
E000739

division of
regional
medical
programs

A communication device designed to speed the exchange of news, information and data on Regional Medical Programs

MAGAZINE FEATURE - Regional Medical Programs Today And In Historical Perspective

September 29, 1969 - Vol.3, No. 27

As a public service the System Development Corporation of Santa Monica, California, has devoted its entire September, 1969 issue to Regional Medical Programs, and a copy is attached for your review.

The lead article tells the story of the development of Regional Medical Programs in historical perspective, and also brings their current activities and problems clearly into focus.

The remaining two articles detail the development and some of the on-going activities of the Tennessee Mid-South and Mountain States Regional Medical Programs.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service • Health Services and Mental Health Administration • Bethesda, Maryland 20014

SDC MAGAZINE

739

Published by System Development Corporation

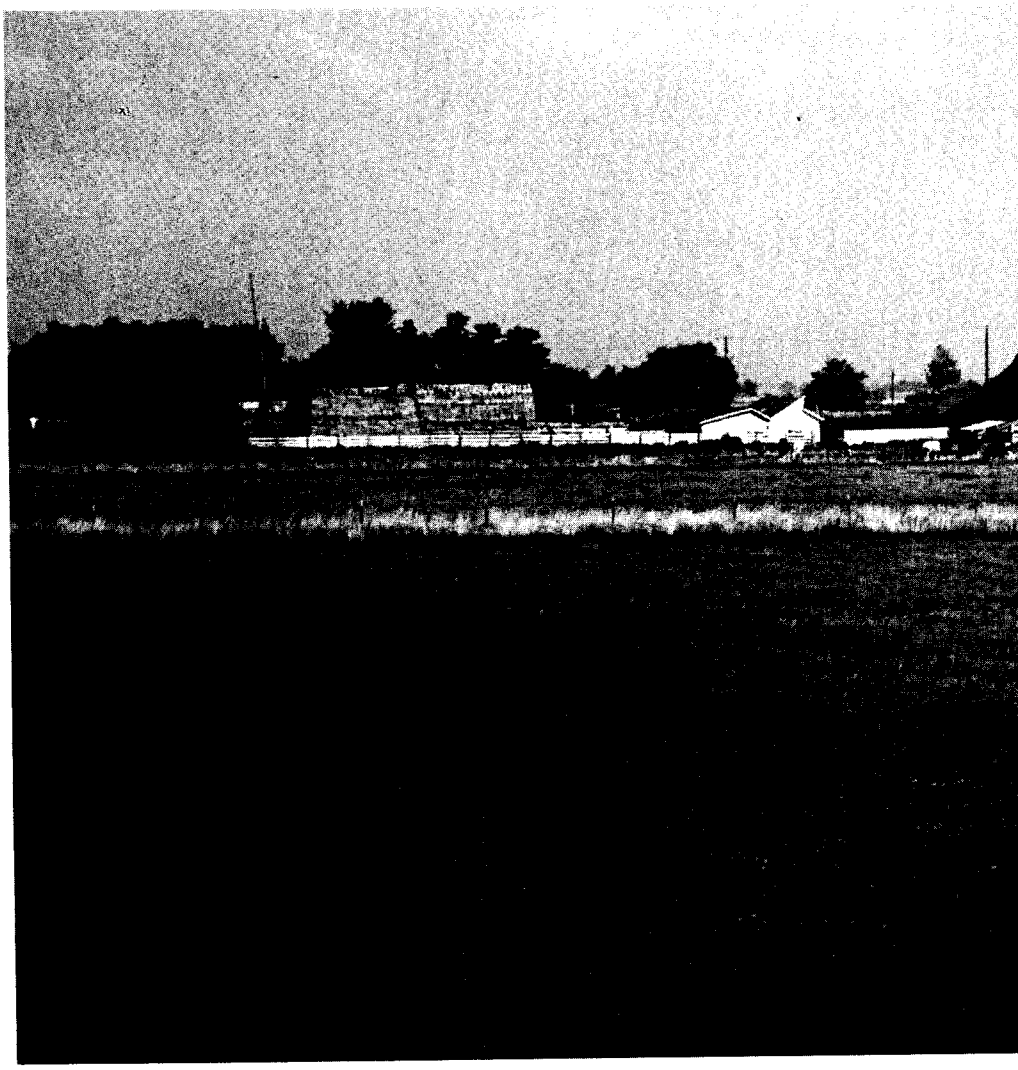
Volume 12 Number 8

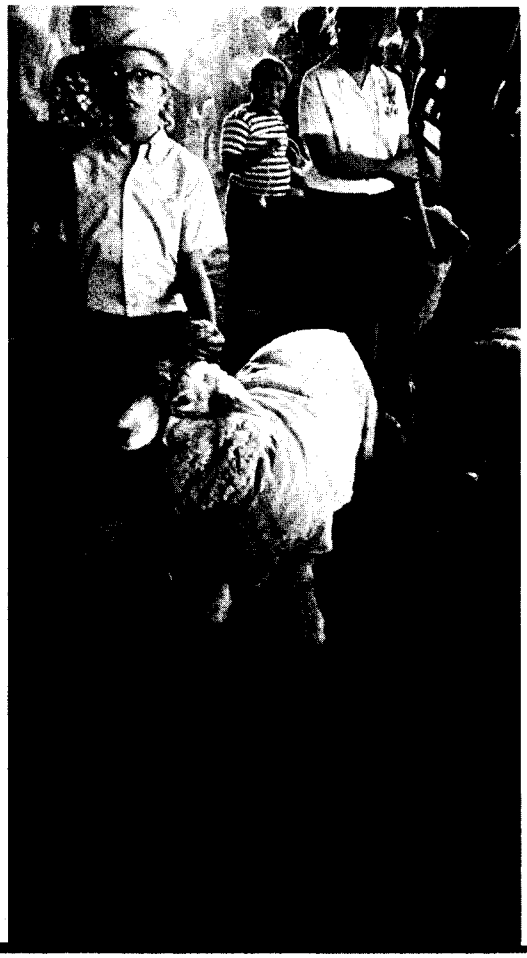
September 1969
Volume 12 Number 8
SDC MAGAZINE
SYSTEM DEVELOPMENT CORPORATION
2500 Colorado Avenue
Santa Monica, California 90406

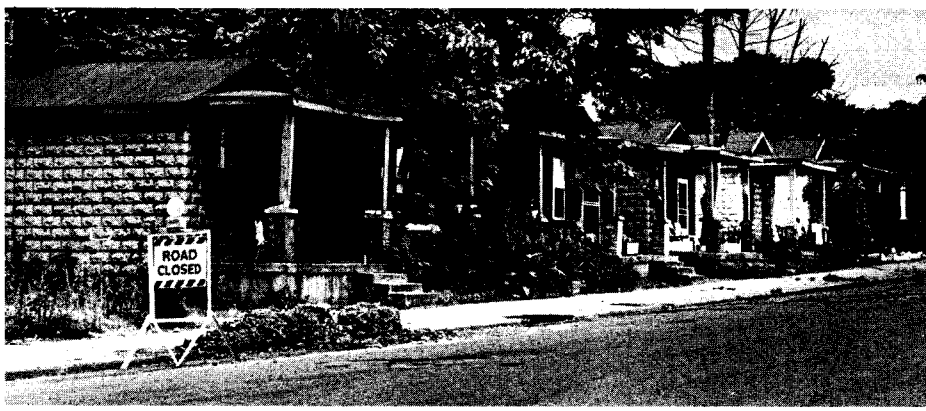
Editor: Virginia Carabillo
Managing Editor: Russell Paquette
Production Manager: Mary Lou Dossett
Editorial Staff: Harry Bain
Peggy Dobrusky
Karen Profet
Art Direction: Allan Walker
Photography: Allan Walker

CONTENTS

Published by
Corporate Communications
Manager: Donald Ramsay
Assistant Manager: Virginia Carabillo
Head of Corporate Publications:
Russell Paquette







A 12-year-old 4-H Club member begins a pattern of life in rural America much like his father before him, while across the country in a large urban area a Negro boy and his brother play on a run-down city street. They share little in common except that they are growing up with a better chance of beating the odds on heart disease, cancer and stroke than their parents. Part of the story is a new federal program that asks us grown-ups to plan and then carry out our own campaigns against these killer diseases. This edition of *SDC Magazine* describes that program.

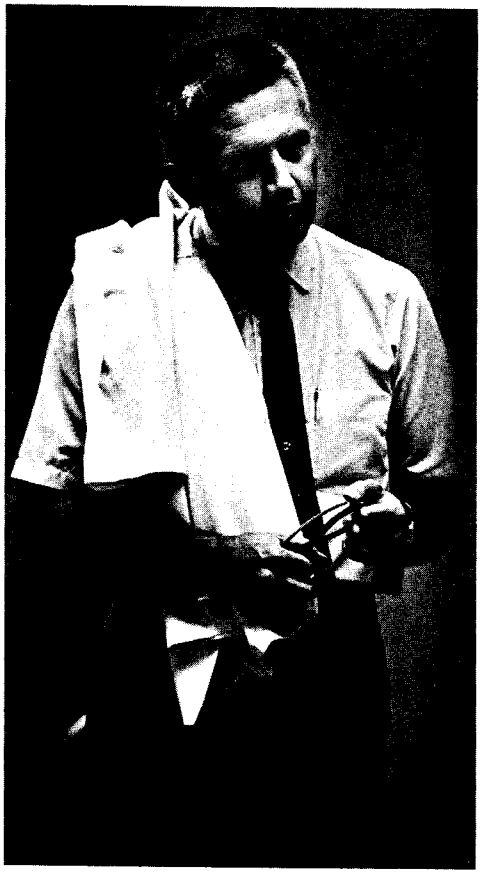

ROSEVILLE

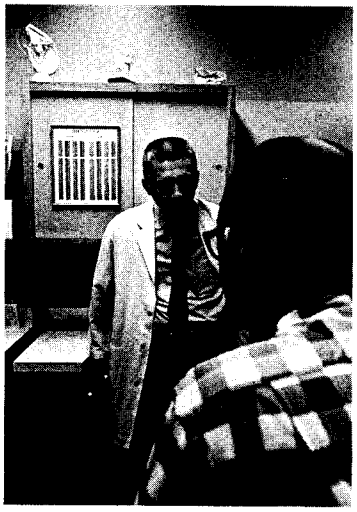
RMP

Rx

for Home Rule in Health Care

by HARRY BAIN





Hal Johnson lives in Roseville, California. To get there you drive north from Sacramento along U.S. Interstate Highway 80. Usually the trip takes about 20 minutes. There's a lot more traffic now than there used to be, and the once vacant grasslands along the way are sprouting tract houses as Sacramento reaches out for more bedroom space. Roseville, an historic Old West railhead, is being sucked into the metropolis.

Since Hal Johnson began practicing medicine for a living nine years ago, he has come to know quite a few of Roseville's 20,000 citizens. He sees patients every day in his office on Oak Ridge Drive or at the Roseville Community Hospital where he's a member of the staff. Johnson and his five partners in group practice are members of a fast disappearing physician minority —the general practitioners.

This doesn't seem to bother Johnson. He takes pride in what he's doing. There's no trace of the defensiveness you sometimes sense among GPs in this age of increasing medical specialization. But if you're getting some mellow notion that he's a storybook country doctor, you're in the wrong town. The word for Hal Johnson is Mod.

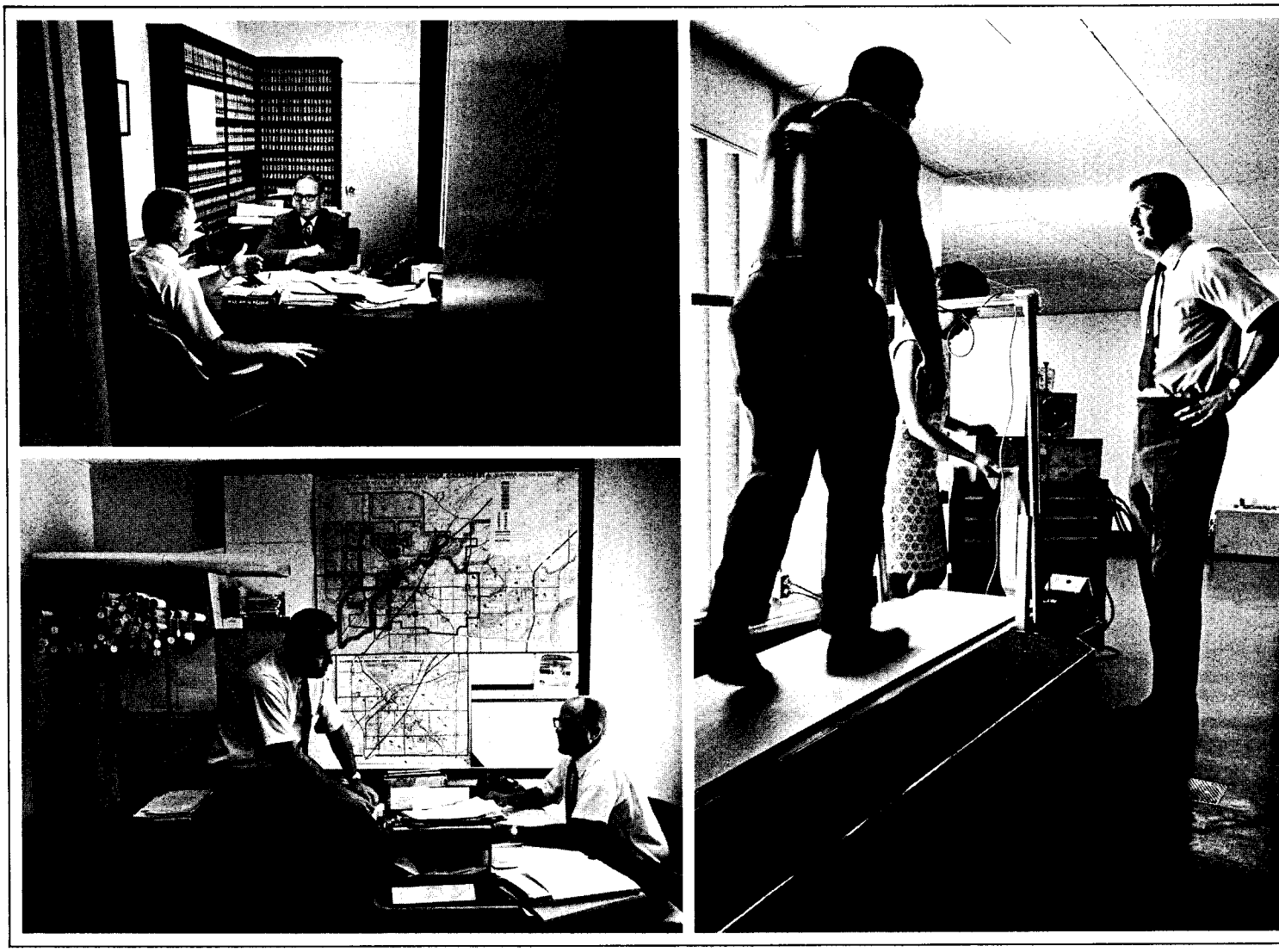
He swings in a medical and scientific sense because he works at it. He reads the right journals regularly—and learns from them. He makes the time to get to two or three continuing education seminars every year to keep up-to-date. You'll usually find him draped across a chair at classes offered by the local hospital.

As a member of the Roseville City Council and the local school board, he also swings in the community involvement sense. He's the councilman with the crewcut gray hair who makes it to all the meetings and has a reputation for being well up on issues that concern the community. Watching him hold up his end during a clash of views on local taxes, you'd have to concede that for a stripling (39) he's politically hip. This applies in medical politics, too, where Johnson has been a president of his county medical society.

