 I Street, N.W., Washington, D.C. 20006

Regional EMS Program: An Example of Cooperative Planning and Funding
Alan Dimick, M.D., Department of Surgery, University of Alabama, University Station, Birmingham, Alabama 35294

Emergency Medical Service in Northeast and North Central Missouri
Jacqueline C. Hall, R.N., Kirksville College of Osteopathic Medicine, Kirksville, Missouri 63501

Review of Developing Rural EMS Systems
Richard Walsh, M.D.; Joan Baker, R.N., 2701 Frontier Place, N.E., Albuquerque, New Mexico 87131

Other Regionalization Activities

Moderator:

Gordon R. Engebretson, Ph.D., Director, Florida Regional Medical Program, 1 Davis Boulevard, Suite 307, Tampa, Florida 33606

Panelists:

North Central Outreach Program
David L. Draves, Director, Regional Medical Services, Marshfield Clinic, Marshfield, Wisconsin 54449

Regional Health Resources Development in New Mexico
Frank A. Otero, Project Director, Community Health Resource Development Project, New Mexico Regional Medical Program, 2701 Frontier Place, N.E., Albuquerque, New Mexico 87131

Regionalization of Health Services in Central Maine
John LaCasse, Deputy Coordinator, Maine Regional Medical Program, 295 Water Street, Augusta, Maine 04330

Regional Drug Information Network
Carol McCarthy, Associate Director, Nassau-Suffolk Regional Medical Program, 1919 Middle Country Road, Centereach, New York 11720

Kidney Disease Control

Moderator:

Frederick C. Whittier, M.D., Chief, Nephrology Section, Veterans Administration Hospital, 4801 Linwood Boulevard, Kansas City, Missouri 64128

Panelists:

Impact of RMP on End Stage Renal Disease in Arkansas
Tom E. Brewer, M.D., Assistant Professor, University of Arkansas for Medical Sciences, 4301 West Markham Street, Little Rock, Arkansas 72201

Experience with Criteria Setting in Two Dialysis Units
Arlene Sukolsky, Kidney Project Director, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

A Survey of Public Opinion on Transplants
Jackie K. Reinhardt, Coordinator, Transplantation Council of Southern California, 1281 Westwood Boulevard, Suite 207, Los Angeles, California 90024

Chronic Kidney Disease Patient Care Systems
H. Earl Ginn, M.D., Chief, Nephrology Division, B2218 Medical Center, Vanderbilt University, Nashville, Tennessee 32232

The Renal Program for Texas
Robert Humble, Deputy Director, Community Programs, Texas Regional Medical Program, 4200 North Lamar Boulevard, Room 200, Austin, Texas 78756

Arthritis Control

Moderator:

David D. Shobe, The Arthritis Foundation, 1629 "K" Street, N.W., Washington, D.C. 20006

Panelists:

Intermountain RMP Discrete Arthritis Activity
Steven J. Anderson, M.D., 325 Seventh Avenue, Salt Lake City, Utah 84103

Arthritis Activities of the Tennessee-Mid South RMP
Richard O. Cannon II, M.D., Director, Tennessee-Mid South Regional Medical Program, 110-21st Avenue South, Suite 1100, Nashville, Tennessee 37203

California RMP Pilot Arthritis Program: Initial Steps Toward the Regionalization of Care for Patients with the Rheumatic Diseases
Charlene Brax, M.P.H., Arthritis Project Director, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

A Model Center-To-Clinic Project
Gene V. Ball, M.D., Professor of Medicine, Division of Immunology and Rheumatology, University of Alabama in Birmingham, University Station, Birmingham, Alabama 35294

Cost-Sharing

Moderator:

Albert M. Donnell, Coordinator, Oklahoma Regional Medical Program, P. O. Box 26901, Oklahoma City, Oklahoma 73190

Panelists:

Oklahoma Regional Health Development Area Program (RHDAP)
Albert M. Donnell

Green Hills Area Cooperative Health Care Project
Herbert Henry, Noll Memorial Hospital, Box 428, Bethany, Missouri 64424

Regionalizing Management
John Richey, Assistant Director, Grants Management, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

