
E000178

ISSUES AND CONCERNS - I*

Marc J. Musser, M.D.
Program Coordinator
North Carolina Regional Medical Program

*Presented at the Conference of
Coordinators of Regional Medical Programs
September 30 - October 1, 1968
Marriott Twin Bridges Motel
Arlington, Virginia

Each of the series of meetings we have had here in Washington since January, 1967 has come to be a landmark in the evolution of Regional Medical Programs. Each has concentrated upon the compelling circumstances at a particular point in time----- from the initial stage setting efforts to amplify the altruistic goals which the program was capable of accomplishing through the periods of:

Conceptualization of the interrelationship of the planning and operational phases,

The much needed exchange between regions of project design and objectives,

And now the constructive sharing between the Division and the Coordinators of the issues and concerns that have emerged as we have been more and more intimately confronted with the realities of the situation and have had to concentrate more of our time, energy, and ingenuity upon the mechanics of making the right things happen.

From the standpoint of the record, there can be no positive evidence of the increasing involvement of the Regions in health affairs and the growing substance of operational activities----- nationwide, than is provided by these landmarks.

Central to the success of this accomplishment has been the splendid cooperative arrangement between the Division and the Regions. This has been a forthright, mutually supportive, and decisive relationship - a "Tell it as it is" affair that has kept

out goals in sharp focus and has expedited our progress toward their accomplishment.

It is indeed remarkable that in such a short period of time we should have reached this point in the promotion and realization of a concept that has been espoused for several decades but seemingly could not be incorporated in the complex and diffuse health system which has grown up more or less like Topsy in our society. Not only did Public Law 89-239 come along at just the right time, but also because of its nature it was able to attract the support of people with the degree of perception and dedication necessary to assure its implementation. The existence of these circumstances has been appreciated increasingly as we have learned that it is much easier to talk and legislate about cooperative enterprise for coordinated planning and the most effective and economic utilization of resources than it is to accomplish all the details necessary to assure its ~~its~~ their reality and durability. As the issues and concerns increase in number and complexity, the need for the right answers becomes more and more acute.

Several months ago the Division sent a questionaire to each coordinator asking him to indicate the issues and concerns which in his region seemed to be the most compelling. These have been consolidated and I have been asked to summarize them. By and large, the issues and concerns reported can be divided into three categories:

those relating to events and activities on the Washington stage, those having to do with interregional relationships,

and those relating to intraregional activities. Pervading each of these categories, however, is the interrelationship between the regions and the Division.

THE REGIONS AND THE FEDERAL GOVERNMENT

The reorganization of the Public Health Service and the realignment of health programs within HEW has, of course, been a matter of concern to everyone. Probably there is no group of health administrators in the United States more keenly aware of the need for better communications and coordination between these health programs----- particularly as they operate in the field---than the Regional Medical Program Coordinators. No other group relates as intimately to the broad array of health professionals and health interests.

Hopefully, the organization of the Health Services and Mental Health Administration will be able to interrelate Regional Medical Programs, Comprehensive Health Planning, Chronic Disease Control, Vocation Rehabilitation, Health Services Research, and Mental Health so that their mutually supportive and complementary features can be more effectively utilized in the interests of Public health. A great deal of this has to be worked out at the State or regional level; add some states have made considerable progress in this direction. However, since it appears that everyone takes his cue from what goes on in Washington it would be immensely helpful if a prototype cooperative arrangement between these programs within the Administration were more clearly visible so that field

representatives would have a stronger motivation to share problems and experiences and work together.

There are other federal health interests outside HEW that well might be brought into this cooperative arrangement. Regional Medical Program efforts to contribute to the improvement of the health care of the poor have established contact with the programs of HUD, OEO, Labor, Commerce, just to mention a few. Efforts to generate education and training programs have created a need to know more initimately the sources and nature of support outside RMP. The importance of a mechanism for better coordination of all of these programs becomes more clear when it is recognized that all of them tend to be directed at and involve the same groups of people------ be they health educators, community or regional health planners, practicing physicians, or allied health professionals. At least in our region more and more of these groups are turning to the RMP for advice as to where to go and what to do, and we are finding this an increasingly difficult challenge.

The increased experience with Regional Medical Program activities and their ramifications has led to several concerns relating to the executive and legislative branches of the government. One of these has to do with the stability and longevity of the Program and the growing need for some assurance of both. The need springs from the pragmatic realization that the full accomplishment of objectives is a long term affair, that our hard won cooperative arrangements and the benefits therefrom can only be secured at this

early stage of the game by our integrity and ability to produce, and that the recognition, confidence, and support we have attained at a regional level can disintegrate in the face of a threatened short life, or increasing evidence of modification of concepts and administrative policies that would deprive regions of their prerogative for determining the nature and modus operandi of their programs.