In medicine, as in city government, Johnson likes to describe himself as a progressive conservative. He says he welcomes change so long as it carries along the positive achievements of the past and is based on politically workable and economically sound assumptions.

Like many of his colleagues in organized medicine, Hal Johnson has harbored deep suspicions about government medical programs, especially those that have emanated from the federal level. He has been apprehensive that they might eventually destroy the personal doctor-patient relationship or undermine the private practice of medicine. Private medicine, he is convinced, is both a wellspring of medical excellence and a powerful witness to individual freedom.

Knowing how Hal Johnson feels on this score makes what he has been doing the past 15 months all the more



remarkable. Since July 1968, he has been helping set up a federally sponsored health program in Roseville. He believes it will benefit his own patients and those of other Roseville physicians. He fought to get it. It is being paid for under Public Law 89-239, passed in 1965 and amended last year by P.L. 90-574. Johnson, and thousands of other physicians who have had their thinking changed by this law, call it Regional Medical Programs, or simply, RMP.

To capture the support of doctors like Hal Johnson, RMP has to be a special program. It is. It is the first federal health program to insist on grass-roots leadership in the decision-making process. Regional advisory councils call the shots, and the law is explicit that the councils be representative of *all* elements of the health community, including consumers. There's a great deal more about RMP that is different from past government efforts, but first let's talk about how the law came into being.

CONGRESSIONAL RESPONSE

Looked at historically, RMP is dollars-and-cents Congressional recognition that there is much more than shortages of physicians, other health specialists and hospital beds to what Presidents Johnson and Nixon have called the health crisis. Shortages may grab the most space in our news media, but leaders in the health sciences are beginning to talk more and more about *a breakdown in our system for delivering health care.*

This was essentially the message of the President's Commission on Heart Disease, Cancer and Stroke when it submitted its report in December 1964. Chaired by famed Houston heart surgeon, Dr. Michael E. De Bakey, the Commission pointed with pride to the great strides made in medical research and then viewed with alarm the slowness with which the results of this research were being made available to patients throughout the nation.

The following summer, Congress acted to improve the delivery of medical knowledge by passing the Heart, Cancer and Stroke Amendments to the Public Health Service Act. This created Regional Medical Programs "to afford the medical profession and the medical institutions of the nation, through...cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis of heart disease, cancer, stroke, and related illnesses." The diseases selected were appropriate targets. As a group, they are our most lethal killers, accounting for 71 of every 100 deaths in America.

The Commission study, now known as the De Bakey Report, had called for the establishment of "centers of excellence" for the dissemination and demonstration of new knowledge. This concept smacked of too much centralism for the medical profession to swallow and was finally scrapped by Congress in favor of "cooperative arrangements" among medical schools, hospitals, medical associations and related elements of the health care system. Such cooperative arrangements are one of the most unusual RMP features.

Congress went even further toward allaying the fears of many physicians when it declared that RMP was to accomplish its ends "without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals...." This guarantee, along with the local autonomy delegated to individual regional advisory councils, in large measure explains why practicing physicians like Hal Johnson have greeted RMP so warmly.

DOWN TO THE GRASS ROOTS

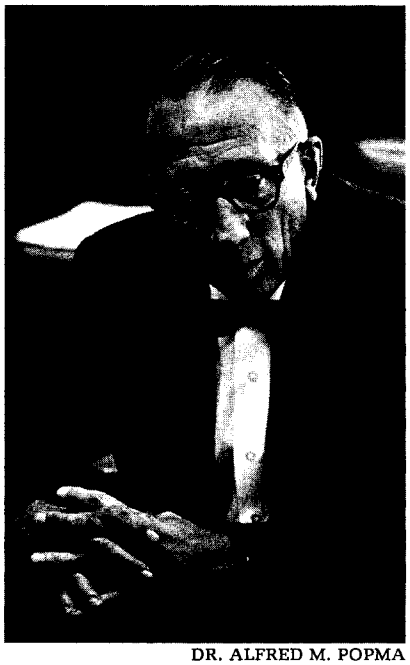
Physicians have been joined in their enthusiasm by nurses, hospital administrators, medical educators and representatives of voluntary health organizations, to name the most prominent professionals whose membership is required, along with that of physicians, on the advisory councils. Congress also made it clear that it expected to see some average citizens among the council members.

In drafting P.L. 89-239, the legislators recognized two distinct but related phases in getting RMP into business—planning and operation. In the first, the regional advisory council draws on all the resources in its area to identify what is needed to deal with the problems related to heart disease, cancer and stroke as they exist in its own region.

Once needs are known, the council must get down to the task of setting priorities among competing needs and hammering out the cooperative arrangements required to develop remedial measures. This effort is supported by planning funds granted under the Law after approval of the National Advisory Council of the Division of Regional Medical Programs. DRMP is the capping agency that administers the RMP program for the Department of Health, Education and Welfare. Planning grant approval hinges on acceptance of the region's organizational plan and method for proceeding.

At this point, the region is ready to enter the operational phase, which is another way of saying it is ready to send in an initial grant proposal to the Division of Regional Medical Programs. As required by the Law, DRMP won't give out money for patient treatment except where such funds are to be used for "demonstration" purposes only, and not to set up permanent care and treatment programs. There is also no provision in the Law for money for construction.

Neither Congress nor the division has laid down any hard-and-fast timetable for moving from planning to operation. It hasn't been unusual for the two to proceed concurrently. A few RMP grantees—North Carolina, Kansas and Missouri, for example—had a long history of regional cooperation and planning and were able to move quickly to full operational status. Others have found it necessary to move more slowly.



DR. ALFRED M. POPMA

The real decision on the timeliness and acceptability of operational activities lies with the division as expressed by the recommendations of the Review Committee and the National Advisory Council on RMP. The latter is a body of distinguished medical practitioners and administrators who review and make recommendations on all regional proposals, again as required by law.

Dr. Alfred M. Popma, a Boise, Idaho, radiologist for more than a quarter-century before turning his full time attention to RMP, knows all the angles in the review process. He is one of the 16 members of the National Advisory Council, has served on the Review Committee and keeps his local perspective sharpened as program director of the Mountain States RMP.

"At council review sessions, we are insisting more than ever on excellence," Popma says. "The successful operational grant must reflect the kind of solid region-wide planning that will enhance and improve patient care in heart disease, cancer and stroke. The council makes its recommendations to the Surgeon General who authorizes DRMP to fund approved proposals. So far, none of our findings has been reversed, but recently some have been deferred because of a lack of funds."

Perhaps the most important factor in council deliberations is the quality and durability of the voluntary cooperative arrangements. Says Paul Ward, coordinator of the California RMP, "All operational proposals are based on voluntary cooperative arrangements. It's the term we're stuck with. What does it mean? Simply plain old verbal agreements between given people to do given things, provided they can get the resources from one place or another." Once plugged into a grant proposal and approved, however, these verbal agreements take on all the legal force of a formal contract.

In form, then, RMP goes well beyond encouraging local participation. It demands it. Moreover, the tactic of local control has been strengthened through the philosophies of Drs. Robert Q. Marston and Stanley W. Olson, the two physicians who have served as directors of DRMP. (Marston moved up in 1968 to become the first administrator of the newly created Health Services and Mental Health Administration and subsequently became director of the National Institutes of Health.) Both have employed the division more along the lines of a flexible staff resource than as a heavy-handed federal director and enforcer. In keeping with this attitude, the *Guidelines* put out by DRMP run but 32 pages.

Refuting the notion held by some that RMP is the beginning of a national blueprint for dictating standards of medical care, Dr. Olson has said, "Even if we knew enough to draw such blueprints—which we do not—this method of procedure is so

PAUL WARD

DR. MARC J. MUSSER

foreign to the American tradition that it would fail if for no other reason than lack of acceptance.

"What in fact *is* intended is that planning shall be accomplished community by community, neighborhood by neighborhood, hospital by hospital, and doctor by doctor, not *for* the consumer but *with* him.... Regional Medical Programs, though federally supported, are intended to strengthen voluntary institutions and organizations of our country in their effort to develop local resources to meet local needs." Olson learned this lesson on the firing line. Before coming to Washington, he was coordinator of the Tennessee/Mid-South RMP.

A LEARNING PROCESS

The idea that local communities should guide their own destinies has caught hold in a number of recently enacted federal programs. Says Irving Lewis, deputy director of the Health Services and Mental Health Administration, within which DRMP now operates, "We have tried to move more and more decision making out into the field, recognizing that coordination of federal action cannot be accomplished in Washington alone....Moving the point of decision to the community, we find there is no one best way of doing things."

Lewis must have been listening in at some of the meetings in the 55 RMP regions funded since passage of P.L. 89-239. Observers have been struck by the innovation and differentiation of approach that have distinguished the groups as they moved to solve their own health problems. Originality in this case is no accident. It is as integral a part of the RMP fabric as local initiative.

Listen once more to Dr. Olson: "A Regional Medical Program requires a wholeness that cannot be achieved by an aggregation of loosely related projects. It fosters innovation and change. Change is constantly taking place, and we can no longer accept at any stage in our development the belief that we have arrived."

Physicians, hospitals, nurses, laymen and the rest have found it anything but simple to live up to this kind of demand. To begin with, they aren't used to sitting down together to resolve their differences and plan a medical future for an entire geographic region.

In this vein, RMP signals a new departure in the way decisions are made in medicine and the health sciences. Dr. Marc J. Musser, executive coordinator of the North Carolina RMP, says, "For the first time in the history of our country, the health professionals and health interests are joining together to make our health care system more cohesive and effective, not by legislation or with large sums of money, but by involvement of the right people, communications, good judgment and a challenge to local initiative."

California's Paul Ward goes even further: "This is a new role for the majority of our institutions and one that is not fully understood or accepted. Involving outside community forces in planning is difficult enough let alone entering into operational projects that give responsibility to those outside the institution."

Adjusting prerogatives, adjudicating local differences and coming up with projects that embody both medical excellence and regional benefit have caused the planning process to move deliberately in most of the regions. Consequently, there has been some impatience both within the programs and in Congress. The latter, always strongly in support of RMP, has had difficulty understanding why the regions as a whole haven't spent all the money that has been appropriated.

RMP has had carry-overs of $22 million from Fiscal Year 1966, $38 million from FY 1967, $36 million from FY 1968 and $20 million from FY 1969. From 1966 to 1968, the fact was that

there was an insistence on quality and compliance with the Law, an insistence that left some funds unobligated as indicated by the carry-overs. However, the most recent carry-over of $20 million from 1969 to 1970 was an administrative decision of HEW and not the result of a shortage of worthwhile projects. The fact remains that at the end of FY 1969 (June 30) there were some $25 million worth of approved but unfunded projects.

In a March 1968 appearance before the House Subcommittee on Public Health and Welfare, Dr. Michael De Bakey anticipated this development. "There have been times when I have been guilty of impatience," he admitted, "but the fact is that this program has developed, I think, at a normal pace and in a very sound way."

He pointed out that the planning phase of RMP had stressed the design, not the implementation, of health programs. This resulted in smaller expenditures than were projected in the beginning, but De Bakey emphasized that regional planning efforts were about to pay off in more expensive operational programs that would require close to $300 million by 1971. He further suggested that Congress "contemplate authorization levels of some $500 million" by 1973 to maintain standards and momentum in the program.

AN EMERGING PATTERN

Through Fiscal Year 1969, the 55 regions had received some $145 million in both planning and operational grants. In part, this paid the freight for the nearly 2500 paid staff members (47 percent physicians) in the programs. It did not reflect the enormous volunteer efforts of the nearly 10,000 private individuals, professional and lay, who man the regional and national advisory councils and serve on various subcommittees, task forces and local action groups.

Active RMPs now blanket the Continental United States and reach beyond to take in Alaska, Puerto Rico and Hawaii, the latter grant including Guam, American Samoa and Micronesia. In land area, the regions range from Washington-Alaska to Washington, D.C. California leads in population with nearly 20 million; Northern New England, headquartered in Vermont, has but 425,000. All Americans now live within at least one RMP area. Because of regional overlapping, some live in as many as three.

Some states, like New York with five and Ohio with four, have set up multiple regions within their boundaries. The opposite has happened in the wide open spaces of the West where the Western Interstate Commission for Higher Education administers a program that takes in four states and overlaps portions of four others that have their own RMP activities. California, in turn, is a single region but has organized itself into "areas" defined by the medical service areas of the state's eight medical schools.

Of the 55 organizations that have fiscal responsibility for the programs, 25 are medical colleges or university medical centers. Seven others are universities, while the remaining grants are split among 17 specially chartered foundations, commissions and associations, four state medical societies, one advisory council and one state agency.

Medical school involvement in RMP is written into the Act, since the medical colleges are at once a prime locus of new knowledge through research and because of their tradition as a vehicle for disseminating such knowledge through established extension teaching activities in their own medical service areas. From the outset Congress intended that RMP have heavy educational emphasis, and it is something of an understatement to say that the most popular and well supported thrust of RMP among doctors and allied health personnel has been in the direction of continuing education courses.

In fact, Dr. Dwight Wilbur, immediate past president of the American Medical Association and a staunch RMP supporter, has said: "These [RMP] programs should be primarily educational, for the better educated physicians are, the higher the quality of medical care they can render.... Facilities and financing are important, but of prime importance is the widespread availability of high quality medical care. The key to this is more and better education of practicing physicians." Small wonder the regions maintain close relations with medical colleges in their jurisdictions, or that operational grants to date have been notable for their innovative approaches to providing educational programs across a wide range of medical and health specialties.

Few, if any, would disagree altogether with Dr. Wilbur's support of continuing education, but there are many who question that such programs should be the dominant theme in RMP. Dr. H. Jack Geiger speaks for many of these when he argues that RMP should devote much greater attention to the *total* health problems of the urban and rural poor.

Now acting chairman of the department of preventive medicine at Tufts University School of Medicine, Dr. Geiger holds that the categorical RMP emphasis on heart disease, cancer and stroke is too narrow and should be broadened to include not only *all* disease problems that confront the poor, but also such pressing extramedical issues as poverty, discrimination, lack of education and unsanitary inner city and rural housing.

Differences of opinion like these don't intimidate Dr. Olson and his staff at DRMP. They call theirs a living program in the sense that they expect to see it change and grow as conditions change and new health pri-

orities emerge. They've already seen the categorical emphasis expanded somewhat through greater attention to kidney, respiratory, diabetic and other diseases that fall under the "related illnesses" portion of P.L. 90-574, and they fought successfully to have dentistry included within the RMP rubric.

Moreover, they have established close liaison with social action agencies both in HEW (Office of Economic Opportunity) and HUD (Model Cities) and have encouraged individual regions to forge cooperative arrangements with these and other programs wherever possible. (A subsequent section in this issue touches on such interagency cooperation in Nashville, Tennessee.)

For all this, the program has experienced some disappointments. One of the most persistent has been the slowness with which RMP has moved in some of our largest and most problem ridden urban areas. This has been accentuated by the speed and success realized in rural and alpine regions. Much of the problem traces to hangups in getting RMP organized in the core cities where, among other problems, there is a plethora of health institutions, people and activities, all of which are essentially autonomous.

The division has made no effort to soft-pedal these difficulties in its testimony before Congress or in its public statements. Olson has said: "The complex problems of our cities pose a national crisis of the gravest order.... We recognize that the complexities involved in developing regionalization in urban areas have delayed the development of regions in the very areas where their services may be most needed. This is a matter to which I have already given a great deal of my time and to which I am prepared to devote more of my personal efforts."

