
*E000703*

Profile: Maine Regional Medical Program

Grantee: Medical Care Development, Inc.
295 Water Street
Augusta, Maine 04330
(Telephone: 207/622-7566)

Program Coordinator: Manu Chatterjee, M.D.

Originally Prepared By: Spencer Colburn
Operations Officer

Original Date: August, 1969

Updated: _____

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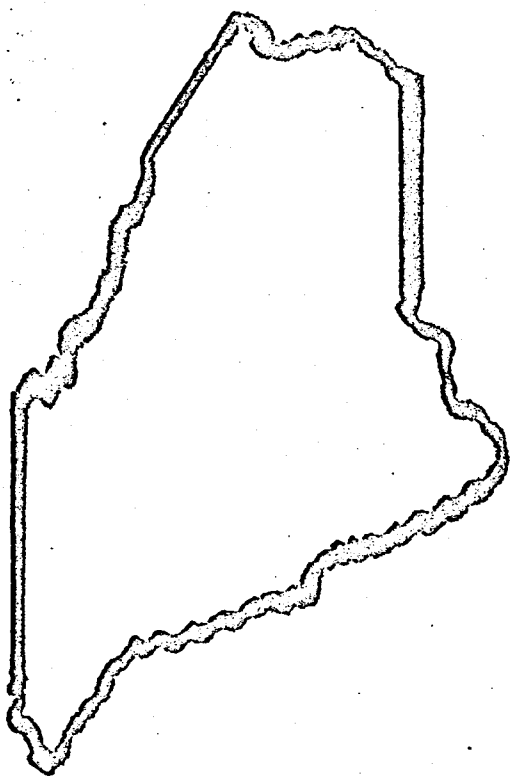
TABLE OF CONTENTS

MAINE REGIONAL MEDICAL PROGRAM



II. Geography

The Maine Regional Medical Program is coterminous with the State.

Many of the same geographic characteristics and resource problems of Maine apply to northern New Hampshire and Vermont and consideration for redefinition of boundaries has been considered, however, due to extremely poor transportation connections between these areas, no redefinition is anticipated. Because Maine problems are so different from Massachusetts, no redefinition is being considered in this direction either.

## III. DEMOGRAPHY

1) Population: The estimated 1965 population is 993,000.

   a) 51% urban
   b) Roughly 99% white
   c) Median age: 31.6 (U.S. average 29.5)

2) Land area: 31,012 square miles

3) Health statistics:

   a) Mortality rate for heart disease--463/100,000 (high)
   b) Rate for cancer--182/100,000 (high)
   c) Rate for CNS vascular lesions--126/100,000 (high)

4) Facilities statistics:

   a) No medical schools

   b) Seven Schools of Nursing, one is university-based and one is based at a junior college.

   c) Three Schools of Medical Technology

   d) No Schools of Cytotechnology

   e) Eight Schools of Xray Technology

   f) There are 58 hospitals, five are federal and 53 are non-federal. Of the non-federal hospitals, 45 are short term with 3,508 beds and eight are long term with 4,802 beds. The five federal hospitals have a total of 1,189 beds.

5) Personnel statistics:

   a) There are 1,078 MDs (110/100,000) and 221 DOs (22.5/100,000) in Maine.

   b) There are 3,856 active nurses (393/100,000) in Maine.

## IV. POLITICS

Governor:

Kenneth Curtis (D) until 1972

Senators:

Margaret Chase Smith (R); Aeronautical and Space Science, Appropriations, Armed Services

Edmund S. Muskie (D) 1959-1970; Banking and Currency, Government Operations, Public Works, Special Committee on Aging

Representatives:

Peter N. Kyros (D) 1966-1970; District of Columbia, Interstate and Foreign Commerce.

William D. Hathaway (D) 1964-1970; Education and Labor, Merchant Marine and Fisheries

## V. HISTORICAL REVIEW

Fall 1965 - Spring 1966 - Interest is generated regarding Regional Medical Programs and the possibility of Maine being part of a New England RMP is considered.

Maine, however, chooses to remain autonomous and the search for an appropriated grantee organization is started. Bingham Associates Fund becomes actively interested and assist in pre-planning.

