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1. RMP AND THE "HEALTH CRISIS": One increasingly hears and reads about the "health crisis" facing the nation. How do you see RMP helping to address and resolve that crisis?

Dr. Egeberg in his opening testimony identified two aspects of the present health care crisis, which warrant reiteration. First, that health care is provided neither through the public nor private sectors alone. Second, that we are largely dependent for the provision of health care on existing resources -- physicians, hospitals, and other health personnel and facilities -- which are, of course, limited.

The kinds of changes required in our health care system needed in order to meet that crisis -- changes designed to insure excellence of care, for greater efficiency in its delivery, and greater equity in the distribution of services so that they are far more readily available and accessible to everyone -- will require the cooperation and participation of the private sector. For over 75 per cent of the care in this country is rendered by it.

Regional medical programs have demonstrated considerable success in eliciting the cooperation and participation of practitioners and organized medicine, community hospitals, medical schools, and the many other health professionals and institutions and organizations. Indeed, this very possibly has been their major achievement to date.

They now also are beginning to show some potential for bringing about long overdue changes in the health system and the delivery of care with the participation and cooperation of providers, and between

providers and consumers, at the regional and local levels. RMP, in short, provides a mechanism and means through which private physicians and community hospitals and others can play an active and constructive role in that change process.

2. EXPANDED PROGRAM SCOPE: What is the reason for broadening the scope of Regional Medical Programs beyond the present categories of "heart disease, cancer, stroke and related diseases?"

The present authority and scope of the program would be broadened so as to specifically add "kidney disease" and substitute "and other major diseases and conditions," which would encompass such major problems as arthritis, epilepsy, and trauma, for the more restrictive "and related diseases." This is essentially the same as the original legislative proposal for Regional Medical Programs introduced in 1965. It has the effect of retaining the categorical focus but removing the categorical limitations.

This would allow individual regions to begin to address and work on other disease problems and conditions which, in terms of their own regional needs and priorities, may be of equal importance or may be more susceptible to dealing with. The discretion to do so would be that of the regions. Only if and to the extent they see fit and have locally determined would the scope of individual programs be broadened.

We expect, however, that many, perhaps most, would move in that direction. Few, if any, regions are finding that the cooperative arrangements approach and the benefits of regionalization are restricted to heart disease, cancer and stroke. To the contrary, the pay-off from some of the present operational activities is, though indirectly, far beyond what their categorical orientation and purpose is. Thus, broadening the program's scope will allow fuller exploitation of Regional Medical Programs' mechanism and the potential benefits of regionalization of services.

3. KIDNEY DISEASE: Kidney Disease has, I believe, been defined as a "related disease." What activities have been undertaken through Regional Medical Programs Service to date dealing with this disease?

The National Advisory Council on Regional Medical Programs has acknowledged the relatedness of kidney disease. However, recognizing the complexity of treating chronic renal disease and the enormous cost of mounting a service program even in a restricted locale, the Council has recommended that Regional Medical Programs grant funds awarded to projects in chronic renal disease be limited to support of those projects which provide for: (1) Training of physicians, nurses, and technologists for management of chronic renal disease patients, and (2) regional planning for a coordinated Regional approach to prevention, diagnosis, and clinical management of renal disease.

As a result of this policy, a total of 11 projects, including training for use of home dialysis, have been approved and funded for a total of some $400,000 in 8 Regional Medical Programs. An additional two projects have been approved but not yet funded in two other Regions. Three projects in three additional Regions are currently waiting on further interpretation of the Council policy.

With the incorporation of the Chronic Disease Program of the National Center for Chronic Disease Control, significant additional activities have been added under the Regional Medical Programs Service aegis. These include .....

* Thirteen (13) programs in various parts of the country to develop methods to educate patients and their families to home dialysis and to provide the equipment and actual training.

In Fiscal Years 1967 and 1968 these projects were funded at a level of $7,150,000; in 1969 at $3,380,000; and the 1970 estimate is $3,604,000.

* A special project to evaluate home dialysis equipment is also funded as part of the foregoing total.
* Eight (8) university and research centers devoted to procurement of human organs for transplantation are funded for that part of their activities related to kidney transplantation. In Fiscal Years 1967 and 1968 these were funded at a total of $150,000; and in 1969 at $1,236,000; and the estimated total for 1970 is $606,000.
* Eight (8) kidney disease screening, detection and diagnostic studies are being supported to investigate various aspects of kidney disease and their relation to end-stage development. During 1967 and 1968 these efforts were funded at $1,590,000 and in 1969 at $688,000. No funds are provided for 1970, however.

4. NON-INTERFERENCE CLAUSE: Sec. 900(c) of the present RMP legislation includes a so-called non-interference clause. The Administration's proposal does not, as I understand it. Would you please explain why?

In the initial legislation the non-interference clause was most important. The program was viewed by many as a direct effort to impose an alien system of care upon the country; a system designed and operated at the Federal level.

Today the program has a four year history with established precedent. The Regions now recognize and are confident of the philosophical base of local identification of problems and decisions as to their solution. As a result of greater maturity of the program, the Regions themselves may now wish to experiment with certain changes in health care delivery practices if this is deemed appropriate and desirable by their Regional Advisory Groups; and is in the best interests of the health of the people served. Deletion of Sec. 900(c) would make clear that locally determined changes are not precluded without in any way suggesting that these would be Federally mandated. Nothing in the implementation of the program to date, nor in the attitudes and actions of those presently responsible for its administration, could give anyone concern in the latter regard.

5. NEW CONSTRUCTION AUTHORITY: The "Report on Regional Medical Programs to the President and the Congress" referred to the need for new construction authority for continuing education and certain kinds of other facilities. Does this need still exist?

The need for continuing education facilities remains acute. Continuing education remains the main force for combating professional obsolescence and introducing "latest advances" into the health care system. This activity falls heavily upon community hospitals already beset by severe budget problems. Thus the ability to meet this need is of critical importance since Regional Medical Programs are a major source of funding support for medical and allied health professional continuing education. In both community hospitals and medical schools, the pressures of rising expenditures for direct patient care have made it impossible for them to allocate sufficient funds to provide facilities and space in which continuing education activities could be undertaken.