Dr. Olson's "complexities" are the same bugaboos that plague most public programs in the cities—inadequate

DR. STANLEY W. OLSON

funds, social fragmentation, the difficulty of bringing together all the culturally diverse groups that must be included in the planning process, immovable bureaucracies, indifference. By and large, the rural regions have had to deal with a far less numerous but more homogeneous population, a circumstance that goes far toward accounting for their rapid progress in getting into operational status. Comparative operational grant histories tell the story about as well as anything else.

Let's consider the Kansas RMP and the Intermountain Program based at Salt Lake City, Utah. These regions, both largely rural, have received grant funds totaling some $3 million and $7.3 million, respectively. Another fast-starting group, the Albany RMP in upstate New York, has received almost $2.8 million. Together, these regions represent about eight million people.

On the other side of the coin, the latest DRMP directory of operational grants lists none for Chicago, Cleveland, New York City or Pittsburgh. The New York Metropolitan RMP alone has more people than Albany, Kansas and Intermountain combined. While awards have been made for projects in Los Angeles, Philadelphia, St. Louis and Baltimore, they have been on a far less ambitious scale than those for some of the more thinly populated regions.

Not that there aren't some encouraging urban programs. Watts-Willowbrook, a project to develop a postgraduate medical center to serve the people of Central Los Angeles, is widely regarded as a possible prototype of future community health centers in ghetto areas. The Tennessee/Mid-South RMP, combining the activities of predominantly black Meharry Medical School with those of traditionally white Vanderbilt University Medical School, is embarked on a preventive medicine program that links multiphasic screening and an OEO-sponsored Neighborhood Health Center in a deteriorating section of North Nashville. Similar programs are on the drawing boards in such regions as Illinois, New Jersey, Detroit, Washington and New York City.

A GLIMPSE AT WHAT'S GOING ON

The working draft of a directory prepared by DRMP at the end of Fiscal Year 1969 required nearly 240 pages to furnish biographical data on the 55 regions and capsule descriptions of the projects in the 41 regions that had achieved operational status. Most of the space was devoted to the latter task.

Predictably, the individual projects differ as markedly in design as the regions themselves differ in topography, demography, and health manpower and facilities. Just as predictably, there are pronounced similarities, for gaps in the armamentarium for attacking heart disease, cancer and stroke have some characteristics that transcend regional boundaries.

For example, the best equipped and trained personnel are found in the major hospitals and university medical centers, whether these are in rural or urban regions. Logically, then, these institutions find themselves involved in some way in nearly all educational, training or demonstration projects that have won approval for operational funding.

Commonly, RMP strategy has been two-fold—to build on existing strengths wherever there is a strong local program and to extend knowledge outward from the medical centers to the smaller community hospitals where specialists and sophisticated equipment are often nonexistent. Nowhere is this strategy better illustrated than in the emphasis on coronary care programs, an emphasis that threads its way through RMP activities from Hawaii to Florida, from sparsely peopled Idaho to crowded New Jersey.

In the Memphis region, the University of Tennessee Medical Center plans to install a 12-bed "showcase" coronary care unit (CCU) that the medical staff will use to give training and demonstrations to health professionals from throughout the area. The Metropolitan Washington, D.C., RMP is literally putting its coronary care program on wheels by designing a mobile CCU that will rotate among three hospitals in the area. The hospitals will provide their own nurses, who will be specially trained, and physicians will be drawn from the Heart Disease Control Program of HEW.

Joint action by the Central Ohio Heart Association and the Ohio State University College of Medicine characterizes coronary care training in the Ohio State RMP, a 61-county region in the central and southern portions of the state. Nurses from hospitals in 10 core cities come to Columbus for two weeks' intensive training that prepares them to return to their own institutions as "nurse educators." Physicians, in turn, are eligible for coronary care seminars right in their own local hospitals.

These projects give some idea of the style, if not the scope, of RMP coronary care activities. There are still other innovations. Some of the regions have installed 24-hour telephone hookups that allow small hospitals to dial regional medical centers directly for electrocardiogram analysis and professional consultation. Another twist has been the development of coronary care training programs in hospitals other than teaching hospitals, an approach that is especially relevant to those medical personnel who live great distances from the large training institutions. Whatever the approach, the separate regional efforts share a common bond of helping the practicing physician, the nurse and others to improve their skills in behalf of coronary patients.

To Marc Musser, it is this recognition of the needs of patients, as much as the recognition of the educational needs of health professionals, that accounts for the RMP emphasis on coronary care units. He says, "Coronary care units represent increased awareness of the acute problems of patients. RMP picked up the CCU program at the right time, since it combined our initial emphasis on continuing education and the means to effectively meet needs in patient care."

What holds for coronary care is no less true of programs in cancer and stroke. Most of the regions have moved solidly into these areas with tumor registries, tumor boards, stroke management programs, and cancer and stroke screening projects. Without exception, the regional plans demonstrate conscious attempts to mount a balanced attack against all the diseases identified in the legislation. (The final segment of this issue includes discussion of a cancer program being developed in Boise, Idaho.)

TOWARD THE FUTURE

Of the many issues that will face RMP in the 1970s, none is likely to remain more visible than the health needs of the urban poor. Dr. Olson believes, "Regional Medical Programs can assist in the improvement of health service activities through projects that *supplement* elements of both old and new systems aimed specifically at the urban poor.

"True, we suffer from several constraints as we attempt to deal with these problems. Facilities are needed, but we have no authority to use funds for construction of facilities. Neither may grant funds be used to pay for the cost of medical services or hospitalization. Nevertheless, there are major contributions which Regional Medical Programs *can* make....

"Regional Medical Programs are functioning organizations specifically designed to link the providers of care together for the purpose of collectively improving services to patients....To do this, RMP must enter into cooperative arrangements with the many local and federal programs already addressing themselves to health problems of the urban poor.

"The [RMP] programs can and should contribute significantly in planning general health services for these populations, because it is only in this fashion that we can come to grips specifically with the problems of heart disease, cancer and stroke." Clearly, the DRMP staff doesn't intend to dodge its responsibilities in the cities.

Nor, if Dr. Olson is to be believed, will RMP diminish its emphasis on continuing education. He is on record as being convinced that continuing education is one of the most significant single components of RMP activity. In years to come, however, the division expects to promote more comprehensive and innovative approaches

designed to make health professionals active participants rather than passive receptacles in the educational process.

In Olson's view there is no conflict between the requirement for continuing education and the need to do something in the cities. In fact, he believes that RMP is flexible enough to accommodate the problems of the rural poor as well. Education and social action can coexist comfortably in Olson's philosophy, because he regards them as essential to each other.

He sees continuing education in urban areas as one sure way to achieve better care and treatment for disadvantaged patients. In the same vein, he believes that cooperative health arrangements worked out by agencies in the cities can be copied elsewhere to benefit the rural poor. This outlook again reflects the importance DRMP attaches to balanced programs.

This emphasis is certain to grow even stronger throughout the 55 regions in coming years. The division—through its own staff, the National Advisory Council, outside consultants and the Review Committee—has traditionally insisted on excellence in the operational proposals that come before it for review.

In recent months, Dr. Olson has strengthened this policy and called on the regions to work harder than ever to improve the quality and regional significance of their requests. Perhaps the most effective means toward this end will be the encouragement of more rigorous standards of review and criticism among the regional advisory councils when they evaluate their own operational proposals.

The quest for excellence doesn't stop there. Today there is also more attention than ever to the problem of project evaluation. All proposals must include formal mechanisms for periodic evaluation, and the division has invested a great deal of effort in developing sensitive tools for this task.

EDWARD M. FRIEDLANDER

The object is to help the regions identify weaknesses and eliminate unproductive programs. It turns out to be a continuing responsibility.

GETTING TO KNOW THE PUBLIC AND EACH OTHER

Programs like RMP recognize that their success is almost totally dependent on timely and accurate communications to a wide and heterogeneous set of audiences. There's Congress, the mass media, the general public, the medical schools, the professional organizations, local governments, state health agencies, voluntary associations, and on and on and on.

At another but equally important level, there is the requirement for open communications between the division and the regions and among the regions themselves. Under DRMP Assistant Director, Edward M. Friedlander, the division has worked out a program to produce maximum reciprocal feedback. Within the separate regions, most core staffs now include a professional public information officer.

It's important that he do a good job, for as Marc Musser has said: "Most of the problems in RMP result from failure to communicate at the right time. Leave someone out and things can get sticky. You might think that busy doctors could care less, but that has been far from the rule so far in RMP. Overlook them and they let you know about it in a hurry.

"Frankly, getting the commitment of local people is only the beginning. Communications exchange must be reciprocal. It must be continuous. A lesson all of us around the country have learned is that good communications in a region don't just happen. You must do a lot of work to make them happen. A good core staff is essential."

This basic lesson hasn't been lost on Ed Friedlander and his group at the division. Early in the game they set in motion a systematic program of interregional meetings designed to draw together RMP staffs from the same geographical parts of the country. Such gatherings serve several purposes. They allow for briefings on what is going on at the federal level in regard to budget and legislative policy. They also serve as a platform for interpreting divisional guidelines and giving the regions a chance to air their gripes about what the division is doing. That way everybody has a chance to learn some of the basic facts together.

If the meetings accomplished no more than this, chances are both Dr. Olson and Friedlander would consider them worthwhile. There's another angle, however, that may prove even more useful to the regions in the long run. Friedlander and his people are using their get-togethers with the regions to encourage permanent channels by which the regions can com-

municate regularly with each other, separately and as groups.

DRMP is convinced—as are many of the regions—that there is a many-fold pay-off in this kind of activity. For one thing, a frank exchange of data on operational program successes and failures can help the respective regions avoid expensive false starts. For another, it can provide late-starting regions with helpful tips on how to secure the enthusiasm of their own people and how to initiate the planning process. Of increasing importance, it can also help iron out jurisdictional problems or stimulate cooperative arrangements among regions whose programs overlap each other.

At a February 1969 meeting in Tampa, Florida, the coordinators and other staff of the 15 regions that make up the Southeastern Region furnished proof that interregional cooperation and exchange are gaining in appreciation. Spurred by Marc Musser and Dr. J. Gordon Barrow who directs the Georgia RMP, the Southeastern group voted to share the cost of an interregional coordinator whose task would be to "ride circuit" among the regions and keep everyone apprised of what his neighbors are doing. The new man has already been on the job for several months.

BUDGET OUTLOOK

The fact that the regions are now ready to look beyond their own immediate interests is an indication that the four-year-old RMP is coming of age. Further proof—if any is really needed—lies in the rate at which programs are moving out of planning into operational status. It is at this point that RMP requires much higher levels of financial support. The program is already feeling a pinch.

Says Dr. Olson: "Clearly, we are moving from a circumstance where there has been a surplus of funds—at times an embarrassing surplus—to one in which the reverse will be the case. Looking at applications already in hand, we can predict that the aggregate demand for grant funds will exceed our appropriations in the Fiscal Year 1970. Beyond that, the amounts that the Review Committee and the National Advisory Council will likely recommend for approval from yet-to-be-received applications will also exceed available funds."

Because RMP didn't spend all the money Congress made available to it in the first four years, some of the lawmakers have been dubious about whether program requests do in fact represent a reasonable estimate of need. Although final Congressional appropriations for RMP grants are yet to be voted, this dubiousness, combined with Administrative and Congressional belt-tightening, resulted in a House Appropriations Committee recommendation of $50 million in grants for FY 1970. This is $24 million less than the Administration asked for and $70 million below what was authorized by legislation.

Many in RMP regard this as a body blow to the future health of the program. Both Marc Musser and Paul Ward serve on the Coordinators' Steering Committee, a group of 10 coordinators elected by their fellows to advise DRMP on national policy and programs. Ward and Musser think present funding projections are far from adequate.

Musser calls the budget outlook unpromising. He warns that some programs may have to cut back and that the fiscal situation will almost certainly discourage new starts. "On the whole," he says, "this is occurring with the worst possible timing, since so many new localities and communities are clamoring to get into RMP."

Speaking to the same point, California's Ward said, "I suppose that at the present time you can say that the program is at its most critical stage. Years of planning are coming to a head, and the projects are rolling in. Now if you don't get the money in a reasonable time, the people who made the cooperative arrangements move away or change their minds, and you have to try to put it all together again. Well, that's very wasteful.

"Understand me, it's not hard to sell Congress on RMP. They were always willing to authorize just about as much as the program could use, because their opinion of us was always high. The only thing Congress has had against us is that in the beginning we asked for too much—more than we could realistically use. That is the problem."

Ward feels much the same as Dr. De Bakey did when he testified last year before the House—that the program must continue to grow and expand. Characterizing RMP as a means for distributing medical knowledge, Ward draws an analogy from the business world: "You know, General Motors would never think of developing a new automobile and then not spend some of their resources on campaigns to get it in the hands of customers. The same is true today in medicine. You might just as well forget the research unless you are willing to devote some money to distribution.

"That's what RMP is all about, and if we are talking $100 million as a plateau for all time, we are engaged in the wrong kind of planning. You've got to preserve your momentum and the faith that people have manifested in the future of the program. Otherwise the voluntary contributions and local participation will largely be lost. That is what would really hurt."

TENNESSEE/MID-SOUTH

Contrast, Cooperation and Quality

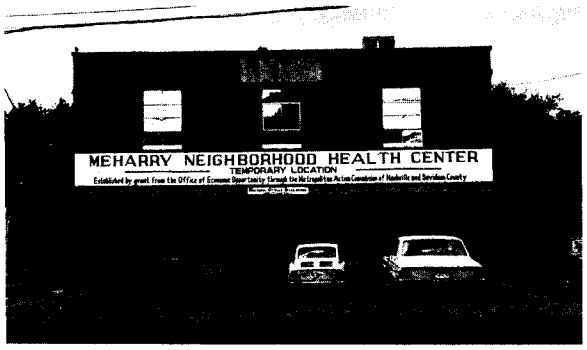
About 120 miles east of Memphis the Tennessee River wheels north and rolls past Wayne, Perry, Humphrey, Houston and Stewart Counties. The Tennessee/Mid-South RMP begins along the river's east bank and stretches some 400 miles farther east to the Virginia line. It takes in 74 counties in Tennessee and a cluster of 14 more in southwestern Kentucky.

That's room enough for a lot of contrast. The 3600 residents of rural Van Buren County follow a life-style that has its roots in the cotton and tobacco culture of the antebellum South. Over in urban Davidson County, some 400,000 Tennesseeans are setting a pace that's about as hectic as you'll find in any other metropolitan section of the nation. Altogether, RMP is planning or providing services for some 2.75 million citizens in the region.

Tennessee/Mid-South activities hub around Nashville, probably less famous now as the educational and cultural "Athens of the South" than as the home of the Grand Ole Opry and a burgeoning country and western recording industry. Nashville's importance to RMP, however, stems from the presence of seven large hospitals and Vanderbilt and Meharry medical schools.

Both schools are committed to the success of RMP. Vanderbilt administers the RMP grant, and faculty from both institutions have been generous in volunteering assistance to the program. The same goes for most of the hospitals throughout the region and for such seats of higher learning as Fisk, George Peabody, Tennessee State and the University of Tennessee.

Tennessee/Mid-South went into business on November 1, 1966, and began operational activities 15 months later. There are now 28 active operational projects, with another four approved but not yet funded. The annual budget comes to about one dollar for every resident of the region. Much of the emphasis is on training programs that give physicians and hospital personnel a chance to improve and expand their skills in the detection, diagnosis and treatment of heart disease, cancer and stroke. The programs have generally started with existing strengths and built from there—more often than not with imagination and a willingness to dare something new.