The Maine Medical Association and the Maine Medical Center are considered as a grantee possibility but it is soon evident that this will not be acceptable to all, especially the osteopathic segment. Consequently, Medical Care Development, Inc. is formed. This corporation has no pre-existing health complex affiliation and is acceptable component of the medical care system.

September, 1966 - Dr. Merle S. Bacastow, Director of Medical Education, Maine Medical Center, and Mr. George T. Nilson, M.P.H., Field Director of the Bingham Associates Fund came to DRMP to discuss a draft application from the State of Maine.

December, 1966 - First Planning Request - Establishes the State of Maine as the Region.

Medical Care Development, Inc. c/o Department of Health and Welfare, Augusta, Maine, was designated as the applicant organization.

Bingham Associates Fund, Boston, Massachusetts, was designated as the fiscal agent.

George T. Nilson, M.P.H. was identified as the active planning coordinator on 100% loan to Medical Care Development, Inc. from

Bingham Associated Fund.

Applicant propose to appoint hospital coordinators to serve as liaison between the community hospitals medical staffs and the RMP.

| | | |
|---|---|---|
| May, 1967 | - | 01 Planning Award $193,909 DC |
| May to Mid Summer 1967 | - | The program's professional staff is assembled and Dr. Manu Chatterjee is appointed full-time program coordinator. |
| Fall 1967 - Spring 1968 | - | Periodic meetings with the health and educational agencies of this Region continue and become established procedure. |
| | | Twenty-eight hospital coordinators are appointed and in 28 other hospitals someone functioning in another capacity (Chief of Staff, etc.) are acting coordinators. These 56 hospitals represent 98% of the regions hospitals beds. |
| | | Three meetings are held with the hospital coordinators. |
| | | Two feasibility studies are initiated. One studies the linking of hospitals with referral centers by Data Phone, visual display by scope monitoring, and a private "hot-line" for voice communication. The other studies the continuing education of private physicians in a community hospital in conjunction with monthly staff meetings. |
| | | RAG membership is completely divorced of the grantee organization to completely eliminate any overlap of membership or legal problems that may arise. |
| February, 1968 | - | First operational request received. This application request support for four projects. |
| | | Project #1 - Visiting Guest Resident<br>Project #2 - Kennebec Valley Regional Health Agency<br>Project #3 - Physician Seminar<br>Project #4 - Smoking Control |
| | | On June 14, 1968, Projects #1, #2, and #4 were funded and the Region became operational. |
| April, 1968 | - | 02 Planning Award $204,709 DC includes $61,713 carryover from 01. |
| May, 1968 | - | $15,000 grant from Maine Heart Association to implement coronary care data-phone feasibility study. |
| June, 1968 | - | Site visit (Dr. William Ruhe, Professor Thompson, Dr. Stephenson, Mr. Strachocki, Mrs. McDonald, Miss Morrill) |

Project #2 - Kennebec Valley Regional Health Agency - Mr. Burt Sheeham appointed Executive Director effective Septembe 25, 1968.

Project #4 - Smoking Control - Program is staffed and public relation efforts are started.

Core staff is expanded and Mr. John LaCasse is appointed Associate Coordinator for Applied Technology.

March, 1969 - 01 Operational Supplement Award $45,414

Project #5 - Coronary Care Program and Project #6 - Physicians Continuing Education Program are funded. These projects were approved by the November 1968 Council.

April, 1969 - 01 Operational Supplement Award $501,437 DC Includes continued funding for core activities support only.

This application is also included request for funding of Project #8 - Directors of Medical Education; and #9 - Regional Library. Both of these projects were approved but unfunded.

June, 1969 - Niles Perkins, M. D. is appointed Assistant Program Coordinator for Project Design.

July, 1969 - All awards are placed under one accounting mechanism. This allowed for the funding of Projects #8 and #9 for one year through the use of carryover funds.

Philip G. Good is appointed Associate Coordinato for Continuing Professional Education.

June, 1968 - 02 Planning Award Supplement $153,460 DC - This award was for additional core staff, consultants, office equipment, and expenses of several feasibility studies.

July, 1968 - RMP assumed fiscal responsibility for its own program and operational projects.