Therefore, the need highlighted in the Report remains. However, the present limited construction authority has enabled RMP to defray costs of alterations and renovations in connection with the conversion of existing space in community hospitals and elsewhere arising from RMP funded continuing education activities. And as Assistant Secretary Egeberg pointed out in his testimony, Federal funding of all construction programs has had to be cut back in the Administration's fight against inflation. This combination of factors would argue against the advisability of a broadened RMP construction authority at this time.

6. MULTIPROGRAM SERVICES: The last extension of RMP provided authority for project grants for multiprogram services (Sec. 910) -- that is, for services needed by, or which would be of substantial use to, two or more regions. How has this been implemented?

The authority for project grants for Multiprogram Services has not been implemented. Although the kind of projects which might have been initiated and the services provided would have undoubtedly been of great value in the development of established regions, the decision of Regional Medical Programs, with the concurrence of the National Advisory Council, was to give first priority to the funding of at least minimal operational capacity in all 55 regions. As has been shown, the funds available to the program since the passage of the legislative extension which established Section 910 (Multiprogram Services Grants) have been sufficient only to cover existing program commitments and to initiate this single program priority.

Guidelines for Multiprogram Services Grants, and a system of priorities for consideration of program uses of the authority, have been developed by RMPS. As a test of the usefulness of such program services, both locally and nationally, a general announcement of the program was accompanied by an invitation for tentative proposals for projects. Some fifty such proposals have been received and represent a wide variety of activities which fall generally into two groups: Those which would provide cooperative efforts among two or three neighboring regions, such as broad scale clinical studies of certain drugs; and those which would provice a service of use to many or all RMP programs such as the training

of critically needed and highly specialized personnel, e.g., radiation therapists, multidisciplinary teams for cardiac surgery, and evaluation experts.

7. CLINICAL FIELD TRIALS: The proposed legislation provides specific contract authority for the conduct of cooperative clinical field trials. What is the significance of this; and how would such authority be employed?

Cooperative clinical field trials are among the most complex research and development activities, particularly in terms of the organizational elements. They frequently involve careful follow-up of very large numbers of subjects over long periods of time. The 55 Regional Medical Programs are a valuable organization resource for mounting such studies. Specific contract authority will permit the high degree of uniformity in experimental protocol which is vital to the success of such studies, especially where several institutions or groups would be involved. For the clinical field trials envisaged by this authority would indeed be cooperative, that is involve more than a single institution or group, in keeping with the underlying philosophy and general character of Regional Medical Programs, which is that of "cooperative arrangements."

8. LISTING OF ADVANCED FACILITIES: The Legislation as originally enacted (Sec. 907) required that the Surgeon General establish lists of facilities equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer, and stroke, including the availability of specialty training in such facilities. Has this been done as yet?

The National Advisory Council of RMP realized that before it would be possible to develop a list or lists of facilities meeting the requirements of Section 907 it would first be necessary to establish criteria against which such lists could be developed. Unfortunately, in 1966 no such criteria existed--none that spelled out what the requirements should be in a medical facility if it were capable of providing the latest advances in the diagnosis and treatment of heart disease, cancer, or stroke. Therefore, the Division has proceeded to make contracts with professional medical organizations which could gather together the leading experts in each of these fields and obtain their agreed judgment on such guidelines. The "Guidelines for Cancer Care" should be available within a few months. Those for Heart Disease should be completed in 1971, and those for Stroke by 1972.

Once completed and subjected to periodic updating, these guidelines can be used by all hospitals as a basis for assessing their deficiencies and potential for improvement and by RMPs as a basis for planning on a regional basis. Various plans for voluntary accreditation and development of lists according to these guidelines are now under discussion.

9. PROGRAM EVALUATION: The last legislative extension of RMP allowed, at the discretion of the Secretary, that a portion of the funds appropriated for grants be available for evaluation of the program. How has that money specifically been used; and what evaluation of the program has been made generally?

Specific evaluation funds relating to this one percent of appropriations provision have not been available to the program as yet. Evaluation, however, has been regarded as an integral and critical activity of Regional Medical Programs and as such has received considerable emphasis over the past four years. In addition to the ongoing evaluation activities carried out through the review of grant applications, progress reports, the studies conducted by the Evaluation Branch, and the use of site visits, several related activities have been initiated. For example, almost two years ago, a major contract was let with the Arthur D. Little Company to develop and test criteria to measure the effectiveness of Regional Medical Programs. In addition, the RMPS is supporting training contracts for the development of medical evaluators to work in local Regional Medical Programs, and an Ad Hoc Committee for the National Assessment of Regional Medical Programs was established in early 1969. Regional Medical Programs' involvement in urban problems is being examined under a contract studying the strategies and problems of RMP in developing programs for the residents of the inner cities.

Thus, the legislative extension of 1968, which encouraged the use of FY70 RMP funds for evaluation provided an additional opportunity to expand already ongoing evaluation efforts. However, uncertainties regarding the availability of FY70 grant funds have served to slow

down the utilization of funds for these activities. The Department has now tentatively designated $133,700 for RMP evaluation activities and in anticipation of these "earmarked" funds, we are considering the support of a major evaluation study concerned with an "Evaluation of RMPs Role in Changing the Delivery of Health Services," probably to be carried out by Harvard University's Center for Health Services Research. The study will examine the effectiveness of Regional Medical Programs in improving organizational arrangements for delivering high quality care.

In addition, the Regional Medical Program Service will sponsor a National Evaluation Conference to be held in the Spring of 1970 which will bring together the evaluators from all the Regional Medical Programs to discuss the nature and extent of evaluation in RMP and to exchange evaluation methodologies and techniques.

10. CONSUMER REPRESENTATION: The CHP legislation requires a majority of representatives on state and areawide advisory councils be consumers. To what extent is there consumer representation on your advisory groups?