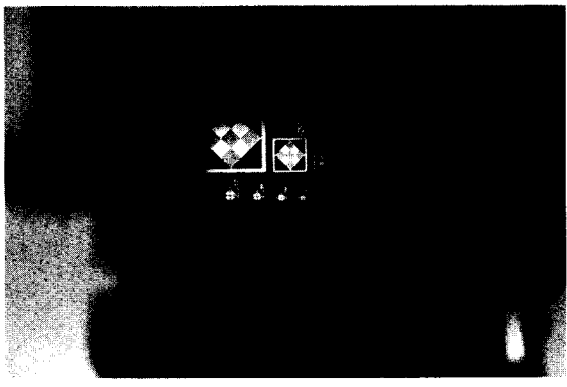
They call it North Nashville. Like other inner city neighborhoods in other American cities, it traces a jagged poverty scar through broken streets where half the dwellings are either deteriorating or dilapidated. Thirty thousand people live here. Of the adults over 25 years of age, only one in three has made it past the eighth grade. Three of every five families have annual incomes of less than $3000, and women head half the households. Negroes make up 80 percent of the population.

Across the country, RMP has had trouble getting started in places like North Nashville. But health officials here think they have come up with an approach to assure delivery of quality health services to Nashville's urban poor. The plan revolves around interagency cooperation between RMP and a new OEO-sponsored neighborhood health center that is one of the first to be constructed in the South.

The center, which began in a run-down store on Jefferson Street, will soon move into brand new quarters. Supervised by faculty and staff from Meharry Medical College, it will offer comprehensive care and treatment with emphasis on the dignity of the patient. It will also be closely tied to another Meharry project, sponsored through RMP and aimed at bettering the health lot of the disadvantaged, not only in North Nashville, but in the rest of the city as well.

Called the multiphasic screening laboratory, and centered in Lyttle Hall across from Hubbard Hospital on the Meharry campus, this operational RMP project will offer the latest advances in the detection of heart disease, cancer and stroke and other disorders that may lead to those illnesses.

Testing for visual acuity and visual field.



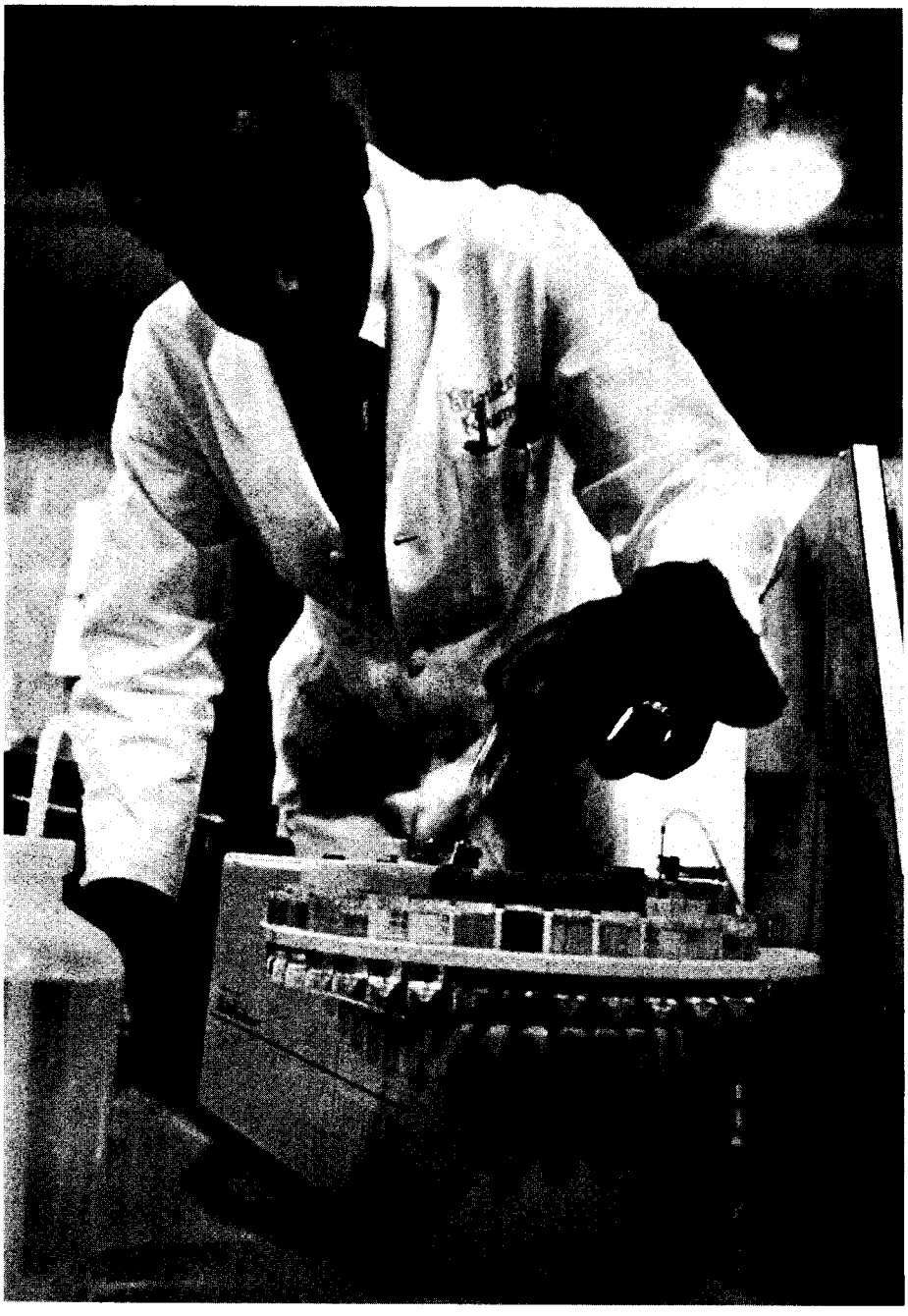
A major aim of the project is to learn how screening services, combined with treatment services at the neighborhood health center, affect levels of health in the area. This will be tested over a 10-year period by clinicians on the project and by social scientists from the Center for Community Studies at George Peabody College.

The clinical program will utilize 21 screening stations to provide such services as electrocardiography, visual acuity testing, spirometry, blood pressure, cervical cytology and a battery of 27 blood tests. Hours will be from 1 p.m. till 9 p.m. to make it easier for those who have to work every day, and the patient will spend from one to three hours on his visit to the lab.

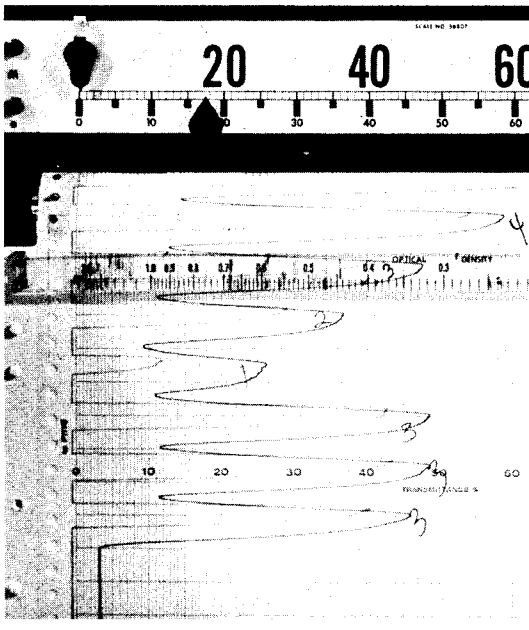
The screening sequence will be automated in an effort to conserve time for the attending physicians and make test results available as soon as possible. Much of the work will be carried on by nurses and technicians, with many of the latter trained and qualified as part of an educational emphasis in the program. To be eligible for screening, patients must be referred by a private physician, a public agency or the neighborhood health center. The goal is about 25,000 examinations annually

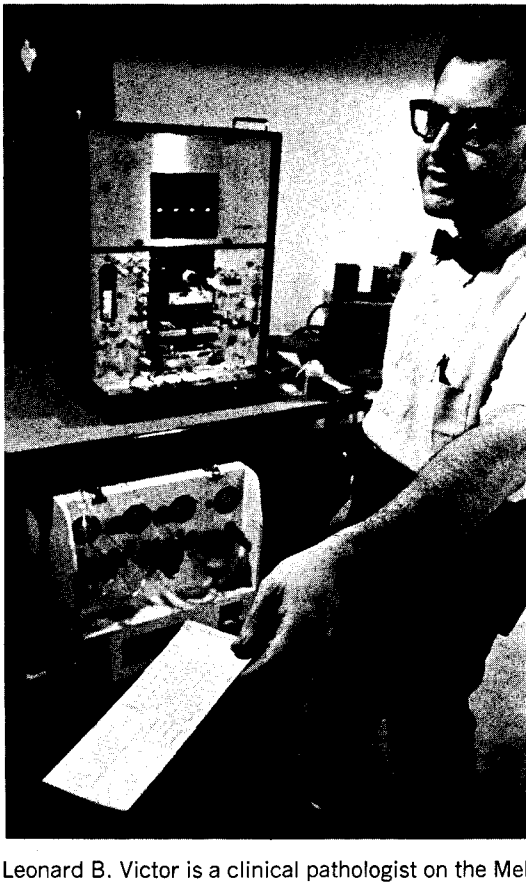
Surgeon Frank A. Perry of Meharry is project director of the multiphasic screening program. His view: *"We will be able to apply preventive measures on a continuing basis as opposed to the episodic care that is now the rule in this area. We have good people. We're excited about our future."*

At the blood pressure station, determinations are made on both arms.

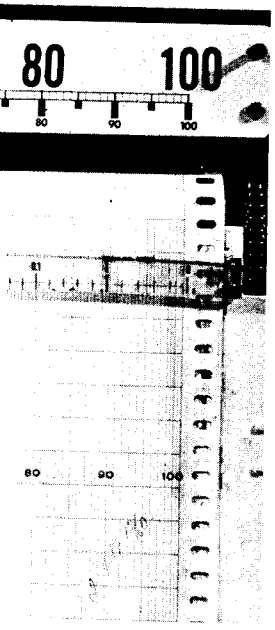


"Blood chemistry screening utilizes two machines and takes one patient sample per minute. It measures electrolytes in the blood. This procedure will also be on-line."

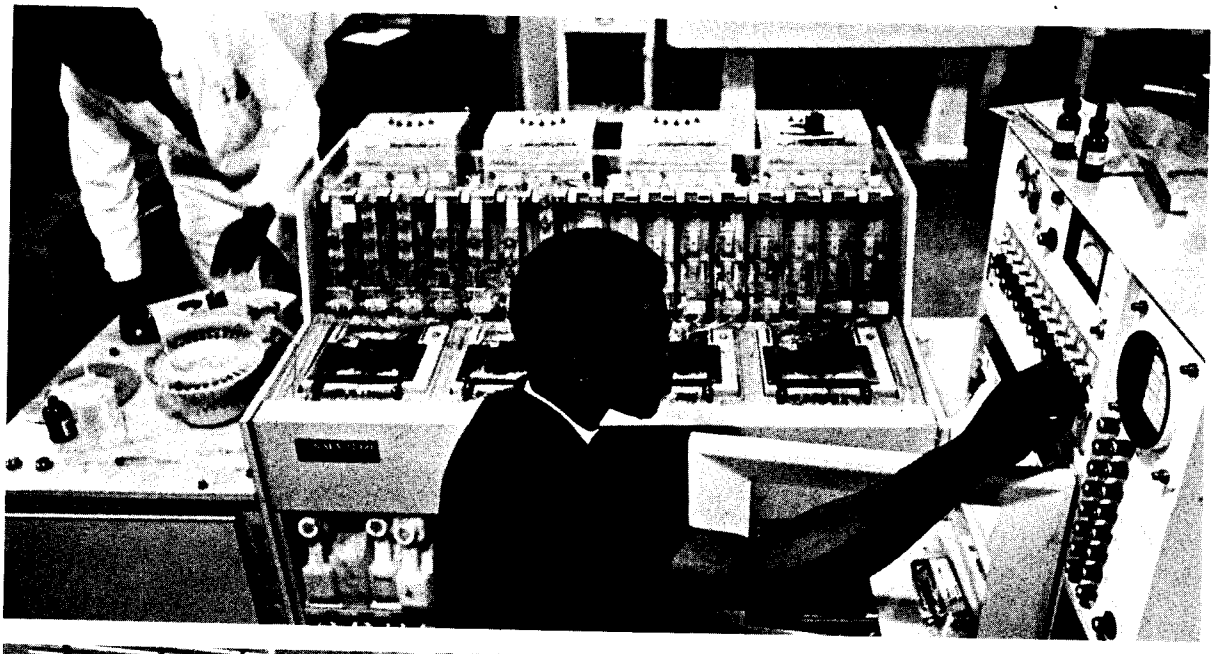


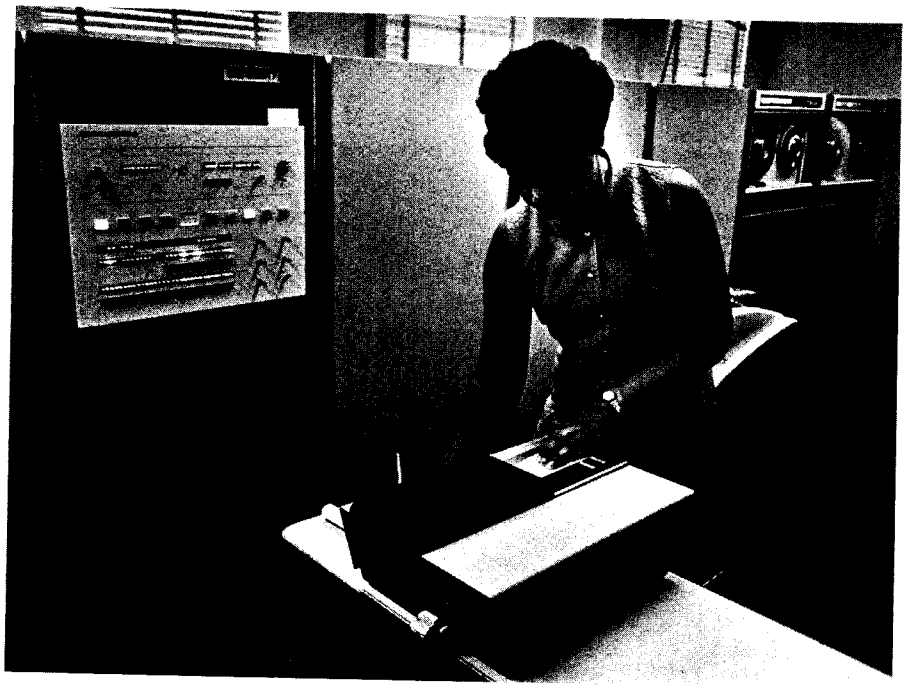


Leonard B. Victor is a clinical pathologist on the Me faculty. He also is director of screening operations. *is the Coulter Counter for hematology analysis. It w on-line and can handle a patient every 20 seconds.*



"This autoanalyzer gives us a blood chemistry profile based on 12 determinations. It is an economical and swift way to let the physician know which patients have abnormal value such as low blood sugar content which is an indication of diabetic tendency."