John Davy, M.D., is appointed Associate Coordinator for Maine Cities.

Summer-Fall 1968 - Project #1 - Visiting Guest Resident-Progress slowly due to change of hous staff in July and recruitment difficulties.

August, 1969 - August Council considered four projects: #11 - Department of Community Medicine - Maine Medical Center; #12 - Coronary Arteriography and Myocardial Resvascularization; #13 - Care of Cerebrovascular Disease; and #14 - Regional Cancer Program.

Council recommended approval of #14, return for revision of #11 and disapproval of #12 and #13 as both of these projects were service oriented and high in equipment cost.

VI. CORE STAFF

Coordinating Headquarters

Maine's Regional Medical Program
295 Water Street
Augusta, Maine 04330
(Tel. 207/622-7566)

Program Coordinator: Manu Chatterjee, M.D.

Staff:

Assistant Program Coordinator for Project Design
Niles Perkins, M.D.

Associate Coordinator - Continuing Professional Education
*Philip Good, M.D.

Associate Coordinator - Maine Cities
John Davy, M.D.

Associate Coordinator - Applied Technology
John LaCasse

Director Administrative Services
Justin Cowger

Director Grant Program Policy
(Mrs.) Janet Jones

Director Community Relations
Jefferson Ackon

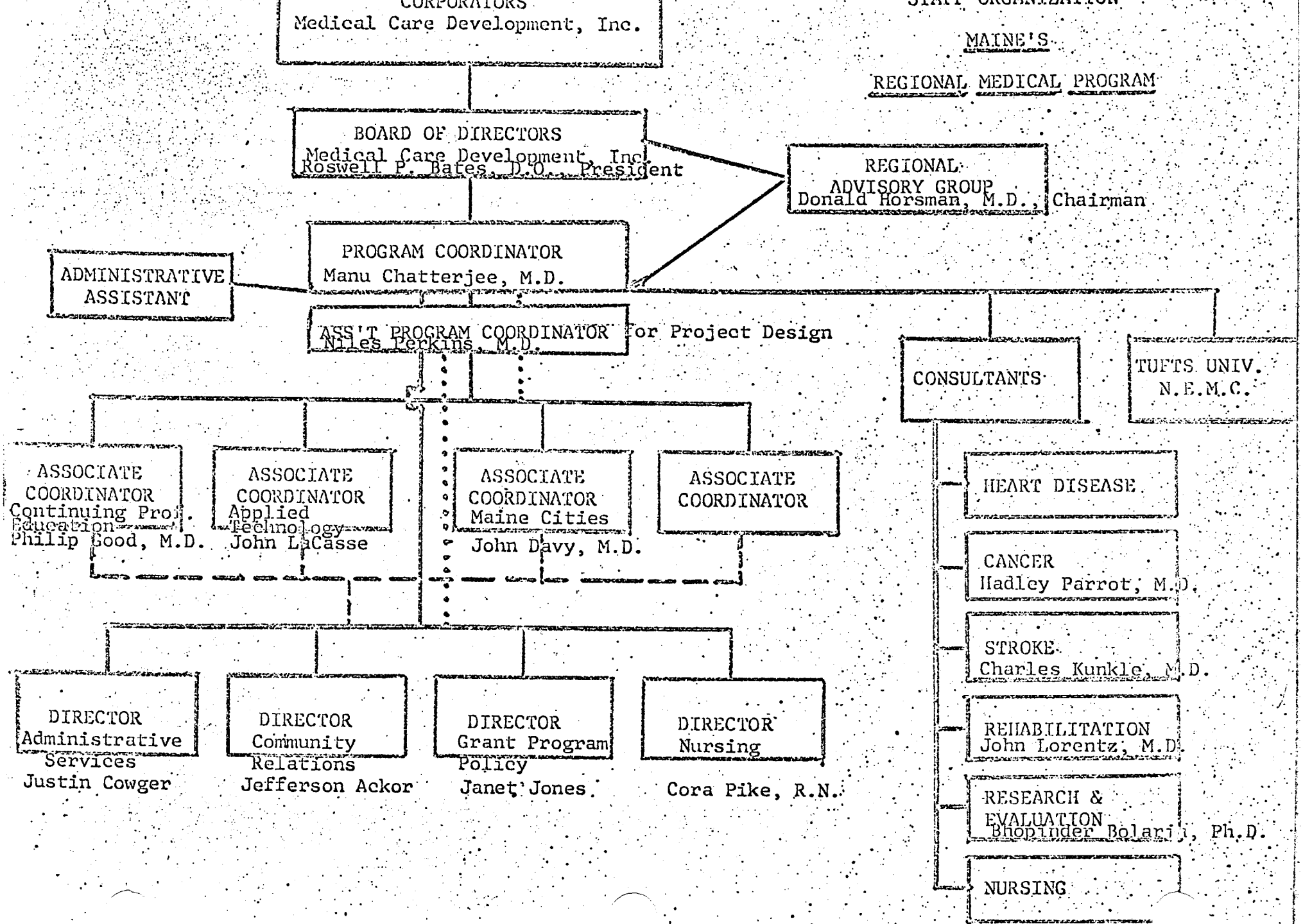
Director Nursing
Cora Pike, R.N.

