PROGRESS REPORT

regional medical programs

For
Heart Disease, Cancer, Stroke,
And Related Diseases

Regional Medical Programs Service
Health Services and Mental
Health Administration
Bethesda, Maryland 20014

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service

55 Regional Medical Programs have been awarded planning grants*. . .

- to develop operational proposals through . . .
  - surveys of needs and resources
  - feasibility studies
  - organization and staffing

As of August 25, 1969


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HISTORY AND PURPOSES OF REGIONAL MEDICAL PROGRAMS

On October 6, 1965, the President signed Public Law 89–239. It authorizes the establishment and maintenance of Regional Medical Programs to assist the Nation's health resources in making available the best possible patient care for heart disease, cancer, stroke and related diseases. This legislation, which will be referred to in this publication as The Act, was shaped by the interaction of at least four antecedents: the historical thrust toward regionalization of health resources; the development of a national biomedical research community of unprecedented size and productivity; the changing needs of society; and finally, the particular legislative process leading to The Act itself.

The concept of regionalization as a means to meet health needs effectively and economically is not new. During the 1930's, Assistant Surgeon General Joseph W. Mountin was one of the earliest pioneers urging this approach for the delivery of health services. The national Committee on the Costs of Medical Care also focused attention in 1932 on the potential benefits of regionalization. In that same year, the Bingham Associates Fund initiated the first comprehensive regional effort to improve patient care in the United States. This program linked the hospitals and programs for continuing education of physicians in the State of Maine with the university centers of Boston. Advocates of regionalization next gained national attention more than a decade later in the report of the Commission on Hospital Care and in the Hospital Survey and Construction (Hill-Burton) Act of 1946. Other proposals and attempts to introduce regionalization of health resources can be chronicled, but a strong national movement toward regionalization had to await the convergence of other factors which occurred in 1964 and 1965.

One of these factors was the creation of a national biomedical research effort unprecedented in history and unequalled anywhere else in the world. The effect of this activity was and continues to be intensified by the swiftness of its creation and expansion: at the beginning of World War II the national expenditure for medical research totaled $45 million; by 1947 it was $87 million; and in 1967 the total was $2.257 billion—a 5,000 percent increase in 27 years. The most significant characteristic of this research effort is the tremendous rate at which it is producing new knowledge in the medical sciences, an outpouring which only recently began and which shows no signs of decline. As a result, changes in health care have been dramatic. Today, there are cures where none existed before, a number of diseases have all but disappeared with the application of new vaccines, and patient care generally is far more effective than even a decade ago. It has become apparent in the last few years, however, (despite substantial achievements), that new and better means must also be found to convey the ever-increasing volume of research results to the practicing physician and to meet growing complexities in medical and hospital care, including specialization,

increasingly intricate and expensive types of diagnosis and treatment, and the distribution of scarce manpower, facilities, and other resources. The degree of urgency attached to the need to cope with these issues is heightened by an increasing public demand that the latest and best health care be made available to everyone. This public demand; in turn, is largely an expression of expectations aroused by awareness of the results and promise of biomedical research.

In a sense, the national commitment to biomedical investigation is one manifestation of the third factor which contributed to the creation of Regional Medical Programs: the changing needs of society—in this case, health needs. The decisions by various private and public institutions to support biomedical research were responses to this societal need perceived and interpreted by these institutions. In addition to the support of research, the same interpretive process led the Federal Government to develop a broad range of other programs to improve the quality and availability of health care in the Nation. The Hill-Burton Program which began with the passage of the previously mentioned Hospital Survey and Construction Act of 1946, together with the National Mental Health Act of 1946, was the first in a series of post-World War II legislative actions having major impact on health affairs. When the 89th Congress adjourned in 1966, 25 health-related bills had been enacted into law. Among these were Medicare and Medicaid to pay for hospital and physician services for the Nation's aged and poor; the Comprehensive Health Planning Act to provide funds to each state for non-categorical health planning and to support services rendered through state and other health activities; and Public Law 89–239 authorizing Regional Medical Programs.