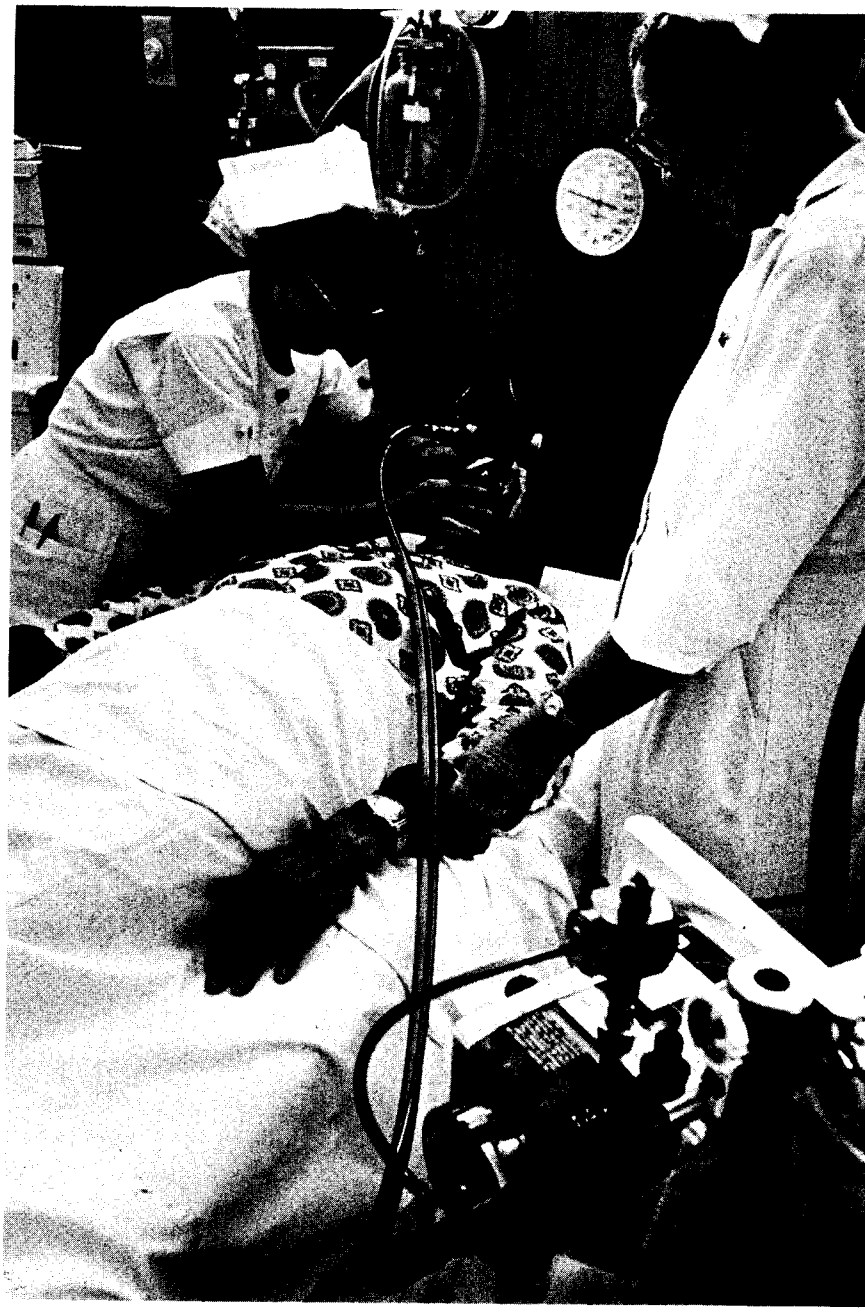


Cooperative arrangements keynote the multiphasic screening program. Fisk University, adjacent to Meharry, is providing accommodations for the computer. Specialists from Vanderbilt's computer center and school of engineering have assisted in planning hardware/software requirements and specifications. Clinicians from both Meharry and Vanderbilt have volunteered their expert judgments on what and how many tests should be included in the screening battery.

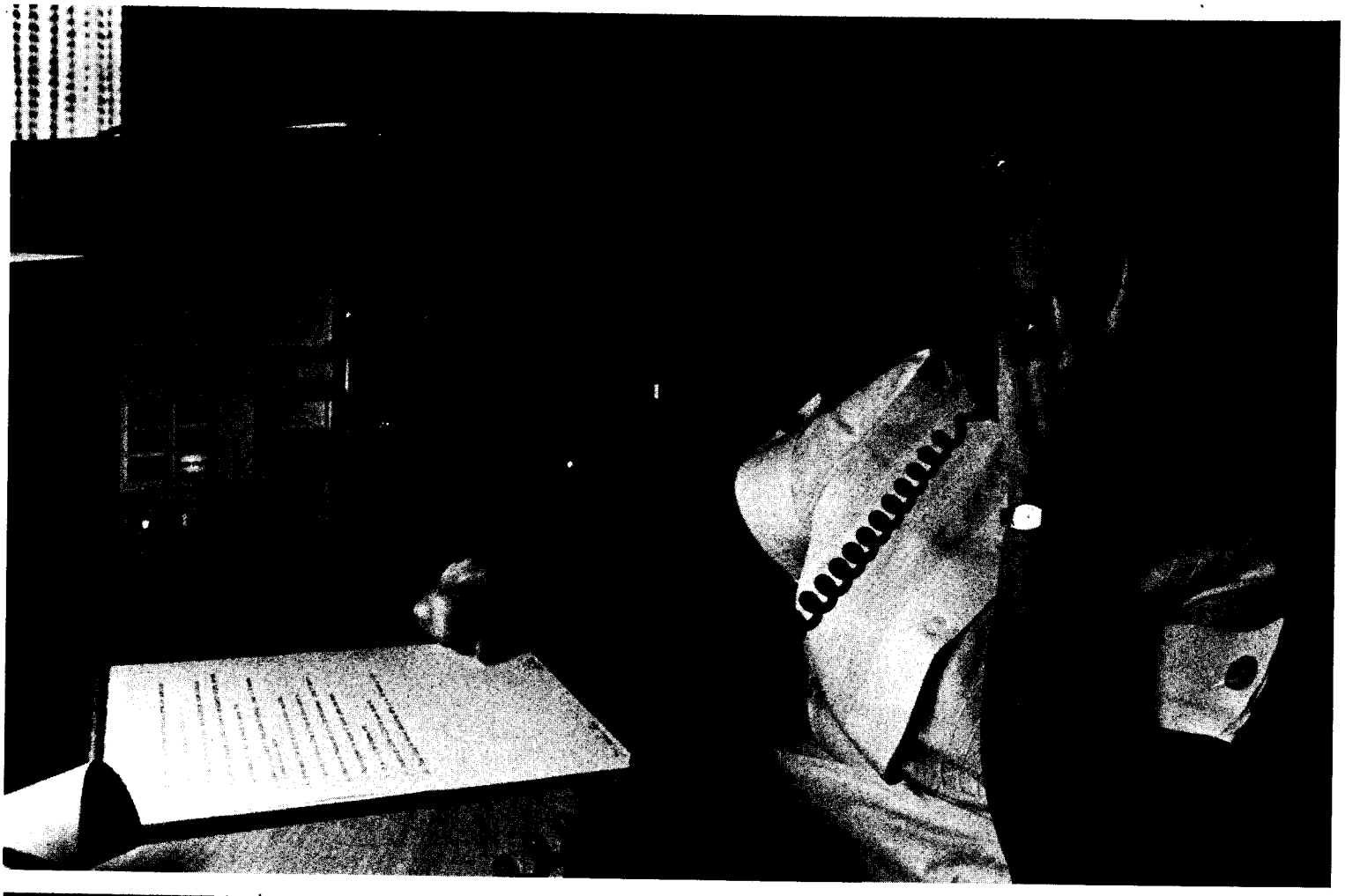
"Our computer is an integral part of the screening process. We have a definite plan for bringing the various screening services on-line. Our object is to provide results to the referring physician or agency as fast as possible."

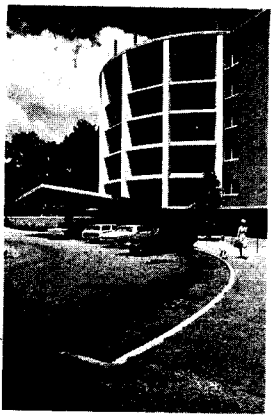
Williamson County Hospital is just outside Franklin, a rural community of 10,000 on the L&N railroad 17 miles south of Nashville. Last year the 100-bed hospital admitted 4128 patients from its medical service area of 30,000 people. About one of every 15 admissions was a cardiac patient, 22 of whom died. Physicians and nurses at Williamson are working to lower that figure through a cooperative RMP arrangement with Vanderbilt Medical School's coronary care center.

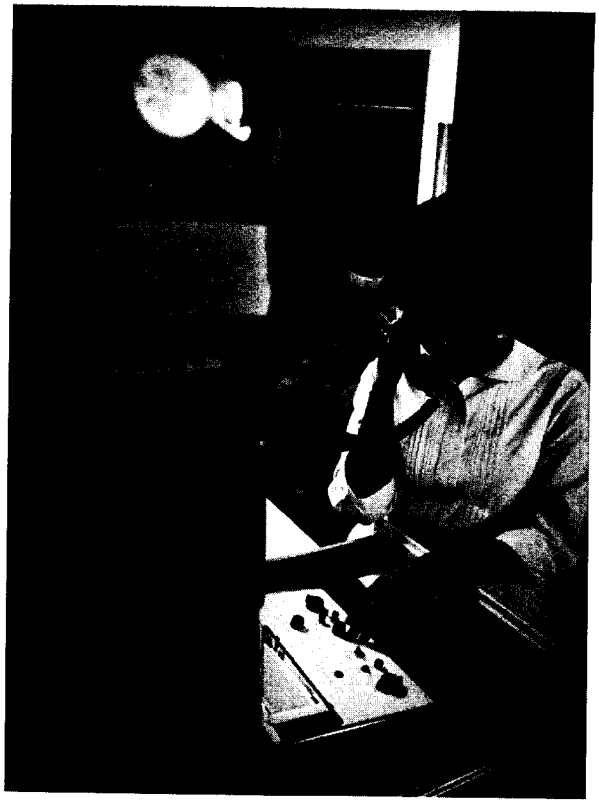
The project, under the direction of Dr. Noel Hunt of Vanderbilt and Dr. Robert Hollister of Franklin, is an effort to find out if a small community hospital can and should maintain a coronary care unit. Williamson has set up a 2-bed unit and designed a 33-hour course to prepare its staff for handling the coronary patient. It also sent nurse Martha Miller through the rigorous coronary nursing program at Baptist Hospital in Nashville.

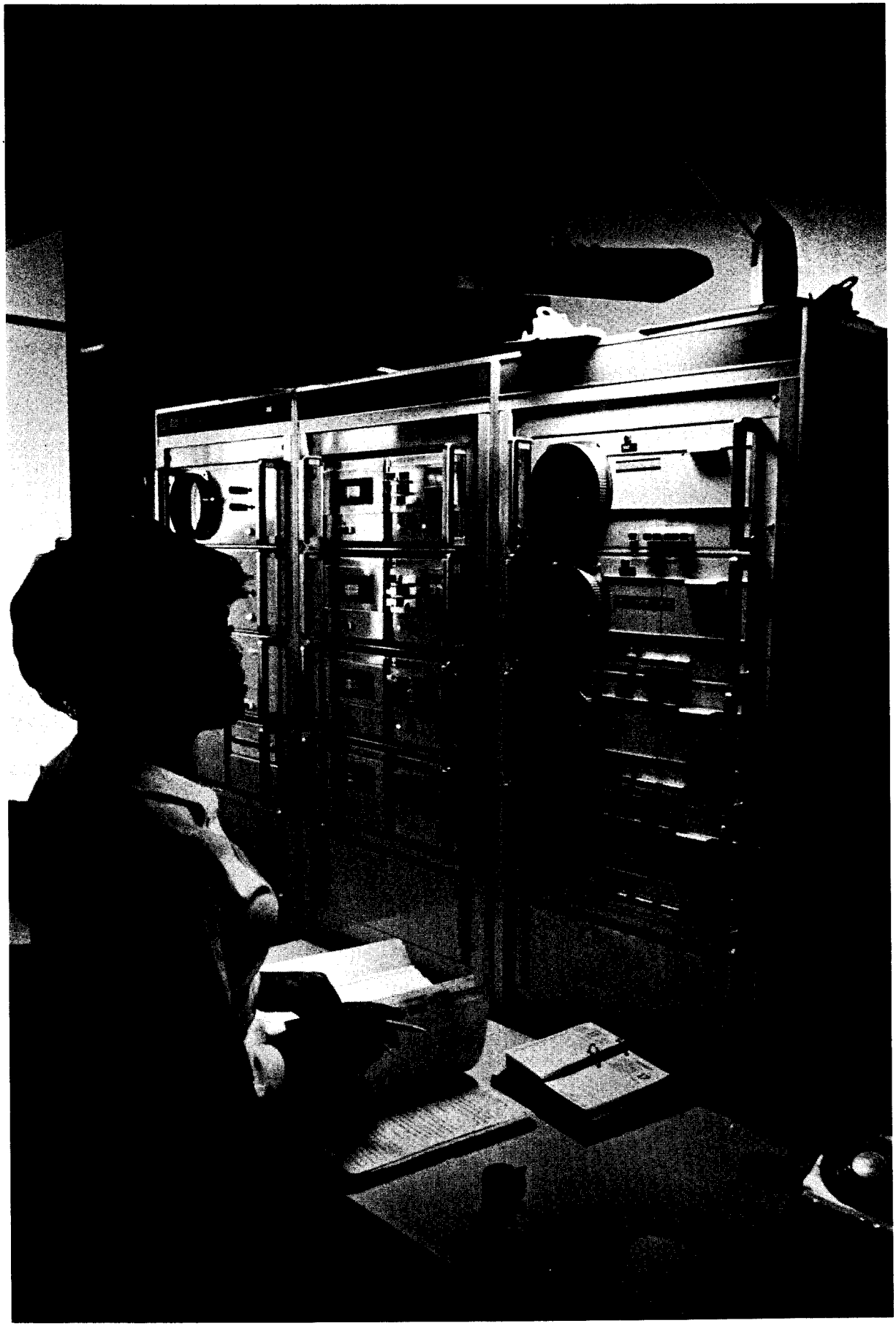


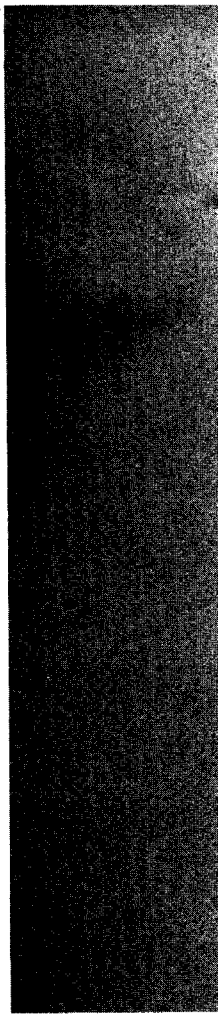
Through a dual monitoring system, patients at Williamson can also be monitored by the nursing and professional staff at Vanderbilt. Moreover, there is a 24-hour data phone hookup to pass vital patient data between attending staff at the two institutions. This arrangement allows any of the nurses or 10 physicians on the Williamson staff to have immediate access to faculty cardiologists and highly trained cardiac nurses at the medical school. Patients, the people for whom all this is being done, have already benefitted. Williamson administrator Cliff Gardner credits the program with saving seven cardiac patients in its first seven months of operation.