The guidelines for Regional Medical Programs stipulates that each Regional Advisory Group have among the membership representatives of the public who are familiar with the health needs of the region. The number of public representatives or consumers on advisory groups has grown slowly but steadily since the inception of the program. Consumers played a significant role on the advisory groups during the formative stages of the program and by December 1966, they comprised 14% of the total Regional Advisory Group membership. Three years later in December 1969, 18% of the advisory group members were consumers. So, in three years the absolute number of consumers on the advisory group has grown greatly and the proportion of consumers has increased by 4%. The rate of growth of consumer representation has varied from region to region. One example of rapid growth is the Regional Advisory Group of the Ohio Valley RMP. The original advisory group of this region had 4 consumers among the 33 members for a percentage of 12%. As of December 1969, 30% of the 37 member advisory group are consumers. Perhaps a more typical example is the Washington-Alaska RMP which had 14% consumer representation on its original advisory group, but now 18% of the advisory group are consumers.

The consumers on the 55 Regional Advisory Groups represent a variety of occupations and interests. The largest segment of consumers is the business or managerial group which constitutes nearly 40% of the consumer representatives. The next largest category, comprising 22%,

is made up of lawyers, educators and other professional people. Representatives of labor unions make up another 12% of the consumers on advisory groups. The remaining 25% of the consumer representatives on Regional Advisory Groups are civic leaders, housewives, city councilmen and other individuals.

In line with suggested legislative changes, it is expected that consumer participation will be broadened. Members of the public familiar with regional health care problems, financing and organization will be encouraged to participate, so as to ensure adequate community orientation.

11. <u>BUDGET CUT-BACK</u>: What has been the effect on RMP of the budget cut-backs in funds this fiscal year and that proposed for next year in the President's Budget?

The effect of the budget cut-back in FY 1970 has been especially critical because of the fact that the program entered the fiscal year with a backlog of $20 million in approved but unfunded applications. Of this amount, some $2.8 million was for the initiation of the operational capability in three regions, the rest being for supplemental activities in operational Regions, many of which represented a very critical second stage in the development of well-balanced Regional programs.

Notification of the reduction in grant funds in the FY 1970 budget to $73.5 million made it immediately apparent that awarding of initial operational grants to the three Regions in approved/unfunded status plus the nine similarly approved early in the present FY would require an amount in excess of the total funds which would remain after meeting current commitments.

By securing the cooperation of the Regions in the judicious use of existing funds and careful rebudgeting of unexpended balances among individual component projects, it appears now that all commitments will be met and all approved initial operational applications will be at least partially funded, out of the funds available in FY 1970. This will not allow a single dollar for supplementation or expansion in any of the

41 previously operational Regional Medical Programs nor for the implementation of a single multiprogram services grant (the authority for which was provided in the extension of Regional Medical Programs legislation in 1968).

With the final Region still to be approved for operational grants, the Program will enter FY 1971 with cumulative funding level of the existing 55 Regions approximately $4.5 million in excess of the amount requested in the President's Budget for grants ($79.5 million).

12. RMP PRIORITIES: We hear a great deal about priorities these days in health and elsewhere. What are RMP's current priorities?

The first priority of Regional Medical Programs is to establish in each of the 55 regions, a viable organization consisting of a competent professional staff and an appropriately representative and effective system of voluntary advisory groups, which has the capability to plan and the operational capacity to initiate a program to improve the existing systems of providing personal health care in the region, (especially to those who have, or are at risk of having, heart disease, cancer, stroke, and related diseases).

Of equal importance, and second priority in time sequence only, is to recognize and strengthen this capability as it is acquired in the regions, by awarding additional funding if at all possible, and also by providing a far greater degree of flexibility in the use of existing grant funds so as to allow for the rapid implementation of local decisions and to facilitate local cooperative efforts with other Federally funded programs, as well as among institutions and agencies.

One important consideration to be taken into account in selecting which regions are to be afforded such additional funds and greater flexibility will be the extent to which their overall programs and regional priorities are responsive to, and reflective of, national priorities--priorities as ennunciated by the Secretary, the Department, and others with respect to health which the National Advisory Council has deemed as appropriate and applicable to the 55 regional medical programs.

13. CORE STAFF AND ACTIVITY: It appears that over half of all the monies granted to date, and nearly half of that currently available to regions, is for so-called core staff and activities. In view of the current tight money situation, wouldn't it be far more productive if a greater portion were spent for operational projects and activities and less for core overhead?

There has been a tendency to equate RMP core staff and activity only with program administration. This greatly understates the importance of core which includes planning, project development and review, and professional and technical assistance and consultation as well as administration. Moreover, so-called core supports many central regional resources, such as data systems, evaluation resources, information networks, and parts of the continuing education systems.

In view of the tight funding situation the functions of the core staff have become even more important than they previously were. Rather than being a primary source of funding to improve diagnostic and treatment capabilities directly, the program must seek to exert the greatest leverage it can with the funds available. This can best be done, not with one or two more operational projects, but by core staff (1) providing consultant or professional services to local institutions and (2) serving as a facilitator or convenor of multiple interest groups to solve local problems.

Acting in its convenor-facilitator role, RMP can exercise leverage, and in some cases bring small amounts of "venture capital" to bear, to bring institutions together for both planning and joint operational activities. Often these activities do not require RMP funds, but can be assisted by RMP to obtain funds from other sources. One example of

such activity is provided in Detroit, where complete staff support for the Model City Health Council Governing Board was provided by the Wayne State University component of the Michigan RMP; and the health plan of its recently funded Model City application was largely developed by the Associate Coordinator and RMP staff at Wayne State.

The technical resource and consultant role is yet another one. In Maine, for example, core staff is deeply involved in assisting an area of that Region in which three towns (Livermore Falls, Wilton, and Farmington) are in the process of deciding upon one joint hospital. The Maine RMP staff is working on developing the total planning program which includes the acute care of the patient with heart disease, cancer and stroke, the concept of progressive patient care, methods of patient flow and referral, new methods of construction, and care payment mechanisms.

Thus the type of activities carried out by an RMP core cover a wide diversity of functions, with considerable variation among the Regions in the balance or emphasis of such activities. It is probably true that the ultimate success of Regional Medical Programs will be measured more against its core activities than against a series of individual operational projects.

14. HEALTH CARE COSTS: What effect, if any, has RMP had on moderating the costs of health care? Or has its impact been just the opposite?