The report of the President's Commission on Heart Disease, Cancer, and Stroke, issued in December 1964, focused attention on societal needs and led directly to introduction of the legislation authorizing Regional Medical Programs. Many of the Commission's recommendations were significantly altered by the Congress in the legislative process but The Act was clearly passed to meet needs and problems identified and given national recognition in the Commission's report and in the Congressional hearings preceding passage in The Act. Some of these needs and problems were expressed as follows:

- A program is needed to focus the Nation's health resources for research, teaching and patient care on heart disease, cancer, stroke and related diseases, because together they cause 70 percent of the deaths in the United States.
- A significant number of Americans with these diseases die or are disabled because the benefits of present knowledge in the medical sciences are not uniformly available throughout the country.
- There is not enough trained manpower to meet the health needs of the American people within the present system for the delivery of health services.

- Pressures threatening the Nation's health resources are building because demands for health services are rapidly increasing at a time when increasing costs are posing obstacles for many who require these preventive, diagnostic, therapeutic and rehabilitative services.
- A creative partnership must be forged among the Nation's medical scientists, practicing physicians, and all of the Nation's other health resources so that new knowledge can be translated more rapidly into better patient care. This partnership should make it possible for every community's practicing physicians to share in the diagnostic, therapeutic and consultative resources of major medical institutions. They should similarly be provided the opportunity to participate in the academic environment of research, teaching and patient care which stimulates and supports medical practice of the highest quality.
- Institutions with high quality research programs in heart disease, cancer, stroke, and related diseases are too few, given the magnitude of the problems, and are not uniformly distributed throughout the country.
- There is a need to educate the public regarding health affairs. Education in many cases will permit people to extend their own lives by changing personal habits to prevent heart disease, cancer, stroke and related diseases. Such education will enable individuals to recognize the need for diagnostic, therapeutic or rehabilitative services, and to know where to find these services, and it will motivate them to seek such services when needed.

During the Congressional hearings on this bill, representatives of major groups and institutions with an interest in the American health system were heard, particularly spokesmen for practicing physicians and community hospitals of the Nation. The Act which emerged turned away from the idea of a detailed Federal blueprint for action. Specifically, the network of "regional centers" recommended earlier by the President's Commission was replaced by a concept of "regional cooperative arrangements" among existing health resources. The Act establishes a system of grants to enable representatives of health resources to exercise initiative to identify and meet local needs within the area of the categorical diseases through a broadly defined process. Recognition of geographical and societal diversities within the United States was the main reason for this approach, and spokesmen for the Nation's health resources who testified during the hearings strengthened the case for local initiative. Thus the degree to which the various Regional Medical Programs meet the objectives of The Act will provide a measure of how well local health resources can take the initiative and work together to improve patient care for heart disease, cancer, stroke and related diseases at the local level.

The Act is intended to provide the means for conveying to the medical institutions and professions of the Nation the latest advances in medical science for diagnosis, treatment, and rehabilitation of

patients afflicted with heart disease, cancer, stroke, or related diseases—and to prevent these diseases. The grants authorized by The Act are to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, hospitals, and other medical institutions and agencies to achieve these ends by research, education, and demonstrations of patient care. Through these means, the programs authorized by The Act are also intended to improve generally the health manpower and facilities of the Nation.

In the two years since the President signed The Act, broadly representative groups have organized themselves to conduct Regional Medical Programs in more than 50 Regions which they themselves have defined. These Regions encompass the Nation's population. They have been formed by the organizing groups using functional as well as geographic criteria. These Regions include combinations of entire states (e.g. the Washington-Alaska Region), portions of several states (e.g. the Intermountain Region includes Utah and sections of Colorado, Idaho, Montana, Nevada and Wyoming), single states (e.g. Georgia), and portions of states around a metropolitan center (e.g. the Rochester Region which includes the city and 11 surrounding counties). Within these Regional Programs, a wide variety of organization structures have been developed, including executive and planning committees, categorical disease task forces, and community and other types of sub-regional advisory committees.