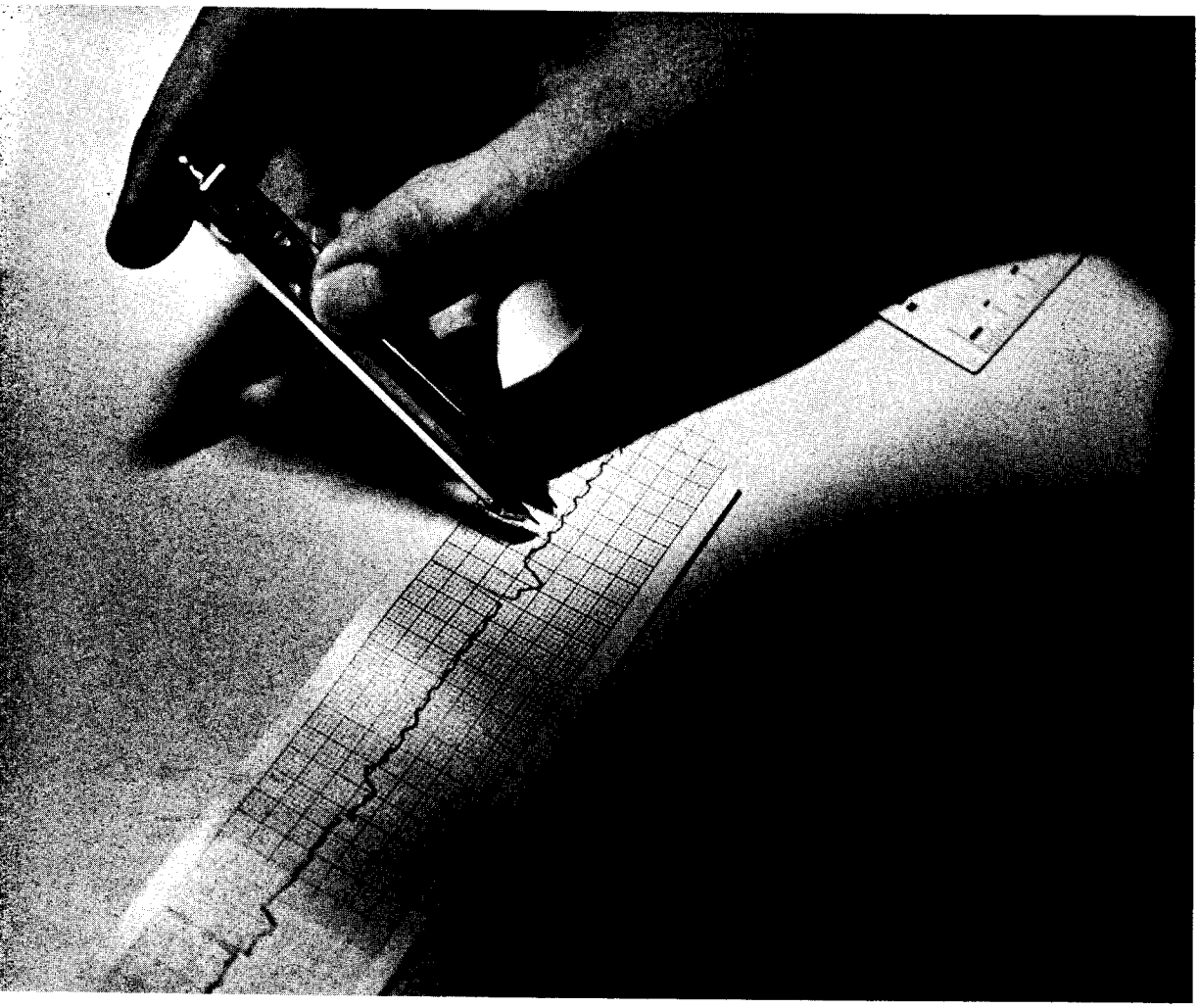


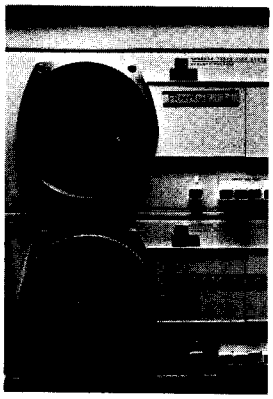




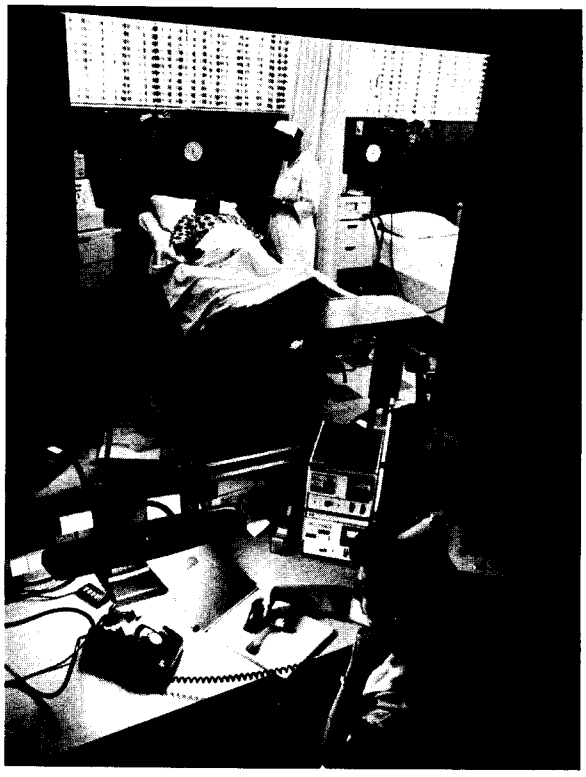


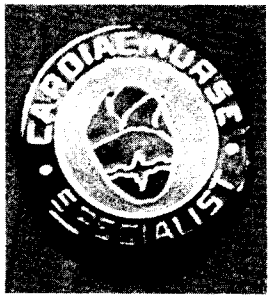
The dual monitorin
tem allows Vande
physicians and nu
to follow the identic
tient signs displaye
the nurse's station i
liamson County Hos



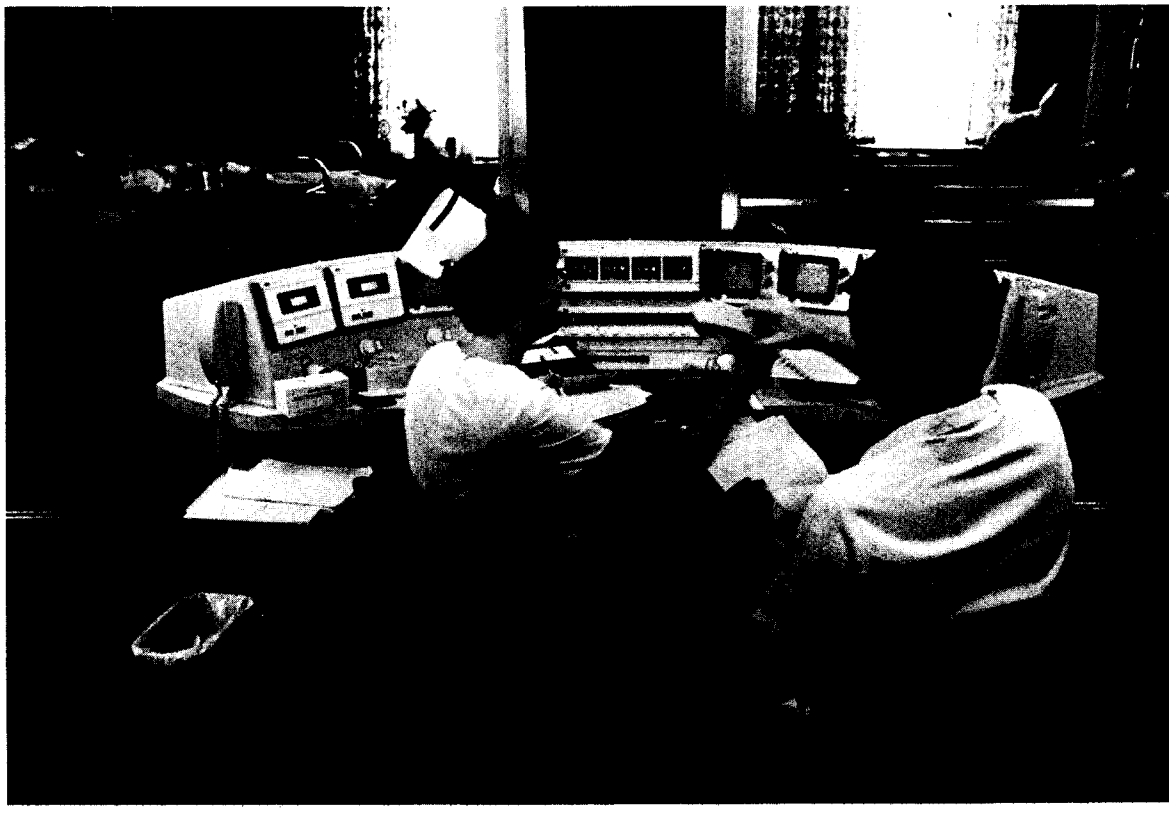


In an emergency, cardiac nurse Martha Miller of Williamson has nurses Bonnie Land and Jeanine Jolly and the full resources of Vanderbilt's coronary care center right at her fingertips.





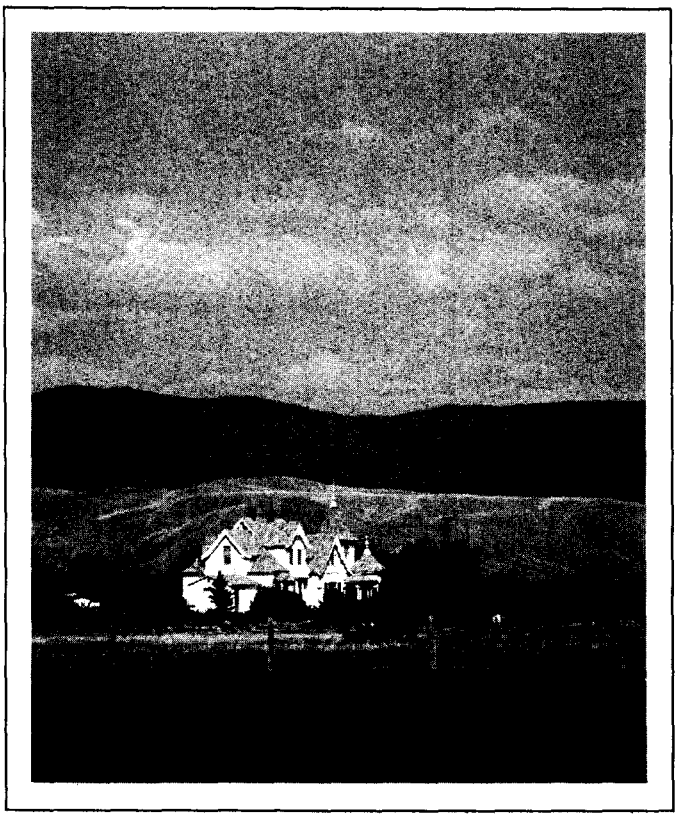
Many of the RNs in the coronary care unit at Nashville's Baptist Hospital have completed that institution's widely respected 8-week training program in coronary nursing and have received their treasured Cardiac Nurse Specialist pins. Most of them now teach alongside the 25 hospital staff members responsible for the curriculum in the program. Given three times a year, the course is restricted to 30 students drawn mainly from the region, but also from as far away as the West Coast. As RMP develops, Baptist will be the primary resource for coronary nurse training.



Baptist Hospital is a 625-bed general facility with teaching programs for interns and residents and a professional s that is more than 90 percent specialist. Its coronary care unit, established in 1964, was the first in Tennessee and several surrounding states. Today, it plays a central role in cardiac nurse training and patient consultation progra carried out through cooperative arrangements with RMP and several small community hospitals in distant to

The intensive care pavilion at Baptist accommodates eight patients, while an adjoining 14-bed progressive care p ion is reserved for those who, in their physicians' judgment, require less intensive supervision.

The coronary care unit will also perform a major advisory and consultative role in the Tennessee/Mid-South coron care network, a hookup that will tie 11 small hospitals to coronary care centers at Vanderbilt and Baptist. Baptis already linked to 2-bed units at Crossville and Tullahoma, with Manchester slated to join the net soon.



MOUNTAIN STATES

A Case Study in Grass-Roots Planning

Al Popma and his wife, Dorothy, were born in Orange City, a little farming town at the northwestern tip of Iowa. Both are from Dutch stock as are most of the people who live around Orange City. They came to Boise, Idaho, in 1938 when Al was a young doctor about to begin the practice of radiology. He kept at it until 1966 when he "retired" to take a full-time post as program director of the Mountain States RMP.

By that time Al had become one of the best known and most respected radiologists in his part of the country and a familiar figure in medical circles at the state and national levels. He is a past president of the Idaho Medical Association, and when the American Cancer Society was reorganized in 1945, he was one of the original board members. He later served as national president of the society.

From 1953 until 1966 he was a commissioner of the Western Interstate Commission for Higher Education (WICHE), the organization that administers the Mountain States RMP and is involved in the total spectrum of educational planning throughout most of the western states. As a WICHE commissioner, Al helped draft the planning grant application that established the RMP program he now directs.

He has strong convictions about RMP. "I came into this program," he says, "because it is perhaps the first program with federal dollars in it that has some local autonomy. For the first time we feel that we have an opportunity to produce projects without regard to state boundaries. This is truly a first in federal health programs. We are also discovering that through RMP, and again for the first time, we can develop autonomous projects... that people at the grassroots can make determinations about their own future in health care."

These advantages share prominence with what Popma sees as RMP's greatest long-range contribution—the encouragement of permanent continuing education programs that benefit the patient by helping physicians, nurses and other health professionals improve their skills. He discusses this and other RMP issues in the following pages.

Al Popma has long been concerned about the lack of formal continuing education programs for doctors, nurses and other health professionals who practice in Idaho, Montana, Nevada and Wyoming, the four states that together compose the Mountain States RMP. In his 13 years as a WICHE commissioner, he became convinced that one of the region's greatest needs was for some permanent mechanism to create and sustain such education and training efforts.

"WICHE undertook a number of studies to assess health training requirements in the four state region," he recalls. "A number of years ago, for example, we made a study of health manpower needs and came out with very accurate predictions of the demand for health personnel, particularly physicians, over the next couple of decades.

"And following the lead of the Faulkner Study on the need for medical schools in this region, WICHE set up an advisory council on medical education facilities. I became chairman of the council, and it was largely through its work that WICHE grew interested in the legislative hearings that led up to the establishment of RMP. In fact, the council went to Washington to testify before the House committee that eventually wrote the RMP law."

Popma and other council members felt at the time that a grass-roots program such as RMP would provide the spark for permanent educational activities in the four state area. "We were in agreement," Popma says, "that although we had a myriad of continuing education courses most were on a hit-and-run basis.

"Nothing was formally organized, and the professions depended almost entirely on volunteer agencies—the Heart Association, the Cancer Society, the medical associations, the nursing societies and so on. To put it another way, the professional groups themselves were entirely responsible for sustaining continuing education in the four states. There was little coordination among them and quite often there was duplication of course content and expenditures."

This was the situation as Popma remembers it in 1965 when Congress passed P.L. 89-239 and launched RMP. From the outset, he and other WICHE members were determined to include Idaho, Montana, Nevada and Wyoming in the new program. The first order of business was to sit down and put together an application for an RMP planning grant.

"This was drafted by the advisory council, working with Dr. Kevin Bunnell, associate director of WICHE," Popma recollects. "To assist in the effort, the council recruited three distinguished practicing physicians from the region—Dr. Frank McPhail from Montana, Dr. Francis Barrett of Wyoming and Dr. Fred Anderson from Nevada. All were WICHE commissioners."