The regional scope and character of these programs and the involvement of the broad spectrum of health institutions, professions, and resources within each Region provides a means for taking specific action to share limited health manpower, facilities, and resources in maximizing the quality of care and services for heart disease, cancer, and stroke available to the Region.

The extensive cooperative planning, along with the process of regionalization -- the linking of health institutions and resources within a Region -- helps assure the coordination and optimal utilization of existing and future resources, and as such has the potential for eliminating wasteful duplication of activities and facilities. This improved planning and sharing of resources may well result in the reduction of the per unit cost of certain health care services.

In a great many of the operational activities currently being funded or proposed, there is a clear and direct concern for the allocation of resources and for the efficiency of their use. Among these activities are:

- Projects to promote prevention and multiphasic screening for early diagnosis of heart disease, cancer, and stroke for large populations.

- Projects to promote increased use of less expensive paramedical personnel and new occupations, such as physician assistants.

- Projects aimed at making the services of expensive medical care equipment available to regional and remote hospitals through computer monitoring and improved communication systems.

- Projects which emphasize out-of-hospital care, such as home health care.

- The strong preventive thrust of the activities of the National Clearinghouse for Smoking and Health with its public information campaign against smoking.

An increasing number of regions are carrying out studies on the economics of health care, particularly as it relates to their own program activities. Drawing upon economics, operations research, and other disciplines, such regions as Texas, Georgia, and Rochester are in this way giving specific attention to some of the interrelationship of Regional Medical Programs and the costs of medical care.

15. COOPERATIVE ARRANGEMENTS: Do cooperative arrangements really result in improved patient care? If so, how?

Regional cooperative arrangements create linkages among medical centers, hospitals, physicians and other health institutions and professionals in order to facilitate the transmission of knowledge, the sharing of scarce resources, and the rational planning and development of health programs. Such linkages are particularly necessary at a time when specialization in medicine has served to fragment medical services and inhibit communications among providers of care, and when the costs of implementing technological innovations in medicine cannot be borne independently by most health care institutions.

To help meet some of these problems, Regional Medical Programs are encouraging the development of cooperative working relationships among practicing physicians, medical educators, medical researchers, hospitals, public health officials and many other health and health related organizations and interest groups. These working relationships, or cooperative arrangements, are already beginning to offer evidence of progress in helping to knit together the various autonomous elements of the health care system for the benefit of those patients affected with heart disease, cancer, stroke and related diseases. For example, in the Tennessee Mid-South region, newly established coronary care units in several small rural hospitals have been electronically linked to Vanderbilt Medical Center for the transmission and diagnosis of EKGs and other physiological signals. Patients in these rural areas now have the

benefit of the medical center's expertise. In the Intermountain Region, university-based neurological specialists are making scheduled visits to rural hospitals to conduct consultative clinics with attending physicians.

In addition, many Regional Medical Programs are helping develop linkages among several hospitals in an area for the direct benefit of their patients. For example, in Maine, a "Regional Blood Bank" is handling 200 pints of blood per month for six of the region's hospitals in one area of the state. Previously, a few of these hospitals were running their own individual blood banks, on a less than optimal basis. Regional Medical Programs helped them develop a blood bank with sophisticated equipment and enlarged storage capabilities which now provides broader and higher quality services.

Cooperative arrangements can help avoid unnecessary duplication of expensive facilities by the process of community involvement in the planning and decision-making of Regional Medical Programs. Such a process brings together the medical, health and community leaders to consider jointly the health needs of the region and develop a consensus on how to meet the needs in the most efficient and effective manner for that particular community.

16. IMPACT ON MORBIDITY AND MORTALITY: What evidence do you have that morbidity and mortality from these diseases has been reduced as a result of Regional Medical Programs?

It is still too early to adduce definite evidence that Regional Medical Programs and the activities specifically being carried out by them have produced any decrease (or other changes) in morbidity or mortality from heart disease, cancer and stroke. The majority of the 55 regions have been operational for just a little more than one year; only four have been operational for as long as three years. It takes longer than this to affect changes and accumulate the data reflective of any that may have occurred.

Since it is too early to assess the program in terms of ultimate impact and pay-off, improved care and health status, program assessment to date must be largely in terms of the RMP organizations and planning process which have been established, the regional cooperative arrangements among health institutions and providers that have been created, and the enhanced diagnostic and treatment capabilities beginning to be brought about through the efforts of the 55 regions. The means by which more comprehensive and improved care is being achieved and hopefully the health of those patients receiving it is benefited.

True, we do have some preliminary and highly tentative evidence in a few isolated instances. For example, preliminary data reported by the North Carolina RMP in connection with a coronary care network in a rural, mountainous area in the western part of that state, indicates a 67% reduction in mortality from acute myocardial infarctions among the first 300 patients who had this service available to them.

Not only is it too early to make any generalizations along these lines, but I would hasten to add that unfortunately it is rarely possible to measure and attribute changes in the health of a population to simple, individual causes. There are many things affecting health other than improved care. The air we breathe, the food we eat (or overeat), and our genetic heritage to cite but a few. Not only are there many variables which must be taken into account, but sometimes we are mystified as to what to attribute certain rather dramatic changes to. Witness the steady decline in recent years of stomach cancer in men.

17. DISADVANTAGED POPULATIONS AND AREAS: To what extent have RMP funded activities helped improve the availability and quality of services for those residing in areas with limited health resources, such as the inner-city poor and many rural populations?

Regional Medical Programs have participated in both planning and operational activities aimed at improving health resources for inner city residents and rural populations.

In the area of planning, the New Jersey RMP has been vitally involved in planning with all community segments for improving health services for the urban areas of Newark, Trenton, and Hoboken. It has provided Urban Health Coordinators to work directly with their several Model Cities programs to plan the health component of the program. This support and the attention and time provided by the staff of the RMP is expediting the development of improved urban health services.