Research Assistant
Patricia Wallace

Secretary/Bookkeeper
Joan Towle

Secretaries
Virginia Roderick
Linda Frantz
Judith Carleton
Sandra Canto
Judith Barnard

*Dr. Good's time is spent 10% in core staff activities and 90% as project director for project #6 - Physicians' Continuing Education Program.


CORPORATORS
Medical Care Development, Inc.
STAFF ORGANIZATION
MAINE'S
REGIONAL MEDICAL PROGRAM
BOARD OF DIRECTORS
Medical Care Development, Inc.
Roswell P. Bates, D.O., President
REGIONAL ADVISORY GROUP
Donald Horsman, M.D., Chairman
PROGRAM COORDINATOR
Manu Chatterjee, M.D.
ADMINISTRATIVE ASSISTANT
ASS'T PROGRAM COORDINATOR for Project Design
Niles Perkins, M.D.
CONSULTANTS
TUFTS UNIV. N.E.M.C.
ASSOCIATE COORDINATOR
Continuing Prof. Education
Philip Good, M.D.
ASSOCIATE COORDINATOR
Applied Technology
John LaCasse
ASSOCIATE COORDINATOR
Maine Cities
John Davy, M.D.
ASSOCIATE COORDINATOR
HEART DISEASE
CANCER
Hadley Parrot, M.D.
STROKE
Charles Kunkle, M.D.
REHABILITATION
John Lorentz, M.D.
RESEARCH & EVALUATION
Bhopinder Bolari, Ph.D.
NURSING
DIRECTOR
Administrative Services
Justin Cowger
DIRECTOR
Community Relations
Jefferson Ackor
DIRECTOR
Grant Program Policy
Janet Jones
DIRECTOR
Nursing
Cora Pike, R.N.

BIOGRAPHICAL SKETCHES

1) Manu Chattergee, M.D.

a) Born Massachusetts, 1920
b) A.B., Olivet College, 1942
c) M.S., Western Reserve, 1946 (Clinical Psychology)
d) M.D., Western Reserve, 1951
e) Positions held:

1952-53 - Residency Internal Medicine, Mary Imogene Bassett
1953-54 - Fellowship - Cardiopulmonary Disease, Mary Imogene Bassett
1954-55 - Fellowship - Department of Medicine, Cardiology, University of California Hospital, San Francisco
1955-67 - Merrymeeting Medical Group - Internal Medicine, Cardiology

2) Niles L. Perkins, M.D.

a) Born Maine, 1919
b) B.A., Bowdoin College, 1946
c) M.D., Tufts, 1950
d) M.P.H., Harvard, 1966
e) Positions held:

1950-53 - General Practice, Bingham, Maine
1953-55 - Medical Director, Bath Iron Works
1960-62 - Residency in Medicine and Cardiology, Maine Medical Center
1962-65 - Private Practice, Internal Medicine and Cardiology, Portland, Maine
1966-69 - Director, Bureau of Medical Care, Maine Department of Health and Welfare

3) Philip G. Good, M.D.

a) Born Massachusetts, 1909 (?)
b) A.B., Bowdoin College, 1936
c) M.D., Harvard, 1940
d) Positions held:

1946 - 1969 Private practice - Pediatrics, Portland, Maine
1958 - 1968 Chief of Pediatrics, Maine Medical Center

## VII. ORGANIZATION

### Grantee Organization

Medical Care Development, Inc.