The group got the job done, producing an application that was approved by the Division of Regional Medical Programs. Mountain States RMP, with Al Popma as program director, began its life in November 1966. It was—and still is—the only RMP region without at least one medical school, a circumstance that some had thought would make the area ineligible for RMP funding.

In Popma's view, the absence of medical schools is the major reason there has been a lack of coordination and continuity in continuing education activities in the four states. Not having medical schools also created a set of organizational problems for the fledgling Mountain States program.

"One of the first things we had to do to meet the requirements of the Law," Popma says, "was to organize a regional advisory group. To satisfy the requirement for medical school representation we had to go outside our boundaries. Logically, we went to medical colleges in surrounding areas to take advantage of traditional relationships to practicing physicians in our region.

HEALTH PROFILE
Nevada
HEALTH PROFILE
Wyoming
HEALTH PROFILE
Montana

"We invited representatives from the schools in Washington and Oregon and chose Paul Ward to represent the several California institutions. For representation on our southern border, we turned to the new schools in Arizona and New Mexico. Since our physicians have always had strong ties to the Universities of Utah and Colorado, we added members from both medical schools. Then we went a little farther away and took in representatives from the medical college at the University of Minnesota, the medical schools in North and South Dakota, and from Creighton University in Omaha."

Once medical school representation was settled, Mountain States asked for recommendations from each of its four states to round out advisory council membership. Seventeen additional people were added, including three Indian members who speak for the major minority group in the region. With its advisory group selected, the program was ready to turn to other matters.

Looking back, Popma recalls that no one in the sprawling region had accurate information on what medical facilities were available or what the training and educational needs of health professionals were. "We recognized that we had to assess these needs," he says, "and we decided to ask the people at the grass-roots level to tell us what they had to have. With this information, we could then attempt to design adequate programs."

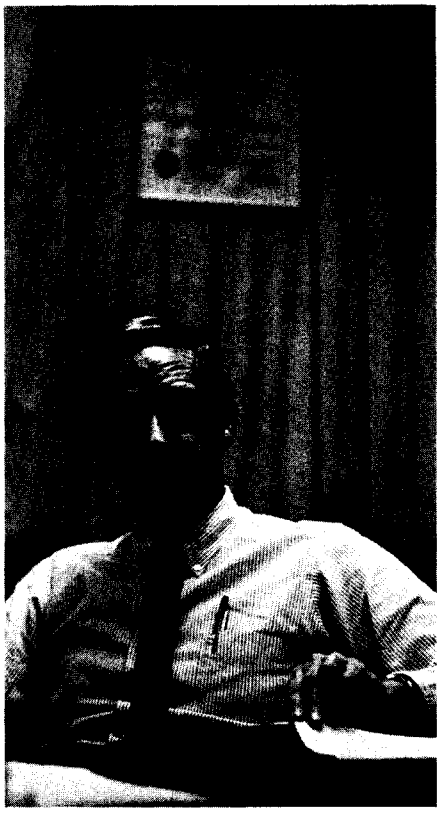
After examining several alternatives, RMP and WICHE staff members decided that the best approach was a field survey using direct mail questionnaires. "There was one problem, though," Popma remembers. "Never having devised such questionnaires or formulated computer programs for this kind of data analysis, we came to the conclusion very quickly that we required some rather sophisticated assistance. And so we made an arrangement with System Development Corporation to provide us the necessary know-how."

Even while the agreement was in negotiation, the program was having to face up to the task of creating a regional organization that could carry out the survey work and become the permanent staff resource for long-range planning and operational activities.

"We decided to set up an office in each state and were fortunate enough to secure four outstanding practicing physicians to serve as state directors," Popma notes. "Although there have been changes, we retain excellent state leadership in Drs. Sidney Pratt of Great Falls, Montana, Dr. Claude Grizzle of Cheyenne, Wyoming, David Barton of Boise, Idaho, and Lorne Phillips of Reno and Las Vegas, Nevada. The opening of our regional office in Boise was the final touch to give a true regional flavor to the whole program."

Of course, it wasn't quite as simple as it reads today, some three years later. Says Popma, "Compared to other programs, we had kind of a rough time getting going. Most of the others emanated from medical schools where there were trained people to write applications and get the program rolling.

"We had to start from scratch. We had absolutely nothing. We had to rent office space here in Boise and in each of the states, and we had to recruit qualified people. To be frank, there's a critical shortage of manpower to do this kind of job.



John Gerdes is one of those qualified people who are in such short supply in health programs across the country. He was on the faculty of the School of Public Health at the University of Pittsburgh but came West because he preferred the clean air and outdoor life.

Al Popma says Gerdes is "one of the top-notch young men anywhere in the country when it comes to developing the kind of community supported health programs required in RMP." Among other projects, Gerdes has been prominent in planning an inhalation therapy training program for the region.

"It began in the fall of 1968 at a meeting in Las Vegas where we were trying to compile a list of physicians who might be interested in undertaking such a program," Gerdes says. "Dr. Richard Browning, a Las Vegas internist, had already gotten one under way for the state of Nevada, and our state directors were anxious to find a way

to extend it to other parts of the region.

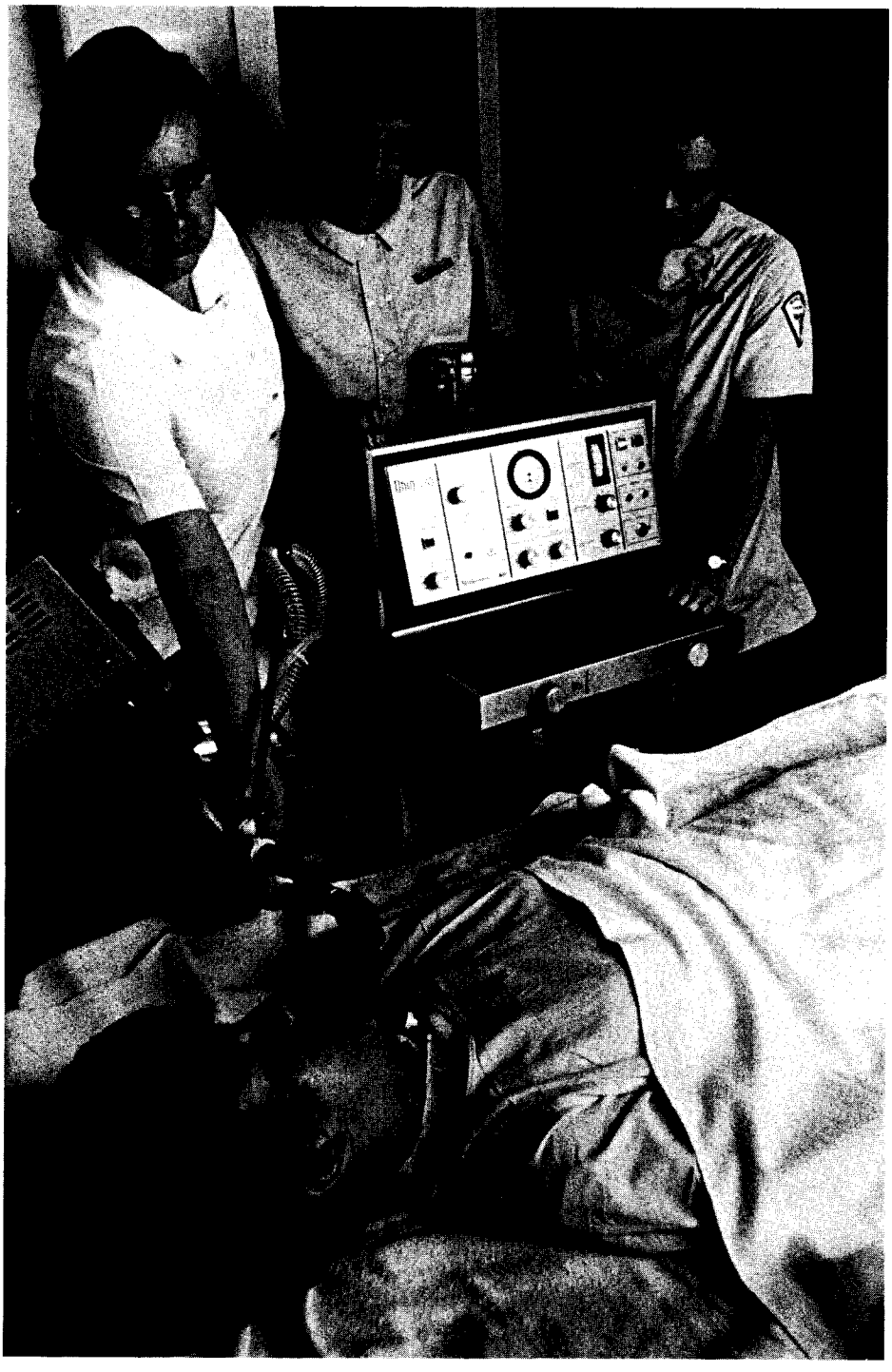
"We already knew of another inhalation therapy training program just 25 miles from our regional office at Caldwell Memorial Hospital, Idaho. It was being run by Charles Reed, a 31-year-old internist, as part of a two-year program at nearby Treasure Valley Junior College."

Gerdes asked Reed and Browning if they would be willing to expand their programs to include shorter-term training for personnel of hospitals in the region. Both were receptive, and they sat down together to design a curriculum and draft a grant proposal to set up complementary inhalation therapy training institutes at Caldwell and at the Southern Nevada Memorial Hospital, Las Vegas. The request is pending before DRMP.

"The exciting thing about this program," says Gerdes, "is that two community physicians, in communities 1000 miles apart, are working in concert on a common project with a real regional emphasis and outlook. Eventually, if we can interest other physicians like Drs. Reed and Browning in becoming instructors, we hope to make this curriculum available to hospitals throughout the four states.

Gerdes points out that up to now Dr. Reed's program has been aimed at students going for a junior college AA degree or expecting to transfer to a four-year school. The Mountain States emphasis, predictably, will be on making the training available to hospital personnel or others who have the aptitude to become inhalation technicians.

Says Gerdes: "Typical enrollees will come from small community hospitals. They may be RNs, but we hope also to attract students who, while they have no special medical training, do have the aptitude to learn the material. Our theory is that we can upgrade the skills not only of RNs, but also of licensed practical nurses, nurse's aides and others with the ability and desire to acquire this training. This is consistent with the Mountain States philosophy of training its own."



For patients with heart and respiratory diseases, inhalation therapy can afford short-term relief and be a significant factor toward recovery. The inhalation therapist also comes into play in such emergency situations as cardiac arrest or serious chest injury. The latter is simulated here by students and faculty of the Caldwell Memorial Hospital Inhalation Therapy Training Program.

And since we were highly geared toward field research and obtaining information, we had to find people who thought along these lines."

Eventually the offices did get set up and staffed, at which point Mountain States was ready to sit down with SDC's Health and Environmental Systems Department to develop the series of questionnaires that eventually would go to nearly all health personnel in the four states.

"Our survey universe included physicians, dentists, registered nurses, licensed practical nurses, hospital administrators, X-ray and lab technologists, physical therapists.... I think there were eight categories we wanted to reach," Popma says. Deciding just how to reach these groups required that the Boise staff meet regularly with state offices and representatives from SDC to work out questionnaire logic and wording.

"It took a lot of time and a lot of wheel spinning to come up with the proper questions," Popma recalls. "Some of our people had never done this, and you can imagine that there were problems. Often there was quibbling or quarreling over the correctness of a single word."

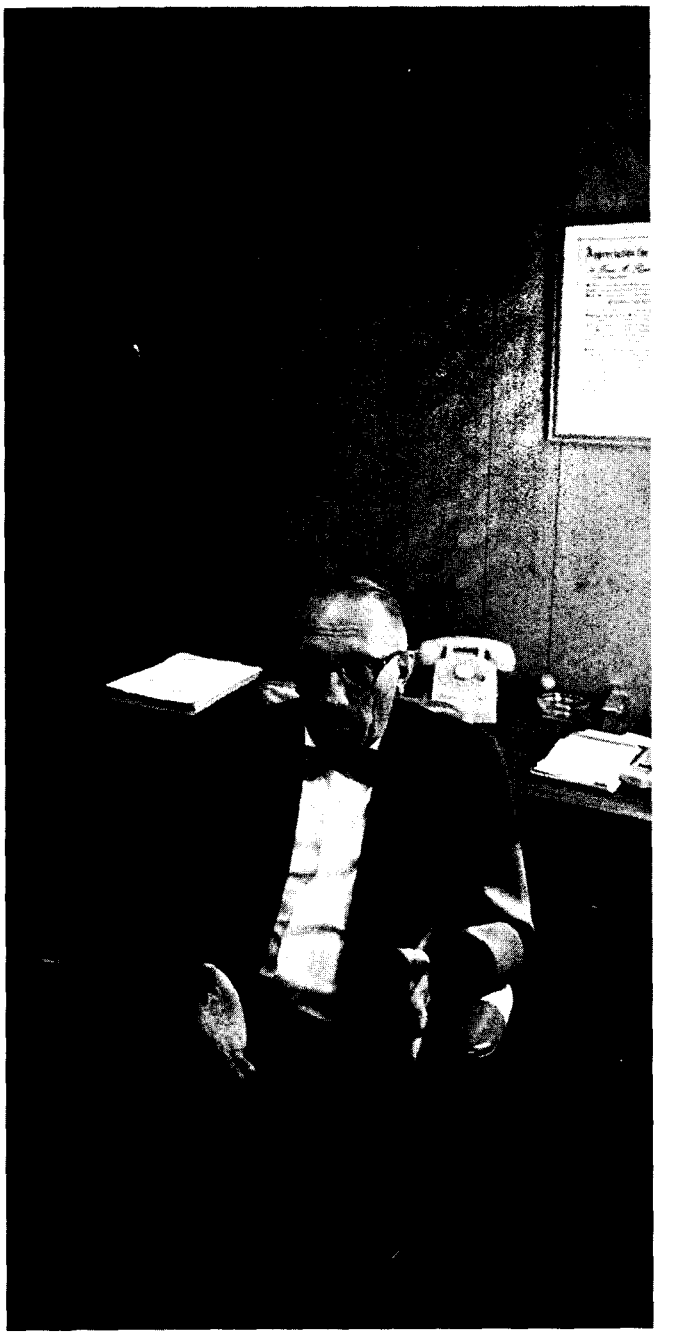
When the rough spots were ironed out to the point that everyone could live with the results, the questionnaires were printed and mailed to 100 percent of all health personnel except RNs and licensed practical nurses. These populations were large enough to require use of a random sampling procedure.

"Across the region we had better than a 50 percent return," Popma says with satisfaction. "The data were keypunched and put on the SDC computer in Santa Monica. So far, we have run two analyses on this file, and the results have helped us in devising certain operational activities. After all, providing data for operational programs was the purpose and function of the questionnaires."

At the same time the health professional survey was in progress, Popma's staff was also busy collecting information on health facilities in the region. To get an accurate line on such things as the number of hospital beds, the number and location of nursing homes, and the adequacy of transportation services, the staff designed what it now calls its Health Profiles.

"These focus down to county levels," Popma explains, "and enable us to tell what the health facilities needs are in individual communities. I should mention that SDC didn't assist on this effort. We devised it almost completely on our own. Naturally there were times when SDC looked at what we were doing and made suggestions, but the work was almost all ours."

However, SDC did have a lot to do with a third data gathering effort aimed at consumers of health services. This survey



is perhaps unique to date in RMP. "As far as I know," Popma says, "ours is the only RMP that has made a systematic broad-scale effort to find out what kind of health services the ordinary citizen wants to have available for patients with heart disease, cancer, stroke and the related diseases.