Regions first may receive planning grants from the Division of Regional Medical Programs, and then may be awarded operational grants to fund activities planned with initial and subsequent planning grants. These operational programs are the direct means for Regional Medical Programs to accomplish their objectives. Planning moves a Region toward operational activity and is a continuing means for assuring the relevancy and appropriateness of operational activity. It is the effects of the operational activities, however, which will produce results by which Regional Medical Programs will be judged.

On November 9, 1967, the President sent the Congress the *Report on Regional Medical Programs* prepared by the Surgeon General of the Public Health Service, and submitted to the President through the Secretary of Health, Education, and Welfare, in compliance with The Act. The *Report* details the progress of Regional Medical Programs and recommends continuation of the Programs beyond the June 30, 1968, limit set forth in The Act. The President's letter transmitting the *Report* to the Congress was at once encouraging and exhortative when it said, in part: "Because the law and the idea behind it are new, and the problem is so vast, the program is just emerging from the planning state. But this report gives encouraging evidence of progress—and it promises great advances in speeding research knowledge to the patient's bedside." Thus in the final seven words of the President's message, the objective of Regional Medical Programs is clearly emphasized.

THE NATURE AND POTENTIAL OF REGIONAL MEDICAL PROGRAMS

GOAL—IMPROVED PATIENT CARE

The Goal is described in the Surgeon General's *Report* as ". . . clear and unequivocal. The focus is on the patient. The object is to influence the present arrangements for health services in a manner that will permit the best in modern medical care for heart disease, cancer, stroke, and related diseases to be available to all."

MEANS—THE PROCESS OF REGIONALIZATION

Note: Regionalization can connote more than a regional cooperative arrangement, but for the purpose of this publication, the two terms will be used interchangeably. The Act uses "regional cooperative arrangement," but "regionalization" has become a more convenient synonym.

A regional cooperative arrangement among the full array of available health resources is a necessary step in bringing the benefits of scientific advances in medicine to people wherever they live in a Region they themselves have defined. It enables patients to benefit from the inevitable specialization and division of labor which accompany the expansion of medical knowledge because it provides a system of working relationships among health personnel and the institutions and organizations in which they work. This requires a commitment of individual and institutional spirit and resources which must be worked out by each Regional Medical Program. It is facilitated by voluntary agreements to serve, systematically, the needs of the public as regards the categorical diseases on a regional rather than some more narrow basis.

Regionalization, or a regional cooperative arrangement, within the context of Regional Medical Programs has several other important facets:

- It is both functional and geographic in character. Functionally, regionalization is the mechanism for linking patient care with health research and education within the entire region to provide a mutually beneficial interaction. This interaction should occur within the operational activities as well as in the total program. The geographic boundaries of a region serve to define the population for which each Regional Program will be concerned and responsible. This concern and responsibility should be matched by responsiveness, which is effected by providing the population with a significant voice in the Regional Program's decision-making process.
- It provides a means for sharing limited health manpower and facilities to maximize the quality and quantity of care and service available to the Region's population, and to do this as economically as possible. In some instances, this may require interregional cooperation between two or among several Regional Programs.

- Finally, it also constitutes a mechanism for coordinating its categorical program with other health programs in the Region so that their combined effect may be increased and so that they contribute to the creation and maintenance of a system of comprehensive health care within the entire Region.

Because the advance of knowledge changes the nature of medical care, regionalization can best be viewed as a continuous process rather than a plan which it totally developed and then implemented. This process of regionalization, or cooperative arrangements, consists of at least the following elements: involvement, identification of needs and opportunities, assessment of resources, definition of objectives, setting of priorities, implementation, and evaluation. While these seven elements in the process will be described and discussed separately, in practice they are interrelated, continuous and often occur simultaneously.