1) There are 51 members and they are appointed by agency represented or elected by Board of Directors.

2) Term is indifinite until replaced by recommending agency or resignation. Automatically suspended if two consecutive annual meetings are missed without due cause.

3) Representation is as follows: Maine Medical Association - 8; Maine Osteopathic Association - 4; Maine Hospital Association - 4; Maine Heart Association - 3; Maine Cancer Society - 3; Governor - 3; Maine Dental Association - 1; Maine Nurses Association - 1; Associated Hospital Service of Maine - 1; A commercial Life and Health Insurance Company - 1; Nursing Home Association - 1; Health Facilities Planning Council - 1; Maine Tuberculosis and Health Association -1; Bingham Associates Funds - 1; Elected at Large by above - 18; to include representatives for health organizations, hospital boards of trustees, educators, governmental agencies, allied health professions, and the general public.

4) Chairman -

5) Meetings are held at least annually (April)

6) Functions: To conduct studies within or without the State of Maine designed to investigate and evaluate any of the characteristics, qualities, or circumstances that may be considered to determine, influence, or otherwise affect the quality, quantity distribution, or resources, or facilities commonly included in or related to those services referred to as "medical care."

### Board of Directors

1) There are 19 members (4 officers, 15 members and 2 vacant); they are appointed at the annual meeting of the Corporation.

2) Term is for 3 years.

3) Representation is as follows: Medical Society - 5; Hospital Association - 1; University - 2; Other Health Professional Society - 1; Affiliated Hospital - 1; Cancer Society - 1; Other Hospital - 1; Heart Association - 2; Other Voluntary Health Agency - 1; Official Public Health Agency - 1; Health Insurance Industry - 1

4) Chairman is Roswell Bates, D.O., President

5) Meetings are at least quarterly

6) Functions: The Board of Directors is the major policy forming body of the RMP. It has determined personnel policies and has been instrumental in defining a policy manual for the entire organization to include financial and accounting methods and the development of affiliation agreements with participating institutions.

Regional Advisory Group

1) There are 33 members (3 vacant); they are appointed by Board of Directors.

2) Term is for 3 years.

3) Representation is as follows: Medical School - 1; Other Health Education Schools - 1; Other University - 2; Hospital Associations - 1; Other Health Professional Societies - 1; Health Practitioner - 1; Affiliated Hospital - 3; Other Hospitals - 10; Other Health Related Planning Agencies - 3; Heart Association - 1; Other Voluntary Health Agencies - 1; Public Agencies (non-health) -2; Health Insurance Industries - 1; Public or Consumer Representation - 2

4) Chairman is H. Douglas Collins, M.D. (Internist)

5) Meetings are held six times per year plus any special meetings called.

6) Functions: 1) Participate in the planning program of Maine's RMP, by offering guidance and suggestions to those who are directly responsible for the planning; 2) Review the immediate and long term plans for the region for relevance to the objectives of the RMP; 3) Recommend approval or disapproval of request which are to be submitted to DRMP for program development and support as part of the DRMP; 4) Prepare an annual statement giving the evaluation of effectiveness of the regional cooperative arrangements established under the RMP.

Categorical and Other Committees

1) Hospital Coordinators: Three committees have been established, made up of hospital coordinators who are chosen by the staff of each individual hospital and whose primary purpose is to define the areas of interest, set priorities for the local institution, and be the liaison between that local institution and the Regional Medical Program. The three committees are made up of: the coordinators in the northeastern section of the state from the smaller hospitals; the coordinators in the southwestern section of the state from the smaller hospitals; so called referral center hospital coordinators representing the larger hospitals of the state.