Regional Medical Audit Review System
Jack Rorex, Director, Health Planning, White River Planning and Development District, P. O. Box 2396, Batesville, Arizona 72501

Cancer Control

Moderator:

Alfred M. Popma, M.D., 1903 S. Roosevelt, Boise, Idaho 83704

Panelists:

The Illinois Cancer Council: An Experiment in Regionalization
Lorraine C. Hannah, Program Administrator, Illinois Cancer Council, 122 S. Michigan, Room 939, Chicago, Illinois 60603

Automated Treatment Planning for Radiation Therapy in Arkansas
Alex P. Turner, Ph.D., Assistant Professor, University of Arkansas for Medical Sciences, 4301 West Markham, Little Rock, Arkansas 72201

Regionalization of Cancer Services
Francis Morrison, M.D., University of Mississippi Medical Center, Jackson, Mississippi 39216

The Regionalization of Cancer Services in Georgia
Don J. Trantow, 938 Peachtree Street, N.E., Atlanta, Georgia 30309

WORKSHOP 4

QUALITY ASSURANCE PROGRAMS

Quality Assurance of health care has been a priority area for RMP resources since 1970. From that time through June, 1975 it is estimated that 143,820 health professionals have been trained in techniques to systematize standards for and determine deficiencies in medical care, develop corrective action and implement activities which result in demonstrably improved quality of care.

The Quality Assurance Workshop provided a forum in which twenty-eight speakers presented information on a variety of RMP-funded efforts to improve patient care through quality assurance projects. Papers dealt with programs in hospitals, nursing homes, and home health care in both urban and rural settings, the development of innovative collaborative arrangements between disciplines to provide quality care, attempts to establish and evaluate quality care standards, management criteria and performance feedback for specific diseases such as hypertension, coronary and pulmonary disease, and for laboratories. Discussion of Professional Standards Review Organization (PSRO) and Joint Commission on Accreditation of Hospitals (JCAH) involvement concentrated on current functions, relationships between professional organizations and RMPs, and the future of health care quality assurance from the federal perspective.

Hospital Quality Assurance Programs

Quality assurance efforts should maintain and improve medical care of patients, and outputs should be professional education, development of new programs of patient care and patient education, and changes in the administration and structure of the system itself.

A key element in initiating quality assurance efforts in hospitals is the establishment of close, positive working relationships with medical and administrative staffs to insure that a quality assurance system, whether urban or rural, will be accepted and operational. A few highly motivated physicians and hospital administrators might form the nucleus of the group designated to establish the system.

The process of establishing criteria has been improved by including patients as participants on hospital medical audit committees. The multidisciplinary approach, which includes physicians, nurses, medical records administrators, hospital administrators and trustees, pharmacists and dentists, has proved highly effective in meeting JCAH and PSRO requirements. Peer review of emergency room medical records has proven as effective as physician interview and examination of patients after discharge.

Non-Hospital Quality Assurance Programs

Although efforts to evaluate patient care in ambulatory settings are not yet mandatory, nor as developed as hospital programs, studies are being conducted to test various current methods of evaluating ambulatory care.

An attempt is being made to validate the "tracer" method utilizing discrete, identifiable health problems in relation to one another.

The relationship between process and outcome approaches in outpatient care has shown that these two methods when applied to hypertensives do not yield similar conclusions, and that cases must be categorized by severity of disease.

Nurses in skilled nursing facilities in an expanded role provided through training document patients' treatment plans, disease status and daily activities more completely, are better able to assess the total patient's needs and provide more appropriate and better quality care.

Quality Assurance Projects Among Professional Disciplines and Organizations

The presentation included programs to train nurses in the development of patient health outcome criteria through seminars using the nominal group technique, and to validate criteria through seminars where outcomes were critiqued by researchers; to computerize a reporting system using social workers in health care to conduct research to study their effectiveness and establish norms for social work service delivery; to develop standards and guidelines for reviewing individual certificate of need applications utilizing a mathematical model and a panel of experts; to train medical records associates in audit procedures, and to use medical self-audit to point out needs for continuing education among an organization of private medical practitioners.

