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ONE COORDINATOR'S VIEW

In view of the foregoing budget discussion, why do we submit these new projects at this time?

Much has been said prior to the recent cuts about the need to create an overall consistent program for each region that meets its unique needs, involves its resources to the fullest extent, defines objectives and sets priorities, implements solutions, and evaluates results. Originally, this program was to be built upon cooperative arrangements which would lead eventually to regionalization of services that in turn would lead ultimately to the availability of equally high quality medical services to all citizens, no matter where they might reside. It was an admirable and ambitious goal.

Further, we believe that the first, second, and part of the third year development of our programs aimed directly at this goal. The major thrust of our early proposals was to focus on a medical center or other facility that provided high quality care, and through cooperative arrangements, provide a system for the higher skills to radiate out, essentially through training experiences, first to the closer-in facilities and personnel, and eventually to all in the region who could profitably benefit from such arrangements.

Although we received some mild criticism for this approach, that is for not beginning projects on a regionwide basis, we still believe that in most cases it was appropriate to begin in a center of high quality and expand out geographically in stages to the regional boundaries. Like the radiating out of ripples caused by dropping a stone in placid water, it provides a more effective way of disturbing the calm of the water than does the attempt to blow up waves over the entire pond all at once. This is especially true since manpower has been more difficult to acquire at the beginning of the projects; but as time passed, generally more became available, thus permitting gradual but effective expansion.

Most of our early projects were capable of this type of expansion. Less than three years ago, when there was still hope that the program would eventually be funded at near the $500 million level, we talked of expanding our CCU training efforts into a regionwide coronary care system, of greatly expanding ICU training for small hospitals, of training stroke teams first in the larger Central Valley hospitals and then in the Coastal and Sierra area. Although projects to accomplish these goals originated in separate CCRMP areas, regional project coordinating committees were later established. They developed regional goals for their categorical problem, as well as shared their project experience among themselves and with the areas lacking funded categorical projects.

We hoped that dosimetry linkages, tumor board activities and related referrals eventually could be developed in a uniform pattern from our

bases in the Bay Area and the Los Angeles metropolitan area. After the Area I dosimetry planning and consultation project was funded, project staff helped Area III with its planning for a similar project with the intent that the San Francisco and Palo Alto centers could blanket the outer areas of Northern California. The Area III project for the other part of this plan was approved, but funds are not available to initiate it. Similar planning for Southern California developed much further than will ever be realized by persons not involved. Those who had worked on these plans decided that it would be a waste of their time to write their plans into an application when potential for funding seemed non-existent. We saw, in essence, a series of systems, each relating to specific disease areas, that would eventually expand throughout the region.

Circumstances, however, never allowed these plans to mature. As the possibility of support for an appropriation adequate to fund this kind of planning and development faded, our hopes of developing systems devoted to quality care along disease categories began to falter. As the national health priorities became more of a factor, as the argument over "primary care" developed and peaked, as the argument ensued over how to extend and administer RMP, CHP and Health Services R and D, as the enforced and ill-timed carryovers of funding were announced, it became abundantly clear that support for the development of quality care as we had perceived the intent of RMP would receive less than enthusiastic support from HEW health policy makers.

We were always acutely aware that the National Advisory Council wanted each Region to develop an overall program to which each project could be related. Part of the approval process was based on each project's relation to the overall program,which in our case is described in our first set of objectives. But we also perceived, with some misgiving, that to pursue this course exclusively would be futile and further, we had an obligation to attempt to implement certain of the national priorities, although they might not be consistent with the overall thrust of our regional objectives.

By the time we had come to these conclusions, the need to develop objectives for the Developmental Component had become apparent. Thus, in drawing these objectives, we had the opportunity to mold them in the image of the national priorities. This created a document, and a program, quite different from that created by the original objectives. Since you cannot turn planning efforts and funded projects on and off like a water spigot, and since some in the program resented deeply this change in emphasis, we begin to develop not an extension of the past consistent program but instead a bifurcated program going down two paths at once. The main difference was that one program was accelerating; the other decelerating. To be sure, we had pieces in our older program that could be classified under the new objectives, but there was a very definite change in emphasis. Later a site visit team reviewed both sets of objectives and the National Advisory Council approved them.