Participating in community planning and at the present time in a major operational activity, the California RMP has played a major role in developing a plan to meet health needs of the disadvantaged population of the Watts-Willowbrook district of Los Angeles. Again in California an operational program is attacking the health care delivery system in yet another way by the use of mobile multiphasic screening for the early detection and identification of health problems among the urban poor and migrant agricultural families in San Joaquin County. There are eight other similar operational disease screening projects in other parts of the country with an approximate Regional Medical Program funding support in excess of $2 million in this area of disease prevention for disadvantaged populations and areas.

18. <u>PROGRESS IN LARGE URBAN REGIONS</u>: Two years ago, at the time of the last RMP legislative extension, progress in the large, complex metropolitan regions such as New York was comparatively much slower. Is this still the case?

There has been and still continues to be a wide variation in the character and stage of development of these programs in the metropolitan areas. Although it is generally true that as a group they have lagged behind in the organization of the core program, initiation of operational projects, and level of funding, many of these regions have overcome the initial organizational problems which deterred their early progress and growth.

In large, complex metropolitan regions such as New York City, Philadelphia, Cleveland, St. Louis, Boston, and Chicago, the rate of development has been slower because the mechanisms required to pull all the elements together for a more directed effort have been quite difficult to align and organize. To some extent, this has been expected because the large cities are--for a number of reasons--more complex in their makeup and are subjected to numerous competing demands and priorities over and above those faced in the health field. As a consequence, these regions have had to stimulate the pulling together of a great multiplicity of resources to bring about a better utilization of available professional manpower and facilities. This has required a considerable amount of time and effort and in some, much more time and effort are required still.

Notwithstanding the complexities, however, RMP has made some progress in the area of urban health in several metropolitan areas; namely, the Watts-Willowbrook section of Los Angeles, Indianapolis, Washington, D.C., Nashville and Newark. Considerable amount of planning has been done in a number of the larger cities and supported directly by Regional Medical Programs. Some of these plans have already emerged and have been forwarded for review and funding by OEO, Model Cities, and other HSMHA programs in addition to RMPS.

19. <u>RELATIONSHIPS WITH OTHER FEDERAL PROGRAMS</u>: What have been your relationships with other Federal programs such as OEO and Model Cities?

In several Regional Medical Programs, relationships with other Federally-funded programs involve both planning and operational activities. One of the best illustrations of planning assistance is with the Model Cities program.

The New Jersey RMP is closely coordinating its planning activities with Model Cities in that state. Three staff persons are assigned as full-time Urban Health Coordinators within the designated Model Cities of Newark, Trenton and Hoboken to develop the health component of the Model Cities plan. Each, working with the elected citizens' health panels, has identified the priorities for health services and developed an operational framework for action, which was submitted as part of the total Model Cities operational plan. Their success has led to requests for five additional such Coordinators for assignment to the newly-designated Model Cities.

There are strong cooperative efforts between the RMP and Model Cities in Richmond, California where the sharing of the salary of an Urban Health Coordinator should soon lead to the development of grant applications in community health for possible sponsorship by Model Cities and RMP.

In Detroit, complete staff support for the Model City Health Council Governing Board was provided by the Wayne State University component of the Michigan RMP; the health plan of its recently funded Model Cities contract was largely developed by the Associate Coordinator and RMP staff at Wayne State.

Such relationships as these are gradually developing in a series of other Regions, with the form of consultation, committee interaction, or joint planning varying depending on the complexity of the local situation and the state of development of both the Regional Medical Program and the Model Cities agency.

An example of RMP cooperation with OEO involving operational assistance is to be found in Nashville, Tennessee where a demonstration project has been established to test and evaluate the impact of early diagnosis of heart disease, cancer and stroke within the confines of a Comprehensive Neighborhood Health Center. Here, health evaluations and utilization studies are being made on a defined population group within a prescribed inner-city area. This demonstration project is being coordinated cooperatively between Meharry Medical College, OEO and the Tennessee Mid-South RMP.

20. RMP-CHP RELATIONSHIPS: How would you describe or characterize the relationships between RMP and CHP? Has there been either conflict or real cooperation, or have the two pretty much gone their own way?

The relationships between Regional Medical Programs and Comprehensive Health Planning agencies are quite varied, ranging from close cooperation to exploratory discussions. General cooperation such as overlapping membership between Regional Advisory Groups and the CHP State Health Advisory Councils are evidenced in 53 of the 55 regions. Furthermore, 23 regions have undertaken common data collection activities with the state CHP agencies and 14 have indicated a sharing or joint participation in special planning studies. In this regard the state CHP agency and the RMP have defined common subregional areas for planning and operations in 6 regions.

Relationships with areawide comprehensive health planning agencies have been somewhat slower in developing, in large part perhaps because the majority of the 114 currently funded areawide agencies have been in operation for less than a year. In that connection, it is significant that 11 regions have assisted actively in the development of areawide agencies and in 4 actually provided some developmental funds.

Evidence of the potential for close working relationships between RMP and areawide CHP agencies is that 26 of the regions have overlapping membership between the Regional Advisory Groups and the Areawide Advisory Committees. In Memphis, the membership of the 314(b) agency advisory group, (Mid-South Medical Center Council), and the Memphis RMP advisory group are the same.

A number of regions have established local advisory or action groups. These groups review projects, assess local needs, encourage

project development and generally coordinate RMP activity at the local level. The Georgia RMP, for example, has established some hospital-based local action groups throughout its region. These groups send all proposed operational projects to the areawide CHP agency for approval, if one exists.

Even closer coordination, collaboration and possibly consolidation have begun in several places. The governors of South Dakota and Vermont have been exploring ways in which the relationships between RMP and the state CHP agency might be formally structured. The Program Coordinator of the Nassau-Suffolk RMP is also serving as the acting Project Director of the Nassau-Suffolk Comprehensive Health Planning Council; and a formal relationship between the two there is being studied.

For the most part there is no concrete evidence of overt conflict or suspicion between the two programs at the state, regional, or local level. Rather, general cooperation, tentative involvement and avoidance of any open conflict characterize the relationship between RMP and CHP.

21. <u>REGIONAL OVERLAPS</u>: Is there still a good deal of overlap among Regions?