"This questionnaire, which we call the Survey of Consumers, went out to 10,000 people in the four states," Popma recaps. "We drew our random sample from telephone directories and from a list maintained by the Department of Agriculture that shows families without telephone service. Again, our rate of return was over 50 percent."

All told, the Mountain States RMP now has three large files of information—health professionals, health facilities and consumers. "This planning data base took almost two years to assemble," Popma sighs, "but when it is all put together it gives us a sound basis for developing operational projects. Both the professional and consumer files are stored on the computer in Santa Monica."

Part of the agreement between Mountain States and SDC was that there would be someone from the Health Systems Department full time in Boise. Speaking of the arrangement, Popma says, "we had Bob Mendenhall who did a very excellent job for us. He is one of the finest people we ever worked with. No job was too great, and there was never any question of hours. If it took till midnight, Bob would be there to do it.

"I was very interested in Bob. Our kind of program was something new for him since it was the first time he had been with a program that fundamentally and physically was attached to the practice of medicine. Naturally, there was a lot he didn't know, but he learned very well and quickly and blended in with no difficulty. Bob gave us a tremendous amount of help, and I was sorry when the contract was up and he had to leave for a job elsewhere."

(Mendenhall is now project leader for SDC on a study to assess health care requirements for residents of the rural Upper Kennebec Valley in the state of Maine. The corporation retains its ties with Mountain States RMP, however, through a formal consulting agreement.)

Popma is quick to point out that not all the effort in Mountain States has been taken up with the surveys. The program has five operational programs under way, another approved by DRMP and four more pending DRMP review and approval.

"We did a small study in Montana to assess the needs in coronary care," Popma says, "and we learned that 85 percent of people having heart attacks die at home. Now Montana is a rural area with many small hospitals of from 15 to 50 beds, meaning that the coronary patient can't be transported to a nearby large medical center with facilities to care for him. So these people die at home.

"We recognized that if we were going to be able to take care of such patients we had to help establish facilities and train people in small hospitals," Popma explains. "Our philosophy is that if a coronary care unit is good for patients in the Los Angeles metropolitan area, it is also good for those in Shelby, Montana. If we accepted the tenet that a hospital has to have 300 beds before a coronary care unit is financially feasible, we wouldn't have any coronary care programs."

Believing this, Popma and his associates sat down and devised a prototype program to prepare both physicians and nurses to provide coronary care in the small hospital. On March 1, 1968, thanks in large measure to the leadership of Montana physician, Frank McPhail, Mountain States opened its first coronary training center at St. Patrick's Hospital, Missoula, Montana. The project draws on cooperative arrangements among the hospital, RMP, the University of Montana and the University of Washington Medical School which furnishes consultants. About 120 people went through the course in its first 16 months.

"A second interesting operational program we have going aims at providing the latest training in cancer diagnosis and treatment," Popma notes. "There is something for physicians and for both the practicing and student nurse. Practicing nurses will have a chance to come to the Mountain States Tumor Institute that we are developing in association with St. Luke's Hospital in Boise. Here they can study and learn the latest techniques in cancer nursing.

"Undergraduate nurses who matriculate at the four baccalaureate nursing schools in the region will have a chance to enter the same program on an elective basis. Since none of the schools has facilities for this kind of training, the opportunity to attend the institute should provide a new dimension in baccalaureate nursing programs."

Like RMP administrators in other regions, Al Popma has given a lot of thought to what it takes not only to get a program started, but also to keep it moving over the long haul. "In my judgment," he says, "the first thing that has to be done is to sell the practicing physicians and the medical societies. You need more than their interest; you have got to have their participation. This also holds true for nurses, hospital administrators and other professionals."

Reactions to RMP have varied among physicians in the four state area. At the outset, there was a lot of fear and suspicion in some communities. "We tried to convince everyone that RMP was their program and was under their control," Popma

recalls. "We said—and we meant it—that they could take part or not take part or even drop out if they got disillusioned."

Once physicians began to get a personal stake in the program, however, attitudes warmed considerably. "Working on the state advisory councils, the committees, the task forces and the surveys produced a 180-degree turnabout in many of our physicians," Popma says. "Feeling grew so favorable that the Montana State Medical Association, for example, went on record supporting continuing education for all health personnel, *if funded through RMP.* It even set up a foundation to help work out cooperative arrangements and assist in health planning."

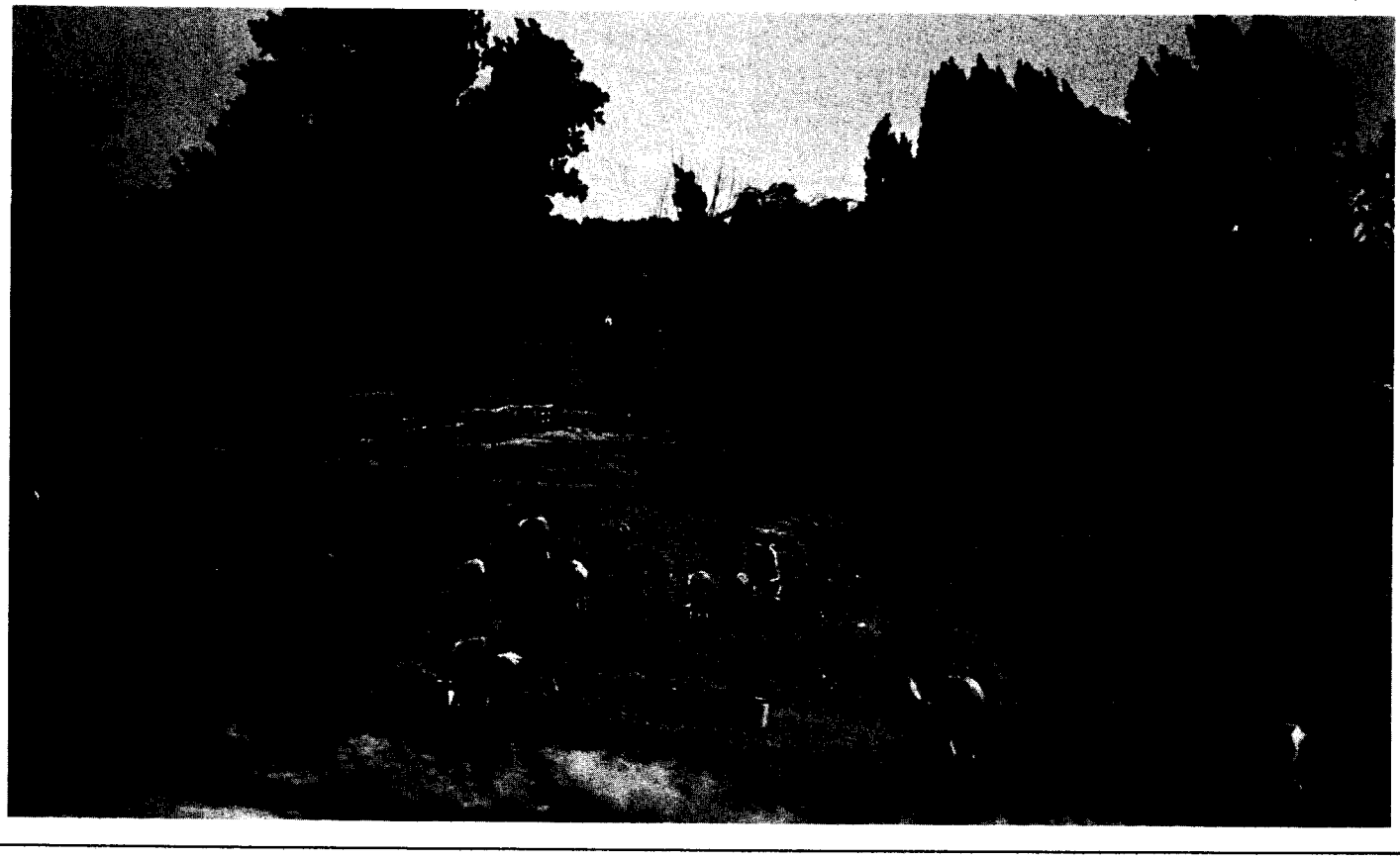
Striving to maintain rapport with health professionals is a task that Mountain States shares with every other region in the country. Another common bond is worry over where to find enough trained people to man the respective regional health care systems. Says Popma, "In my experience, the shortage of qualified people is universal. But in our area, the hospitals and other institutions don't have the means to compete salary-wise with the major medical centers. That's why our strategy of training our own is obvious... and reasonable."

Looking ahead, Popma doesn't expect RMP to fade out of the picture any time soon. In his view there will simply be too much community involvement at stake to let this happen. H tells a story about the Mountain States Tumor Institute Boise to make his point.

"To finance the Tumor Institute," he explains, "we ar drawing on all the resources we can bring to bear. St. Luke Hospital is providing the facilities—about $800,000 wort Over the first three years, RMP has approval to provid $621,000. We'll derive additional income from patient fe and we expect to realize part of our operating expenses fro philanthropic gifts.

"Take what just happened at our annual Fundsy Drive i Boise, for example. The Fundsy Drive is a community proje in which local companies and individuals donate gifts that ar auctioned off, with the proceeds going to designated charitabl institutions. This year the Tumor Institute received $70,00 for capital outlays.

"Taking all this together, I think it makes a good case stud in how RMP can spark local enthusiasm and involvemer Because of this we fully expect the institute to become pe manent and self-supporting when and if RMP money must b used elsewhere for other activities. But local support and co mitment will remain. This is what we need. This is the geniu of the RMP approach and its most durable feature."



Cancer training for nurses is but one facet of the medical services Mountain States Tumor Institute is providing in the region. Under Dr. Maurice Burkholder, Dr. C. Ronald Koons and other clinical specialists in the community, the institute is polishing an ambitious program to help the practicing physician acquire the latest diagnostic and treatment assistance for his cancer patients.

Koons, a young internist who was on the faculty at Johns Hopkins and studied radiation therapy there and at the M.D. Anderson Hospital and Tumor Institute at Houston, came to Boise because he liked the challenge of developing a "first-rate" cancer program in the region.

"The purpose of the Tumor Institute," he says, "is to give this region a fully staffed and equipped cancer treatment and education center so that patients and their physicians won't have to travel the vast distances they have been traveling to benefit from such facilities." It isn't uncommon for physicians in the four states to refer cancer patients as far away as Seattle, San Francisco and Denver.

"At this institute," Koons continues, "we'll concentrate on outpatient treatment, using radiation therapy, chemotherapy, conventional X-ray, radium and a special unit for skin cancer [a common medical problem in the area]. We are also about to add a physicist with experience in radiation physics and radioisotopes. When the institute is fully operational we expect to offer about as much as any medium-sized center in the country."

Physicians who staff the institute are emphasizing an interdisciplinary approach. "There are no 'stars,'" Koons says, "but there are a number of qualified clinicians with sound training in the various modes for treating cancer. We will offer recommendations only. The community physician will select the course of treatment and continue to care for his patient. We will simply provide specialized diagnostic and treatment data."

DR. C. RONALD KOONS

At the heart of the program are the Cancer Planning Conferences, held every Monday, Tuesday, Thursday and Friday, at which community physicians present cases to the institute staff. Every effort is made to schedule live patients, some of whom are brought in from as far away as Pendleton, Oregon (200 miles), and Twin Falls, Idaho (120 miles).

Initiative for the conferences remains with the community physician who decides he would like consultation, a review of treatment or other assistance from the institute staff. The physician contacts the institute, asks to present his patient and takes responsibility for sending along relevant X-rays, pathological slides, patient histories and records of any special medical treatment. If necessary, a conference can be arranged within three or four days.

Says Koons: "Our aim is to encourage the community physician to bring in any and all cancer problems, because the staff is seeking the widest possible opportunity to discuss and demonstrate newer techniques. In keeping with our interdisciplinary approach, we want to stress how different modes of treatment—surgery, chemotherapy, radiation therapy, for example—can complement each other to the ultimate benefit of the patient.

"The attending physician presents his own patient, including pre- and post-treatment data, and we emphasize bringing the patient in as early as possible. The interdisciplinary approach makes the institute staff both teachers and learners. We learn from the community physicians and other members of the staff.

"Our interdisciplinary philosophy even carries over to the design of the institute outpatient facilities here at St. Luke's Hospital. Examination and treatment areas will be close to each other in an attempt to maximize interaction among the attending staff."

Cancer training for nurses is but one facet of the medical services Mountain States Tumor Institute is providing in the region. Under Dr. Maurice Burkholder, Dr. C. Ronald Koons and other clinical specialists in the community, the institute is polishing an ambitious program to help the practicing physician acquire the latest diagnostic and treatment assistance for his cancer patients.

Koons, a young internist who was on the faculty at Johns Hopkins and studied radiation therapy there and at the M.D. Anderson Hospital and Tumor Institute at Houston, came to Boise because he liked the challenge of developing a "first-rate" cancer program in the region.

"The purpose of the Tumor Institute," he says, "is to give this region a fully staffed and equipped cancer treatment and education center so that patients and their physicians won't have to travel the vast distances they have been traveling to benefit from such facilities." It isn't uncommon for physicians in the four states to refer cancer patients as far away as Seattle, San Francisco and Denver.

"At this institute," Koons continues, "we'll concentrate on outpatient treatment, using radiation therapy, chemotherapy, conventional X-ray, radium and a special unit for skin cancer [a common medical problem in the area]. We are also about to add a physicist with experience in radiation physics and radioisotopes. When the institute is fully operational we expect to offer about as much as any medium-sized center in the country."

Physicians who staff the institute are emphasizing an interdisciplinary approach. "There are no 'stars,'" Koons says, "but there are a number of qualified clinicians with sound training in the various modes for treating cancer. We will offer recommendations only. The community physician will select the course of treatment and continue to care for his patient. We will simply provide specialized diagnostic and treatment data."

DR. C. RONALD KOONS

At the heart of the program are the Cancer Planning Conferences, held every Monday, Tuesday, Thursday and Friday, at which community physicians present cases to the institute staff. Every effort is made to schedule live patients, some of whom are brought in from as far away as Pendleton, Oregon (200 miles), and Twin Falls, Idaho (120 miles).

Initiative for the conferences remains with the community physician who decides he would like consultation, a review of treatment or other assistance from the institute staff. The physician contacts the institute, asks to present his patient and takes responsibility for sending along relevant X-rays, pathological slides, patient histories and records of any special medical treatment. If necessary, a conference can be arranged within three or four days.

Says Koons: "Our aim is to encourage the community physician to bring in any and all cancer problems, because the staff is seeking the widest possible opportunity to discuss and demonstrate newer techniques. In keeping with our interdisciplinary approach, we want to stress how different modes of treatment—surgery, chemotherapy, radiation therapy, for example—can complement each other to the ultimate benefit of the patient.

"The attending physician presents his own patient, including pre- and post-treatment data, and we emphasize bringing the patient in as early as possible. The interdisciplinary approach makes the institute staff both teachers and learners. We learn from the community physicians and other members of the staff.

"Our interdisciplinary philosophy even carries over to the design of the institute outpatient facilities here at St. Luke's Hospital. Examination and treatment areas will be close to each other in an attempt to maximize interaction among the attending staff."

"I believe we could experience a true revolution from the middle class unless we develop a health delivery system that does a better job of meeting its expectations. The middle class, not just the poor, is telling us unmistakably that there cannot be a continuation of the same situation in health services. RMP provides a means toward solving this problem by moving into new and original patterns of health care delivery."

ROBERT M. METCALFE, MD
ASSOCIATE DIRECTOR
TENNESSEE/MID-SOUTH
REGIONAL MEDICAL PROGRAM