Quality Assurance Programs Related to Specific Diseases

Discharge summaries were evaluated in order to determine changes in blood pressure levels of hypertensive patients resulting from educational programs; it was found that present techniques for educating such patients have proved successful only temporarily and that better methods must be sought.

Through the conduct of medical audit for a hypertension registry, established criteria provided to hypertension clinics are used to reallocate resources according to the needs of patients.

Setting standards for data collection and providing performance feedback have led to improved patient care and a 50 percent drop in in-hospital mortality from acute coronary disease.

In an area of high incidence of respiratory problems and considerable patient movement between hospitals, pulmonary care standards and a computerized inter-link system have led physicians to use findings of tests completed at other hospitals and to avoid repetition.

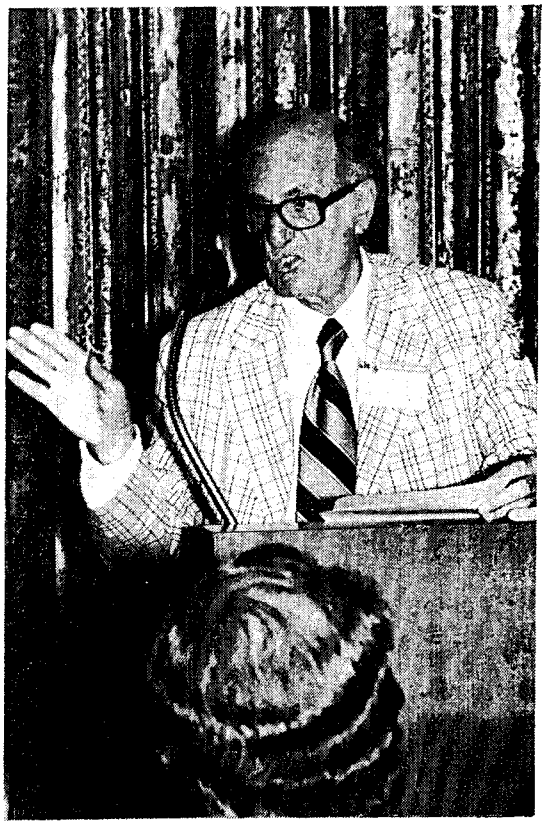
Small rural hospitals with few trained laboratory personnel formed a preceptorship system stressing feedback to health care professionals on how their performance met standards.

JCAH and Federal Perspective

Quality assurance activity as a continuing trend in health care has shifted from voluntary to required. Assessment of the actual process of health care delivery and the outcome of health care services has taken precedence over assessment of structure. Organized quality assurance activity has expanded from the acute hospital setting to the long term care and ambulatory sector and has become more the ongoing responsibility of organized external groups than the function of internal staff committees on an episodic basis.

Major quality assurance issues will be review of additional nonfederally funded care by PSROs, the need to prepare for National Health Insurance, the need for a national strategy to define problems, address them and establish priorities, and the need to reduce over-reliance on PSROs as mechanisms to lower costs.

PSROs should function as coordinating nuclei for community-wide quality assurance systems which include representatives from all health care disciplines and reflect needs and practices of the locality.



WORKSHOP PARTICIPANTS

QUALITY ASSURANCE PROGRAMS

Current PSRO Activities

Moderator:

Samuel R. Sherman, M.D., Director, Quality of Care Program, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

Speaker:

Edward Zivot, Executive Director, California PSRO Support Center, 215 Market Street, Suite 1301, San Francisco, California 94105

Hospital Quality Assurance Programs

Moderator:

Leslie Sandlow, M.D., Vice President for Professional Affairs, Michael Reese Hospital and Medical Center, 29th Street and Ellis Avenue, Chicago, Illinois 60616

Panelists:

Quality Assurance in Community Hospital
William P. Nelson III, M.D., Associate Professor of Medicine, Veterans Administration Hospital, Albany, New York 12208

Rural Hospital Quality Assurance Consortia
John T. Rorex, Director, Health Planning, White River Planning & Development District, P. O. Box 2396, Batesville, Arizona 72501

Health Care Review in Rural Hospitals
Robert H. Barnes, M.D., Director, Health Care Review Center, 909 University Street, Seattle, Washington 98101

Quality Assurance Workshop and Follow-up System
Samuel R. Sherman, M.D.