These three committees have been instrumental in all the planning programs of this Regional Medical Program. They have participated in the development of the operational grants. Surveys taken from their local institutions have determined the content of operational grants, and they have approved, in principle, the finished products. Their individual assessments of their areas point the direction for feasibility studies. They themselves are data-gathering arms in terms of assessment of regional resources. Their involvement in this Regional Medical Program has probably been one of the most important single inputs, and these three committees represent the basis of physician involvement.

2) Cancer Advisory Committee: This is a group which is selected from the Cancer Coordinating Committee of this region established by the American College of Surgeons. This Advisory Committee serves the function of defining areas of involvement for Regional Medical Program activities. Their first order of priority was an educational program in cancer management and a cervical cancer program.

3) Director of Medical Education: This is a committee made up of the five full time Directors of Medical Education of this region. Their chief function has been to define areas needs in continuing medical education. They were instrumental in developing two operational grant requests; one was the continuing education program for physicians and the second, a Director of Medical Education program for the entire state to include a third-faculty concept. They have been of assistance in defining a library program for the region.

4) Physician Manpower Committee: This committee is made up of advisors to premedical students in the four major Maine college, the Commissioner of Education for the region, and two medical schools. The purpose of this committee is to design programs for attracting more Maine undergraduates into medical schools, as this region rates fiftieth in the nation in this respect.

5) Radiologists' Committee: This is a committee made up of all the radiologists in the region involved in supra voltage therapy. They are concerning themselves with determining a "grand design" for supra voltage therapy units for this region to include necessary personnel, Patient referral patterns, and cost effectiveness. They are still having difficulty resolving some issues. They have reviewed an oncology proposal for the establishment of a super center in an unsuper area. This proposal was not approved.

6) Mercy Hospital-Regional Medical Program Committee: This committee is made up of four physicians and the Executive Director of the hospital. They are at the present time defining what the needs of this 250-bed acute care Catholic hospital are and how they may relate to this region and Maine's Regional Medical Program.

7) Joint Committee of Allied Health Organizations: This is a committee made up of 15 representatives of the allied health fields. They have concerned themselves with the alleged nursing shortage problems of the region and the need for definition of types of educational programs for the entire allied health field. They have been instrumental in assisting Maine's Regional Medical Program in devising a questionnaire which has been circulated to all hospitals in the region. Personal site visits for definition of the above-mentioned factors have been made.

8) Maine Medical Center-RMP-Task Forces in Heart, Cancer & Stroke: This is a large committee made up of subcommittees representing heart disease, cancer, and stroke, whose areas of emphasis have been to establish the relationship of this largest medical complex in the region to the needs of the rest of the state. After a couple of years of work, they have been instrumental in several operational projects which have been presented for review. They have concerned themselves with a regional approach to these categorical areas and defining areas where health care from the standpoint of sophisticated, diagnostic, and treatment facilities are lacking for the entire region.

Local Advisory Groups

1) Upper Kennebec Valley, a voluntary health organization: This is an organization which has been developed under the impetus of this Regional Medical Program for defining the total health care needs and activating programs in a subregion of this state including 80,000 people and 4,000 square miles. It has representation from a city of moderate size to include a large, disadvantaged rural area. This committee is made up of representatives of all the hospitals, health organizations and consumers. During the past two months, it has structured its organizational makeup to conform with 314b requirements. As this organization also exists outside any health power structure, it has made major inroads into establishing lines of communication between physicians in small communities and the larger communities. It has developed a regional facility such as a blood bank for the entire ten-hospital region and has a Director of Medical Education for the region as well. It is pioneering a systems approach to the health care system. It is originating a multiphasic screening project for the CAP population of 65 years of age and over.

2) The Bangor Regional Health Advisory Group: This is an organization made up of the three hospitals in a subregion of Maine which is a referral area and which has the responsibility for the health care of a large region. There are two allopathic and one osteopathic hospitals. They have developed a program for a combined Director of Medical Education, a program in emergency medical care, and training programs

with a mix of the osteopathic and allopathic physicians of the areas. They are currently exploring new methods for establishing medical care for small hospitals in rural areas to include Data-Phones, interactive television, etc.