Involvement—The involvement and commitment of individuals, organizations and institutions which will engage in the activity of a Regional Medical Program, as well as those which will be affected by this activity, underlie a Regional Program. By involving in the steps of study and decision all those in a region who are essential to implementation and ultimate success, better solutions may be found, the opportunity for wider acceptance of decisions is improved, and implementation of decisions is achieved more rapidly. Other attempts to organize health resources on a regional basis have experienced difficulty or have been diverted from their objectives because there was not this voluntary involvement and commitment by the necessary individuals, institutions and organizations. The Act is quite specific to assure this necessary involvement in Regional Medical Programs: it defines, for example, the minimum composition of Regional Advisory Groups.

The Act states these Regional Advisory Groups must include "practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives of other organizations, institutions and agencies concerned with activities of the kind to be carried on under the program and members of the public familiar with the need for the services provided under the program." To ensure a maximum opportunity for success, the composition of the Regional Advisory Group also should be reflective of the total spectrum of health interests and resources of the entire Region. And it should be broadly representative of the geographic areas and all of the socioeconomic groups which will be served by the Regional Program.

The Regional Advisory Group does not have direct administrative responsibility for the Regional Program, but the clear intent of the Congress was that the Advisory Group would ensure that the Regional Medical Program is planned and developed with the continuing advice and assistance of a group which is broadly representative of the health interests of the Region. The Advisory Group must approve all proposals for operational activities within the Regional Program,

and it prepares an annual statement giving its evaluation of the effectiveness of the regional cooperative arrangements established under the Regional Medical Program.

Identification of Needs and Opportunities—A Regional Medical Program identifies the needs as regards heart disease, cancer, stroke and related diseases within the entire Region. These needs are stated in terms which offer opportunities for solution.

This process of identification of needs and opportunities for solution requires a continuing analysis of the problems in delivering the best medical care for the target diseases on a regional basis, and it goes beyond a generalized statement to definitions which can be translated into operational activity. Particular opportunities may be defined by: ideas and approaches generated within the Region, extension of activities already present within the Region, and approaches and activities developed elsewhere which might be applied within the Region.

Among various identified needs there also are often relationships which, when perceived, offer even greater opportunities for solutions.

In examining the problem of coronary care units throughout its Region, for example, a Regional Program may recognize that the more effective approach would be to consider the total problem of the treatment of myocardial infarction patients within the Region. This broadened approach on a regional basis enables the Regional Program to consider the total array of resources within its Region in relationship to a comprehensive program for the care of the myocardial infarction patient. Thus, what was a concern of individual hospitals about how to introduce coronary care units has been transformed into a project or group of related projects with much greater potential for effective and efficient utilization of the Region's resources to improve patient care.

Assessment of Resources—As part of the process of regionalization, a Region continuously updates its inventory of existing resources and capabilities in terms of function, size, number and quality. Every effort is made to identify and use existing inventories, filling in the gaps as needed, rather than setting out on a long, expensive process of creating an entirely new inventory. Information sources include state Hill-Burton agencies, hospital and medical associations, and voluntary agencies. The inventory provides a basis for informed judgments and priority setting on activities proposed for development under the Regional Program. It can also be used to identify missing resources—voids requiring new investment—and to develop new configurations of resources to meet needs.

Definition of Objectives—A Regional Program is continuously involved in the process of setting operational objectives to meet identified needs and opportunities. Objectives are interim steps toward the Goal defined at the beginning of this section, and achievement of these objectives should have an effect in the Region felt far beyond the focal points of the individual activities. This can be one of the greatest contributions of Regional Medical Programs.

The completion of a new project to train nurses to care for cancer patients undergoing new combinations of drug and radiation therapy, for example, should benefit cancer patients and should provide additional trained manpower for many hospitals in the Region. But the project also should have challenged the Region's nursing and hospital communities to improve generally the continuing and in-service education opportunities for nurses within the Region.