Evaluation of Nurse Practitioner in a Hospital Emergency Room Department
Glen E. Hastings, M.D., Associate Professor of Medicine, University of Florida, Center House Inn, 1400 N.W. 10th Avenue, Suite 15F, Miami, Florida 33136

Non-Hospital Quality Assurance Programs

Moderator: **Robert G. Rowland,** Coordinator, Quality of Care Program, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

Efficacy of Tracers in Ambulatory Care
Ira Gabrielson, M.D., Chairman, Department of Community and Preventive Medicine, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphis, Pennsylvania 19129

Quality Assessment Through Outcome Analysis
Fred Nobrega, M.D., Director, Health Care Research Unit, Mayo Clinic, Rochester, Maine 55901

Improvement of Quality of Care in Skilled Nursing Homes
Patricia Wihtol, R.N., Nursing Instructor, 16 Crescent Ave., Scituate, Massachusetts 02066

Patient Care Audit in Skilled Nursing Facilities
Lila Maples, R.N., President, California Nurses Association, 2172 DuPont Drive, Suite 215, Irvine, California 92664

Quality Assurance in Home Care
Rita Berkoben, Project Director, Quality Assurance Project, Pennsylvania Assembly of Home Health Agencies, 200 Meyran Avenue, Pittsburgh, Pennsylvania 15213

Professional Disciplines and Organizations

Moderator: **Kay Horswill, R.N., M.S.,** Nursing Coordinator, Wisconsin Regional Medical Program, 5721 Odana Road, Madison, Wisconsin 53719

Panelists:

Patient Outcome Criteria by Peer Review
Connie Keyes, R.N., M.S., Project Associate and Clinical Nurse Specialist, 6622 Maywood Avenue, Middleton, Wisconsin 53562

Computerized Social Work for Patient Care Project
Miriam Birdwhistell, A.C.S.W., Ed.D., Chairman, University of Virginia Medical Center, Division of Social Work, Box 275, Charlottsville, Virginia 22903

Developing Standards for Specialty Care
Skip Habich, Associate Coordinator, New Jersey Regional Medical Program, 7 Glenwood Avenue, East Orange, New Jersey 07017

California Medical Records Quality of Care Project
Cynthia A. Boudreau, R.R.A., Member, CMRA Committee on Patient Care Audit, 250 Masonic Avenue, San Francisco, California 94118

Medical Association's Voluntary Self-Audit
Daniel Hamaty, M.D., Director, Connecticut Medical Institute, 90 Sargent Drive, New Haven, Connecticut 06551

Specific Diseases and Procedures

Moderator: **Edward W. Francisco, Ph.D.,** Coordinator, Northern New England Regional Medical Program, Executive Square, 346 Shelburne Road, Burlington, Vermont 05401

Panelists:

Assessment of Quality of Care for Hypertensives
Gerald Wolf, M.D., Associate Professor of Radiology and Pharmacology, University of Nebraska, 42nd Street and Dewey Avenue, Omaha, Nebraska 68105

Use of a Hypertension Registry in Medical Audit
Fredric L. Coe, M.D., Director Renal Division, Michael Reese Hospital, 29th Street and Ellis Avenue, Chicago, Illinois 60616

Coronary Care Management Criteria
Richard E. Bouchard, M.D., Associate Professor of Medicine, University of Vermont, Burlington, Vermont 05401

Laboratory Standards
Clay Elting, Allied Health Specialist, Washington/Alaska Regional Medical Program, 1107 N.E. 45th Street, Suite 500, Seattle, Washington 98105

Pulmonary Care Standards
Tom Pace, Coordinator, Quality of Care Programs, Intermountain Regional Medical Program, 540 Arapeen Drive, Suite 201, Salt Lake City, Utah 84108

Future of Quality Assurance Programs

Moderator: Samuel R. Sherman, M.D.