3) Indian Health Committee of the Maine Medical Association: This committee was appointed, in part, by the Maine Medical Association and by Maine's Regional Medical Program. Maine's Indian population is a State responsibility, not Federal, and represents one of the most impoverished pockets of this region. This committee has been involved in defining what the actual medical needs are and methods of entry into the health care system. This effort is still in the planning stage with recommendations for implementation to be formulated soon. These meetings are chaired and organized by this Regional Medical Program.

Subregions (Map on following page delineates areas)

Six subregions have been delineated. In two of these areas voluntary health organizations have been established for planning for the subregion as well as the future development of operational projects. One of these subregions is presently the recipient of an RMP grant in area-wide health care. This particular region is to serve as a prototype for the other five, and it is hoped to model similar type organizations in the other subregions.

The purpose of these subregions is to facilitate planning, operations, and local participate and liaison.

The areas were determined with regard to hospital planning and medical trade areas.

MAINE REGIONAL MEDICAL PROGRAM
Six Subregions

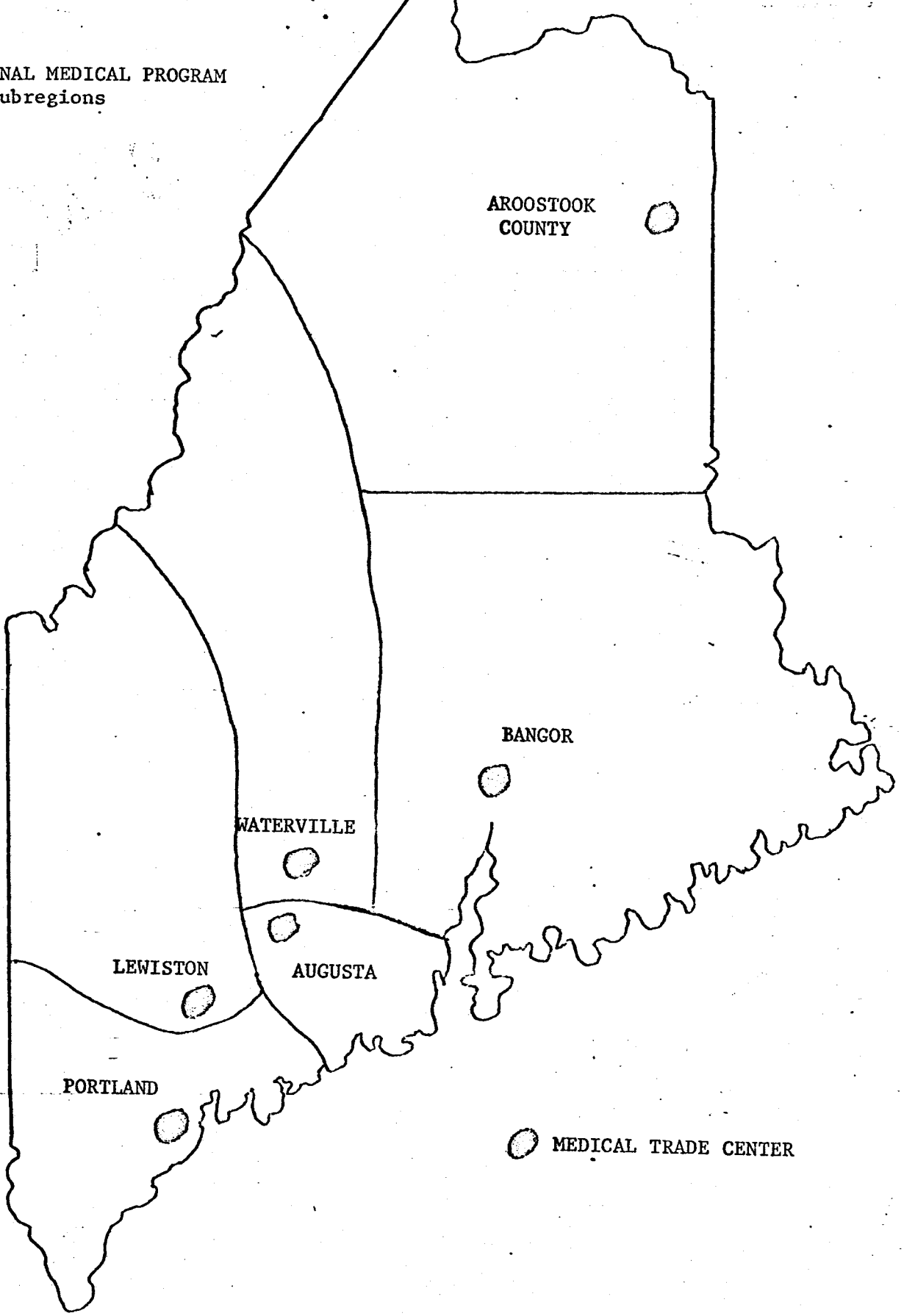


EXHIBIT 1

# DECISION-MAKING PROCESS

MEETINGS & DEADLINES

RAG MTG. — 12 WEEKS

PROJECT SUBMISSION DEADLINE — 8 WEEKS

RAG MTG. — 6 WEEKS

BOARD MTG. — 5 WEEKS

RAG MTG. — 3 WEEKS

FINAL DEADLINE

PROJECT INITIATION AND FORMATION

HEALTH PROFESSIONS REGIONAL ADV. GROUP
BOARD OF DIRECTORS
CORE STAFF

1. CORE STAFF
2. AD HOC COMMITTEES
3. CONSULTANTS

RECOMMENDATIONS ADVICE

REGIONAL ADVISORY GROUP

RECOMMENDATIONS SUGGESTIONS APPROVAL

BOARD OF DIRECTORS

COMMENT APPROVAL

REGIONAL ADVISORY GROUP

FINAL DECISION

DIVISION OF REGIONAL MEDICAL PROGRAMS

## IX. FUNDED OPERATIONAL PROJECTS

### #1 -- VISITING GUEST RESIDENT PROJECT

Objectives: To continue and expand a program initiated by the Bingham Associates Fund which sent senior residents or fellows at Tufts--New England Medical Center to small community hospitals. This establishes a line of communication between the University Hospital Center and the relatively isolated practitioners. The recruitment base for residents has been expanded beyond the Boston area. During the first year, sixteen residents or fellows spent a combined 17 weeks in eight community hospitals. It is anticipated that during the second year, 10 hospitals will each receive 4 resident visits making a total of 40 weeks of Guest Residency Programming.