Setting of Priorities—Because of limited manpower, facilities, financing and other resources, a Region assigns some order of priority to its objectives and to the steps to achieve them. Besides the limitations on resources, factors include: 1) balance between what should be done first to meet the Region's needs, in absolute terms, and what can be done using existing resources and competence; 2) the potentials for rapid and/or substantial progress toward the Goal of Regional Medical Programs and progress toward regionalization of health resources and services; and 3) Program balance in terms of disease categories and in terms of emphasis on patient care, education and research.

Implementation—The purpose of the preceding steps is to provide a base and imperative for action. In the creation of an initial operational program, no Region can attempt to determine all of the program objectives possible, design appropriate projects to meet all the objectives and then assign priorities before seeking a grant to implement an operational program which encompasses all or even most of the projects. Implementation can occur with an initial operational program encompassing even a small number of well-designed projects which will move the Region toward the attainment of valid program objectives. Because regionalization is a continuous process, a Region is expected to continue to submit supplemental and additional operational proposals as they are developed.

Evaluation—Each planning and operational activity of a Region, as well as the overall Regional Program, receives continuous, quantitative and qualitative evaluation wherever possible. Evaluation is in terms of attainment of interim objectives, the process of regionalization, and the Goal of Regional Medical Programs.

Objective evaluation is simply a reasonable basis upon which to determine whether an activity should be continued or altered, and, ultimately, whether it achieved its purposes. Also, the evaluation of one activity may suggest modifications of another activity which would increase its effectiveness.

Any attempt at evaluation implies doing whatever is feasible within the state of the art and appropriate for the activity being evaluated. Thus, evaluation can range in complexity from simply counting numbers of people at meetings to the most involved determination of behavioral changes in patient management.

As a first step, however, evaluation entails a realistic attempt to design activities so that, as they are implemented and finally concluded, some data will result which will be useful in determining the degree of success attained by the activity.

CRITERIA—EVALUATION OF REGIONAL MEDICAL PROGRAMS

The criterion for judging the success of a Region in implementing the process of regionalization is the degree to which it can be demonstrated that the Regional Program has implemented the seven essential elements discussed in this Chapter: involvement, identification of needs and opportunities, assessment of resources, definition of objectives, setting of priorities, implementation, and evaluation.

Ultimately, the overall success of any Regional Medical Program must be judged by the extent to which it can be demonstrated that the Regional Program has assisted the providers of health services in developing a system which makes available to everyone in the Region improved care for heart disease, cancer, stroke, and related diseases.

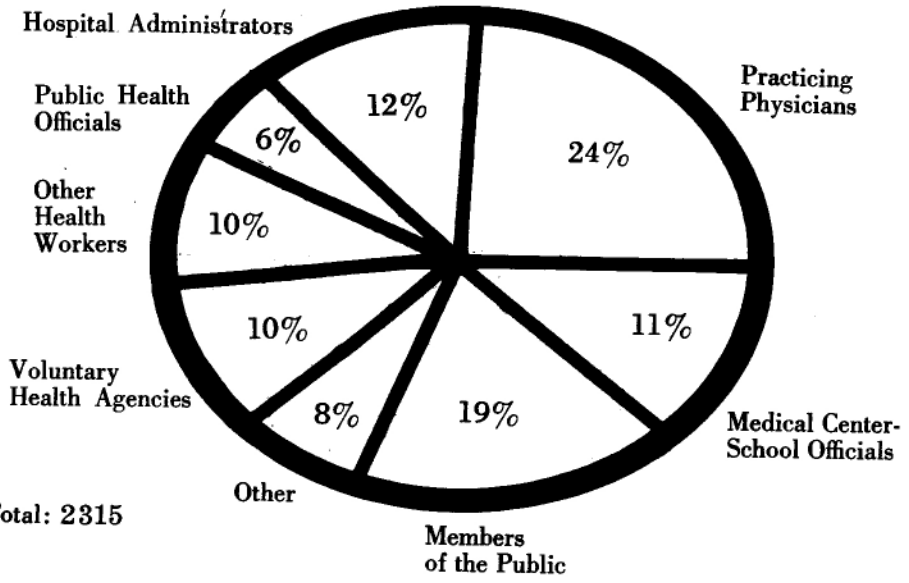
PUBLIC LAW 89-239

Through grants, to afford to the medical profession and the medical institutions of the Nation the opportunity of planning and implementing programs to make available to the American people the latest advances in the diagnosis and treatment of heart disease, cancer, stroke, and related diseases by establishing voluntary regional cooperative arrangements among . . .