There are approximately 13 cases in which two Regions both have some responsibility for developing activities within a certain geographical area. Discussions among neighboring Regional Medical Programs have resulted in both planning and the development of operational projects which cross regional boundary lines and thus are designed to capitalize as much as possible on regional resources to meet local health needs. It is sometimes best for individual hospitals and groups to participate in different aspects of several programs, such as the continuing education program of one Region and the medical library program of another.

The definition of regional boundaries is regarded by most Regions as a flexible determinant of regional activities, rather than as a fixed, geographic limit for activities. In placing responsibility for determining boundaries at the regional level, it was felt that local planning groups could best determine the relative weight of criteria to be used.

Generally a Region aims at being an economically and socially cohesive area, taking into account such factors as population trends and patterns of growth; location and extent of transportation and communication facilities and systems; and presence and distribution of educational and health facilities and programs. In defining medical trade areas, the attempt is made to follow appropriate existing relationships among institutions and existing patterns of patient referral and continuing education. Thus some 36 Regions have defined themselves as essentially coterminous with one or more States, while the other 19 are essentially parts of one or more States.

The definition of regional boundaries has not changed significantly since the Regions first delineated their boundaries for planning purposes. Of approximately 9 Regions making changes, most were a matter of adding or subtracting specific counties because of areas of overlap with adjacent Regions.

22. FUNDS TO COMMUNITY HOSPITALS: In the past, some persons have alleged that the preponderance of RMP grant funds has gone to medical schools, and conversely, that comparatively little has found its way into community hospitals. Is this true?

Since the beginning of Regional Medical Programs, the medical schools have functioned as one of the significant organizers and resources for the RMP's development. Commonly the center of the "medical trade areas" along whose boundaries the fifty-five regions were formed, the schools provided a natural resource for the establishment of the RMPs and for the conduct of their activities. Historically, the medical schools and their affiliated hospitals have been the recipients of the greatest part of RMP grants funds, but this situation is now beginning to change. While this is still true in many of the regions, particularly in those which are in their initial operational phases there has been an increasing emphasis on the community hospital as a local resource as operational programs mature. The community hospital is recognized as one that is better able to accomplish the foremost objective of the RMP--"to strengthen and improve the personal health care system in order that the quality of care received by individuals may be constantly improved..." Clearly, the community hospital, being oriented to the care of the individual, provides the setting which can best carry out programs which will fit the needs of the community.

In examining the progress of several regions which have been operational two years or longer, one can discern what seems to be a trend away from the medical school and toward the community hospital. The hospital is becoming more involved in Regional Medical Programs and consequently

it is receiving a greater share of the funds. The RMP of Kansas typifies this trend: the University of Kansas Medical School was the primary recipient of funds and central resource when the RMP in that state went operational almost three years ago. At the present time, community hospitals are taking a much more active part in nearly every operational project in the region, and twenty hospitals are sponsoring or co-sponsoring six of the fifteen projects.

The Regional Medical Program of Albany, New York, is another case in point. The RMP here was established by the Albany Medical College and has been operational since the spring of 1967. A quick look at the operational projects of this region is enough to discern that efforts to increase community hospital involvement have been fruitful: of Albany's ten projects, four are sponsored by community hospitals, only one by the college medical center. In seven projects, forty-eight community hospitals are the recipients of RMP funds totaling approximately 110,000 dollars.

23. COMMUNITY HOSPITAL INVOLVEMENT: To what extent have hospitals, and I mean Community and voluntary hospitals, not just the major teaching hospitals of medical schools, been involved in and benefited from RMP?

In the early stages of RMP, there was concern on the part of the Congress that there was insufficient community hospital involvement in the various regional programs. At this point, however, it is evident that community hospital involvement is increasing and that the hospital is becoming a center for program activity, both at the division level and in the regional programs. RMPS has designated a senior staff member with primary responsibility for strengthening relationships with community hospitals, and a joint invitational conference was held in June 1968 for the American Hospital Association and RMPS.

Community hospital impact is also being felt in the regions--while total membership on the Regional Advisory Groups has almost doubled since December 1966, the number of hospital and hospital association representatives on the RAG's has increased by 135%, and now comprises 12% of the total membership as compared to 8% three years ago. Community hospitals are also represented on other planning and policy and decision-making bodies of the RMP organization-about 18% of the combined membership of planning committees and area and local advisory groups is community hospital representation.

Almost a third of the nations 6000 community hospitals are represented on regional, area, and local advisory groups, planning committees, regional task forces, and the various other decision-making groups. Community hospitals comprise about a third of all institutions and organizations represented on these bodies.

A number of local hospitals, hospital associations, and hospital planning councils have been or are presently conducting planning and feasibility studies for the various RMP's. Of the 96 subcontractual studies cited by the regions, 14 are being performed by community hospitals and 11 by hospital associations or planning councils.

Community hospitals play an important part in operational activities within the regions. About 1700 hospitals are participating in operational projects, comprising 70% of all institutions and organizations involved in RMP.

Over a thousand of these hospitals are considered primary participants-either sponsoring the project, receiving RMP funds or serving as the location of all or part of the project. Project sponsorship is probably the most indicative of active involvement, since it entails overall administrative responsibility for the conduct of a project, including, in some cases, the disbursement of RMP funds; approximately 160 community hospitals are acting as sponsors or cosponsors of operational projects.

- Eight community hospitals in the Ohio Valley RMP are jointly sponsoring a project concerned with establishing a full-time Director of Continuing Professional Education in each of the hospitals; eight additional hospitals are participating in the project in other capacities.
- The Georgia RMP has undertaken a statewide cancer project which is sponsored by nine community hospitals and the Emory University School of Medicine, its teaching hospital. When the project is fully implemented, it is anticipated that excellent services and facilities will be available within a reasonable distance of the

home of every cancer patient in the region.

There is no doubt that community hospitals have derived benefits from their association with RMP. In many instances the hospital has been able to obtain equipment and services which would not have been financially possible without RMP support; and many hospitals have been able to upgrade their staffs through RMP continuing education programs. Moreover, RMP has fostered the development of relationships among community hospitals which previously had little knowledge of or involvement with one another.

24. FEDERAL HOSPITAL INVOLVEMENT: To what degree are VA and other Federal hospitals participating in and benefiting from RMP?