Speakers: John D. Porterfield, M.D., Director, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Illinois 60611

Leslie Ford, M.D., Division of Peer Review, Bureau of Quality Assurance, 5600 Fishers Lane, Rockville, Maryland 20852

WORKSHOP 5

IMPLEMENTATION OF PUBLIC LAW 93-641

With inflation in the health industry rising 50 percent faster than the federal economy panelists saw governmental intervention in the market place as inevitably growing, and the Health Planning and Resources Development Act of 1974 as perhaps a fresh attempt to solve a stubborn problem. Intending to combine health planning as a tool of regulation to achieve effective cost controls and more optimal distribution of health services, the law poses difficult and complex choices.

Health Systems Agencies are being developed as both advocates of areawide health needs and enforcers of Department of Health Education and Welfare policy. In its administration of the legislation DHEW will try to satisfy Congress, on whom it depends for funding; similarly the HSAs will implement the law as satisfactorily to the department as possible. But in this process it was felt there is likely to be a blunting or a disregard of the legitimate needs for health services arising from local communities.

The Congressional charge to the HSAs is much more sharply focused than it was for Comprehensive Health Planning Agencies; statutory authority will be much greater. Selection of HSA board members with mandated representation quotas, should include "the yeast of at-large, maverick consumers and nonestablishment consumers" to forestall provider or establishment domination of board direction. The very explicitness of the law and its inherently contradictory elements may overwhelm the health planning process and cripple its operation.

Public Law 93-641 evokes a particularly skittish reaction from hospitals, since they receive such a large share of the health care dollar and thus feel most vulnerable to new regulatory procedures. The law pumps planning in at "too late a stage" and gives the impression that regulation pre-empts planning rather than being an accompaniment to it. While hospitals may not have a cohesive stand, the new law nevertheless engenders widespread dissatisfaction. It does not regulate in a simple, easy to understand manner; some of its regulations cannot be equitably administered; others cannot be administered at all. Perhaps sixty per cent of the federal cost control effort is likely to be directed at hospitals, yet they may have no more than one or two representatives on an HSA governing board.

Control over much of the health care system in the United States is passing through this legislation into the hands of the Secretary of DHEW, allowing him to exert whatever measures he finds necessary to achieve the purposes of the law. His power over state agencies and how they operate, through the withholding of Public Health Service funds from states deemed to be implementing the law too slowly, or inappropriately, is immense; it usurps traditional prerogatives of state government.

If the state fails to meet the requirements of the law and of the Secretary within a specified time, then the Secretary may withhold all federal health funds appropriated under the Public Health Service and related acts from use within that state. This could involve a significant sum of funds since this group of federal acts includes all federal funds for research grants, medical education, nurse training, allied health, mental health, mental retardation, alcoholism programs, facility construction, support funds for Departments of Public Health, and other related programs. These funds may not only provide support for state activities, but also go to universities, local government and some private non-profit corporations.

State powers are further eroded through Public Law 93-641 by the mandate that acceptable certificate of need legislation must be passed before a state government can enter into an agreement with the DHEW Secretary. Providers believe that such legislation must be linked with rate-setting; the rate-setter ought not be an important major purchaser of health care, as both state and federal governments are. Thus, there is a glaring conflict of interest in the new law permitting the Secretary of DHEW to be both a regulator and a purchaser of health care services, leading to captured regulation in the hands of vested interests.

Finally, although it appears that a majority of the HSAs now being developed to fulfill the first purposes of the legislation will have received conditional designation by June 30, 1976, there is no clear commitment to fund the program at levels sufficient to begin realistically to achieve the ends of the new law.

WORKSHOP PARTICIPANTS

IMPLEMENTATION OF P.L. 93-641

Planning

Moderator: **Gary Fink,** Associate Coordinator, Iowa Regional Medical Program, Oakdale Hospital, Oakdale, Iowa 52319

Panelists:

Progress Report on Health Systems Agencies
Collin Rorrie, Ph.D., Assistant to the Associate Director, Health Resources Planning, Health Resources Administration, 5600 Fishers Lane, Rockville, Maryland 20852

Functions, Staffing and Board of Health Systems Agencies
Steve Sieverts, Special Consultant, American Hospital Association, One Farragut Square South, Washington, D.C. 20006

Health Systems Agencies: Advocates of Community Needs or Enforcers for DHEW
Darwin Palmiere, Ph.D., Dean, Human Resources, State University College, Brockport, New York 14420