- Physicians
- Hospitals
- Medical Schools
- Research Institutions
- Voluntary Health Agencies
- Federal, State, and Local Health Agencies
- Civic Organizations

REGIONAL ADVISORY GROUPS

The activities of Regional Medical Programs are directed by fulltime Coordinators working together with Regional Advisory Groups which are broadly representative of the medical and health resources of the Regions. Membership on these groups nationally is:



Total: 2315

		EVENTS	ACTION
1964	DECEMBER	Report of the President's Commission on Heart Disease, Cancer, and Stroke	
1965	FEBRUARY TO JULY	Congressional hearings	
	OCTOBER	Enactment of P.L. 89-239	
	DECEMBER	National Advisory Council meeting	Initial policies and Guidelines reviewed
1966	FEBRUARY	Establishment of Division Publication of preliminary Guidelines National Advisory Council meeting	Policy for review process and Division activities set
	APRIL	Review Committee meeting National Advisory Council meeting	7 planning grants awarded
	JUNE	Review Committee meeting National Advisory Council meeting	3 planning grants awarded
	JULY	Publication of Guidelines Review Committee meeting	
	AUGUST	National Advisory Council meeting	8 planning grants awarded
	OCTOBER	Review Committee meeting	
	NOVEMBER	National Advisory Council meeting	16 planning grants awarded
1967	JANUARY	Review Committee meeting National Conference	National views & information for Report provided
	FEBRUARY	National Advisory Council meeting	10 planning and 4 operational grants awarded
	APRIL	Review Committee meeting	
	MAY	National Advisory Council meeting	5 planning and 1 operational grant awarded
	JUNE	Report to the President & Congress	
	JULY	Review Committee meeting	
	AUGUST	National Advisory Council meeting	2 planning grants awarded
	OCTOBER	Review Committee meeting	
	NOVEMBER	National Advisory Council meeting	2 planning and 3 operational grants awarded
1968	JANUARY	Conference Workshop	Regional activities and ideas presented
		Review Committee meeting	
	FEBRUARY	National Advisory Council meeting	5 operational grants awarded
	APRIL	Review Committee meeting	
	MAY	National Advisory Council meeting	1 planning and 10 operational grants awarded
	JULY	Review Committee meeting	
	AUGUST	National Advisory Council meeting	1 operational grant awarded
	OCTOBER	Review Committee meeting	
	NOVEMBER	National Advisory Council meeting	1 planning and 7 operational grants awarded
1969	JANUARY	Review Committee meeting	
	FEBRUARY	National Advisory Council meeting	9 operational grants awarded
	APRIL	Review Committee meeting	
	MAY	National Advisory Council meeting	5 operational grants awarded
	JULY	Review Committee meeting	

Additional publications on Regional Medical Programs which are available on request are:

- DIRECTORY OF REGIONAL MEDICAL PROGRAMS
  Revised as of June 4, 1969 to Include
  All Approved Operational Projects and
  Program Data
- GUIDELINES—Regional Medical Programs
  Revised May 1968
- SELECTED BIBLIOGRAPHY of Regional
  Medical Programs First Revision
  February 1969
- CUMULATIVE INDEX (May 1967-May 1969)
  For *News, Information and Data*
  Publications

These publications and other material on Regional Medical Programs may be obtained from:

Publications Service
Office of Communications and Public Information
Regional Medical Programs Service
Wiscon Building, Room 308
9000 Rockville Pike
Bethesda, Maryland 20014

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