Federal hospitals, especially Veterans Administration hospitals, are becoming increasingly involved in planning and decision-making and operational activities of Regional Medical Programs. This increased participation is largely due to the fact that the law governing RMP was amended in October of 1968 to permit Federal hospitals to be reimbursed for participation in RMP activities.

There are a total of 72 VA hospitals presently involved in activities in 39 regions, as compared to only 37 hospitals in 28 regions a year ago. Forty-six (46) have representatives on regional planning and decision-making bodies (regional, area, and local advisory groups, planning committees, etc.) and 38 are participating in operational projects. Twenty-six (26) other Federal hospitals, both PHS (13) and military (13), are also involved in operational activities.

* The VA Hospital in Tuscaloosa, Alabama, is conducting, with RMP funds, a training program in "reality orientation technique" designed to improve the care and rehabilitation of older patients with cerebrovascular disease and stroke. The training is directed toward a broad spectrum of health personnel in the Alabama region with special attention to those working in nursing homes.

* The California RMP is supporting an operational project in the San Francisco area (AREA I) for the comprehensive care of patients with hypertension. Sponsored by the San Francisco Medical Center, the project involves 9 other hospitals throughout the country, including the Fort Miley VA Hospital. It is a major teaching hospital and the primary Veterans' facility in the Bay Area. A demonstration clinic for consultation and care of patients with hypertension has been established there under the auspices of the California RMP.

* The Washington/Alaska RMP has been instrumental in developing the Alaska Health Sciences Library at the USPHS Alaska Native Medical Center in Anchorage. When the Library was established by the Hospital in 1967, there was only one medical library in the entire state; and until RMP support became available in early 1969, the Center Library operated on a very limited and inadequate scale. At this time, however, the Library is fully staffed and has advertised its services to all physicians and dentists in the state. A recent survey shows that 38% of all private physicians in Alaska already have used the Library.

25. <u>CONTINUING EDUCATION</u>: How has continuing education of physicians helped to improve health care?

Over 50 per cent of all operational grant funds awarded have been for continuing education and training activities which address themselves quite directly to the primary purpose of RMP, the improvement of health care. Another 32 per cent have been awarded for demonstrations of patient care. Many of these projects have an educational component.

The ultimate standard of effectiveness resides in the measurement of changes in health care. Limitation of present evaluation methodologies are such that quantification of the direct effect on patient care is not generally feasible. However, on an individual basis, it is sometimes possible to identify the specific impact of an education program. This is exemplified in the case of the California physician in a small community hospital who successfully treated six cases of cardiac arrest as a result of the skills developed in an RMP-sponsored course at the Pacific Medical Center. This RMP-trained physician, with his colleagues and in cooperation with the local heart association and junior college, in turn offered courses for nurses and allied health personnel in coronary care. With trained supportive personnel from this program, the hospitals were able to provide critical 24-hour surveillance of myocardial infarction patients in intensive coronary care units.

Whereas the direct relationship between continuing education activities and patient care changes often defy exact measurement, a component of effectiveness, such as the program's ability to reach the desired audience, is more readily assessed. By June, 1969, over 16,000 physicians had been trained with RMP funds in the 55 regions. Also trained with RMP support were well over 38,000 personnel whose services are supportive to those of physicians and thus contribute to the total quality of health care.

Another component of effectiveness is the quality of educational design and instruction. Regional Medical Programs Service, in an attempt to improve the quality of physician instruction and of evaluation in educational programs, has initiated five contracts in as many universities (University of Illinois, Ohio State, University of Southern California, University of Washington, Michigan State) for long-term courses leading to advanced degrees, as well as providing funds for workshops and short-term training courses. Graduates are now found in RMP staffs throughout the country.

Regional Medical Programs also have been instrumental in significantly improving the planning aspects of continuing education programs. They have involved institutions and health professionals in a team effort so that the programs planned are more relevant, duplication has been avoided, patient care needs and practitioner needs have been dominant in the setting of objectives, and the best possible resources of the region are utilized. They increasingly are serving a coordinating function as well. The West Virginia RMP,

for example, is cooperating with the state medical society in studying ways to devise statewide programs based on the patient care review mechanism.

26. HEALTH MANPOWER: Has RMP done anything to help develop and train new types of health manpower?

RMP has funded a few operational projects for the training of new types of health manpower.

* Georgia RMP. Grady Memorial Hospital in Atlanta trains "medical specialty assistants" to work in medical and coronary intensive care units. The two-year program accepts high school graduates or medical corpsmen.
* Indiana RMP. Flanner House in Indianapolis offers a 6-8 week course for the training of screening technicians and community health organizers. Trainees live in the community, have less than high school education and are generally unemployed or under-employed.
* Washington-Alaska RMP. Spokane Community College, Spokane, has just completed a two-year training program for cardiopulmonary technicians.
* Maine RMP. Maine Medical Center offers a 16-week training course for registered nurses to become pediatric nurse associates.
* North Carolina RMP. Extension of the 24-month physician assistant program at Duke University. This proposal has been approved by the August DRMP National Advisory Council but is as yet unfunded.

In addition to the operational projects mentioned above, many regions have, as part of their "core" activities, been supporting planning studies, and meetings of representatives from universities, junior colleges, clinical resources and professional associations to discuss needs, training resources

and placement, etc. of new types of health personnel. Some RMPs have published survey findings.

27. <u>PHYSICIANS IN RURAL AREAS</u>: Has RMP in any way affected the availability and distribution of physicians in rural areas (for the better)?

Regional Medical Programs most significantly affect the availability and distribution of physicians in rural areas through helping create a more intellectually stimulating environment. More readily available continuing education opportunities, and greater accessibility of colleagues in the medical center made possible through RMP, helps overcome two often repeated objections to rural practice. Increasingly, through the process of subregionalization, circuit riding courses and the use of communication technology, among others, the distance is lessening between the rural practitioner and the medical world outside.