### #2 -- KENNEBEC VALLEY REGIONAL HEALTH AGENCY PROGRAM

Objectives: This project would allow Maine's Regional Medical Program to cooperate with the Regional Health Agency to Maine's Upper Kennebec Valley in developing a regional approach to health care and health planning for residents in an isolated area.

### #4 -- SMOKING CONTROL

Objectives: This project is designed to improve the health status of Maine people through an educational and action program directed against "cigarette disease." Basic work has already been done by the Maine Interagency Council on Smoking and the Health Council of Maine. This project would involve Maine's Regional Medical Program in these activities and provide a coordinator and other staff assistance, office equipment and supplies, and other administrative costs.

### #5 -- CORONARY CARE PROGRAM

Objectives: This is a comprehensive program designed to bring the latest advances in diagnosis and treatment to patients with acute coronary disease by establishing coronary care units in 20 community hospitals over a five-year period. These hospitals will be linked by remote monitoring methods to referral areas where expert consultation services are available on a 24-hour basis. Included in this program are: (1) planning consultation service; (2) training programs for nurses; (3) training programs for physicians; (4) visiting physician program; (5) paramedical consultation service; (6) operational aids, data collection, and evaluation; (7) hospital cardio-pulmonary resuscitation programs; (8) possible mobile coronary care units (future) and, (9) remote monitoring by communications media.

#6 -- PHYSICIANS' CONTINUING EDUCATION PROGRAM

Objectives: This project will establish teaching programs in 20 community hospitals and five groups of small community hospitals. Four programs will be presented annually to the staffs of these hospitals.

#8 -- DIRECTOR OF MEDICAL EDUCATION PROGRAM

Objectives: Proposes a "third faculty" of Directors of Medical Education to alleviate the need for continuing education of health professionals in rural and semi-rural areas.

#9 -- REGIONAL LIBRARY

Objectives: Expand the existing facilities of the Maine Medical Center Medical Library so that it can more adequately function as a regional medical library.