It does, however, create a situation comparable to two artists painting a picture on the same canvas. If they are both painting the same picture, which is unlikely, or if they are cubists, it might work out. Ordinarily though, it would have a sad effect on symmetry and you would probably end up with Whistler's Mother rocking on the Sea of Galilee.

To mix up the metaphors a bit further, it's like the pieces of two jigsaw puzzles all mixed together in the same box, and with a few pieces for each puzzle missing. Some of the pieces are even distorted, because of the cuts they have taken. And so it is with our program in the California Region. You have to work a little bit harder to relate the pieces, but above all, you have to be aware of the fact that there is more than one puzzle in the box.

Had all this not happened, had we been able to utilize the entirety of our funds, our people, and our planning momentum for the original objectives, we were near the time when our initial diverse project and core efforts could be collected to form this overall regional program which the National Advisory Council always urged us to develop. Not only had some of our specific categorical activities neared this stage, but so had our decision-making capacity.

As stated above, the Region had first prepared categorical objectives. The early experience in some of the projects and project coordinating committees and other experienced planning groups provided capacity in this Region to take the categorical objectives and write down activity plans to achieve the objectives. The Region's evaluation personnel had developed a system for reporting data about progress and achievement in the funded projects. The Region's review process had reached maturity to judge the technical merits of proposals. The inevitable coming together of these factors was the capacity for achievement of what RMP was all about. The CCRMP could have evaluated experience, applied the results to decisions about the plans (no longer isolated projects), then closely monitored the progress.

Since all this was never allowed to reach its logical conclusion, this submission represents at least three, and perhaps four, separate thrusts. Prior to the beginning of the current CCRMP review cycle, there were twenty-one proposals for consideration. After the review process, the enclosed twelve emerged as approved by CCRMP. This round of reviews was the most thorough to date. Those involved in them felt that the process had matured and was producing adequate, consistent results. But what has to be noted is that there appears to be more of a heterogeneity than a homogeneity about the pieces of our program now. Although it may be temporary, at this time we seem to be going in at least two different directions, at different levels and different speeds, and apparently serving different masters.

We feel certain that any site visit team will want to inquire about this. It has concerned us to no lesser degree, but in all honesty, the

reasons relate to the fact that we have attempted to anticipate and to meet changes in direction of the program, the national priorities at the HEW level, and at the same time provide a response to the Congressional intent.

One proposal is a response both to Congressional intent and direction from the National Advisory Council. This project was referred to in the foregoing "Budget Narrative" as the Comprehensive Plan for Renal Disease. The National Advisory Council had requested a regionwide plan in response to our earlier renal proposal. Outstanding professionals in the field responded by working many hours on this proposal; and we believe we have met the legislative intent of the Kidney disease amendments.

But, as pointed out in the "Budget Narrative", not all of the proposals in this submission were recommended for funding by the Priorities Committee and the renal proposal is recommended for only partial funding. The reason is simple: although the proposals were judged to be of high quality, there just were not enough funds to go around. As indicated previously, the Priorities Committee made a hard choice, but it did so on certain described criteria, and in so doing, did not wish to prejudice the unfunded proposals from receiving funds from other federal programs or private sources. It was believed that approval by CCRMP and the National Advisory Council might be helpful in obtaining funds from other sources. Therefore, although a proposal may not be in line for immediate funding from RMP sources, we respectively request NAC review in order that we can keep the hope alive that our planning efforts have not been in vain.

Some of these proposals have been in the planning stage for at least eighteen months, others are more recent, but all have been thoroughly reviewed and CCRMP has set the priorities for funding.

We realize, all too well, that there appears to be a multiplicity of programs, not a single program to which each proposal in this submission relates, but we request your understanding during this period of transition. We are shifting to placing emphasis on the national priorities, the developmental component objectives, and the directions indicated in the memorandum to Secretary Richardson which emerged from the National Meeting of Coordinators in Atlanta on March 24, 1971.