The Washington-Alaska RMP reports that a total of 11 physicians have started practice in the rural communities in central Washington since the start of one of its continuing education projects in the summer of 1967. This project is based in the subregional medical center of Yakima, a city of 44,000 ringed by 10 isolated communities. A regular exchange of teachers and practitioners goes on between the Seattle Medical Center and Yakima and between the latter city and its surrounding small towns.

The 11 new physicians include a cardiologist sent by the Washington-Alaska RMP to Yakima for a teaching consultation seminar. He decided to stay to practice. A University of Washington affiliated pathologist who moved to Yakima early in 1969 stated:

> "The ambitious continuing education programs here have created such a stimulating atmosphere that I felt I could move from a University Center to this remote community without any professional penalty at all."

Speaking of a coronary care preceptorship program, one family practitioner said:

> "It has already changed the type of myocardial infarction care in our area. It stimulated other physicians to seek out similar courses and awakened the dormant education programs among our nurses."

The use of communication technology has made accessible the most recent medical information in many rural areas. The Dial Access System in North Dakota has been enthusiastically received by rural practitioners; and the Alabama RMP-sponsored Medical Information Service provides direct telephone communication between the inquiring practitioner and the specialist at the University Medical Center in Birmingham best qualified to answer his questions. In the Intermountain region, characterized by widely scattered small hospitals, 52 hospitals participate in its Network for Continuing Education. Medical grand rounds and physicians' conferences are broadcast weekly.

Regional Medical Programs have also brought to rural practitioners opportunities for greater emphasis on disease prevention through screening projects. Two such projects are occurring in 4 rural counties of Florida and in Southern Tennessee. Large segments of medically indigent in these two rural communites will be among those screened for cardiovascular disease as a result.

28. ADL-OSTI CONTRACT: I understand you have a large, two-year contract with Arthur D. Little which is providing both an evaluation of, and some basis for, future evaluation of RMP progress. What has it turned up?

We expect a final report from this two-year effort in the summer of 1970. The work is still in progress. We have received various interim reports orally and in writing, so it is possible to indicate the lines along which the contractors are working. Some of their tentative findings are as follows:

* RMP can and often does contribute to the regionalization of health services. The regionalization processes it can employ are varied, but more often than not, many steps are required; first, to develop relationships between two or more institutions, professions or communities, then to create subregional networks; and, finally, to broaden and deepen these networks by associating them with other networks--all to serve tangibly to improve the quality of care, or its availability.
* RMP starts with specific, tangible projects, not usually with a "grand design." "Grand designs" in RMP experience so far have not in most cases, speeded things up, because these plans have usually been expressed so early in the process of regionalization that they were perceived as either threatening or irrelevant by too many of the people whose voluntary cooperation and enthusiasm was necessary. Whether a "grand design" is useful in RMP appears to depend on whether people reach a point where they want such a plan.

* RMP has no power to enforce any preconceived pattern of regionalization. How regionalization begins and progresses in the early stages (the first few years) depends accordingly on

  -- The energy and enthusiasm of voluntary participants.

  -- preexisting conditions: the conflicts, needs, patterns of care, and institutions that were there before RMP.

  -- RMP core staff skill in identifying and encouraging energetic people, and in helping to develop useful processes and projects (facility sharing, encouraging more referrals, and consultations, e.g., to improve early diagnosis, promoting appropriate institutional mergers, developing continuing education networks, etc.)

  -- The skill of the Program Coordinator and the success of Regional Advisory Group and Directors (if any) in making RMP accessible to all interested parties without becoming the captive of any of them.

* RMP in most cases acts as a broker, a convenor, and a facilitator. When it is effective, it helps to catalyze the efforts of others. RMP is forced into this role (1) by P.L. 89-239, with its emphasis on voluntary cooperative arrangements, (2) by the need for such a catalyst in many parts of the country, (3) by the fact that RMP resources are relatively very small (e.g., one tenth to half a percent of national expenditures for health care

and only a few percent of expenditures attributable to diagnosis and treatment of the categorical diseases).

* Evaluation of RMP. Because there is wide variation in the starting conditions of the regions, and because of the relatively high degree of local autonomy demanded in the law, as well as other aspects of P.L. 89-239 mentioned earlier, the contractor believes that the regions (and accordingly, the program as a whole) must be evaluated in terms of regional RMP effectiveness in its primary role: that of facilitator-broker. The ultimately necessary evaluation of the program's detailed impact on the health of the people cannot now be accomplished because of the delay between cause and effect. Furthermore, it is rarely, if ever, possible to measure and attribute changes in the health of populations to simple, individual cases. But the plausibility of specific projects and their progress toward reaching either planned or perceived goals can be estimated. More important still, the skill and effectiveness with which RMP's in the various regions have carried out a process of involvement, planning, and achieving genuinely useful health care regionalization can be examined and substantially judged against the back drop of the conditions under which a region started and the resources available to it.

* RMP appears to be able to enlist the participation of practicing physicians, and to provide them with an acceptable opportunity to

act in concern with members of other health professions and the general public. The contractor believes that this ability, though still partly unrealized in fact, is a great asset to RMP, and an absolute precondition to any voluntary effort to achieve regionalization.

29. CHRONIC DISEASE PROGRAMS: How do you justify and explain the phasing out of the Heart Disease, Cancer and other Chronic Disease Control Programs?

Regional Medical Programs was established to deal with the problems of heart disease, cancer and stroke and improve the care of those suffering from, or threatened by, those diseases. To do this, it was authorized to make grants for planning, research, training, and demonstrations of patient care; through fiscal year 1969, nearly $150 million in awards have been made to the 55 regions for this purpose. Of that for operational activities, about $23.5 million has been in the area of heart disease; almost $7 million for cancer; $7.7 million for stroke; approximately $5 million for related diseases; and over $30 million for activities of a multi-categorical nature.

A program review of the several Chronic Disease Control Programs indicated that there was very considerable overlap between them and Regional Medical Programs as to the training, development, demonstrations, and other activities being carried out. It was felt that these could be carried out more effectively, and in a manner that would be more consonant with regional needs and priorities, by Regional Medical Programs.

This is why they are being phased out. Those several programs where there was little overlap, or not the case, are not being phased out. These are the Kidney Disease, Nutrition, and Smoking and Health Programs.