Regulation

Moderator: **Paul D. Ward,** Executive Director, California Regional Medical Program, 7700 Edgewater Drive, Oakland, California 94621

Panelists:

Theory and History of Regulation
Henry Zaretsky, Ph.D., Director of Research, California Hospital Association, 925 "L" Street, Suite 1250, Sacramento, California 95814

Regulatory Aspects of P.L. 93-641
Paul D. Ward

Health Facility's Reaction to P.L. 93-641 Regulation
Robert Derzon, Director, Hospitals and Clinics, University of California Medical Center, San Francisco, California 94143

Health Resource Development

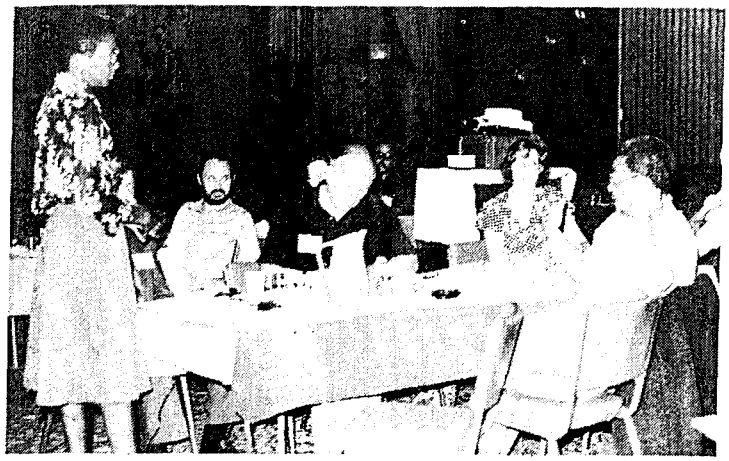
Moderator: **Charles D. Holland,** Director, West Virginia Regional Medical Program, 258 Stewart Street, Morgantown, West Virginia 26506

Panelists:

Title XVI Replaces Hill-Burton Agencies
Edward N. Duncan, Director, Facilities Development, Bureau of Health Planning and Resources Development, 5600 Fishers Lane, Room 12-11, Rockville, Maryland 20852

Resource Development by the State and by the Health Systems Agency
Charles D. Holland

Resource Development and the Federal Government
Richard L. Russell, Chairman, Developmental Fund Work Group, Bureau of Health Planning and Resources Development, 5600 Fishers Lane, Room 11A-46, Rockville, Maryland 20852



HEALTH CULTURAL AWARENESS

Health Cultural Awareness

Failure of health planners to take into consideration varying cultural backgrounds often leads to health legislation and programs that neglect the very people they were designed to serve. Usually such people are of ethnic minority groups whose approach to health problems differs widely from that of the majority.

The Health Cultural Awareness discussion was conducted in response to a request from Regional Medical Program coordinators to consider the needs of these minority groups. Sponsored by the Center for Human Resources Planning and Development (7 Glenwood Avenue, East Orange, New Jersey 07017), the session included presentations by a multi-cultural panel of experts, representatives of a variety of health programs and agencies, both public and private.

Panelists related their personal experiences and cultural differences and similarities in terms of ethnically traditional as well as current and projected health needs. Viewpoints specifically represented included Island Blacks, Chinese, Mexican-Chicano, American Indian and Puerto Rican. Panelists called for a plan of action that would incorporate ethnic and cultural considerations appropriately into national health legislation.

NATIONAL ASSOCIATION OF REGIONAL MEDICAL PROGRAMS

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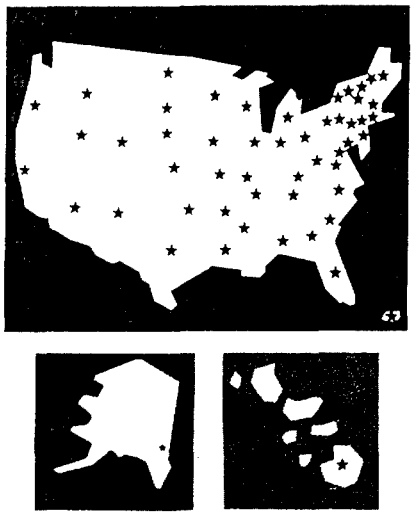

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