The greatest asset to acceptance at a local level has been the assurance of local determination, local decision making, and local administration. There are many with whom the coordinators and their staff deal every day who still don't believe this is really true and are continually on the alert for any indication of bureaucratic intervention.

This is especially true of practicing physicians. Their full commitment to the Regional Medical Program is of critical importance, now and for the future. Fortunately, we have been able to obtain a large measure of this because of the sound principles upon which the Program is based. Interestingly enough the intensity of committment to the Program seems to run parallel to the intensity of feeling about the principles. Recently a key physician in our Program summarized the state of affairs very succinctly, "Regional Medical Program has been accepted in its original intent, and as such is good. With conceptual changes and if allowed to be infiltrated it will die aborning. Be assured I will turn 180° for what little that is worth."

Perhaps pertinent to this consideration is the issue raised

by one of the coordinators - local planning vs. national planning. Thus far, the bulk of planning at the Division level has been in support of the needs of the Regions, and this has been good. Concern has been expressed, however, that over-enthusiasm or impatience might lead to centrally conceived projects which might appear to compete with local initiative. Unfortunately, the earmarking of certain funds by the Congress last year was interpreted by some as an example of this, and thereby a fair number of ties were strained.

Indeed there is a need for frequent exchanges and joint planning between the regions and the Division in regards to issues problems, mechanisms, and needs. We also need to share knowledge of what is working and what isn't. As we become more involved in registries and reporting systems the value of uniformity of basic data becomesobvious. The leadership which the American College of Surgeons is taking in working out with coordinators, the NCT and the Division staff a concept of cancer registries which might be adopted nation-wide, is a fine example of how some of these things can be accomplished in an appropriately cooperative manner.

Finally, it is important that neither the legislative nor the administrative branches of our government lose sight of the fact that for the first time in the history of our country, the health professionals and the health interests are joining together to make our health care system more cohesive and more effective,

not by legislation or with large ~~sums~~ *sums* of money, but by persuasion, good judgement, common sense, and a challenge to local initiative

INTERREGIONAL RELATIONSHIPS

The anticipated need is now materializing to refine concepts and procedures for interregional activities and relationships. This is reflected in an increasing enthusiasm for interregional meetings. Some of these are on-going; more are being planned, and it is likely that many of the questions and issues will be resolved between the coordinators. Some will require decisions at a Division level.

There is a growing need for exchange of more detailed planning and operational information between regions, especially adjacent regions. This creates problems of supply and demand. No ideal solution exists at the moment. There is a fair movement of annual reports, operational grant applications, and project proposals, but the very volume of most of these negates their practical utility. A while back, Ed. Friedlander conceived the idea of a brief, but complete, profile of each region's program - - something that could be periodically updated to assure currency. A satisfactory format for this hasn't been worked out thus far, but it still seems a good idea. Also, it has occurred to me that broader use could be made of the splendid project summaries Martha Phillips and her staff prepare. These could be incorporated in the profile of a region; also they could be regrouped on a disease category or subject basis and made available whenever there is a need to know what is going on nationally.

For example, many regions have concerned themselves with the care of the acute coronary patient. Perhaps there are twenty-five to thirty projects dealing with one aspect or another of this problem. It would be most helpful to a planning group to be able to review the essential features of these projects, and also, when such information becomes available, to have some assessment of a project's effectiveness. Presently there is no way to get this information unless one corresponds with every region. And yet it seems to me the availability of this information for bibliographic purposes would contribute materially to improved project design. The Science Information Exchange has provided a service of this type for some years.

Yesterday a group of directors of hypertension projects met to consider the feasibility of a uniform system of data collection and reporting. They also had an opportunity to discuss their plans and share experiences. Perhaps this will become an increasingly attractive mechanism for interregional communications and coordination of activities.

The problem of information exchange will be compounded as regional programs grow and become more complex. If indeed we are preaching the availability of the "latest advances" we need to practice it within the family.

The desirability has been expressed of interregional or, when appropriate, national libraries for support materials, such as audiovisual aids, etc. and also of a multi-regional speakers bureau. In this latter regard it would be helpful if such a

bureau were coordinated with other organizations that provide speakers such as the American Cancer Society and American Heart Association.

Efforts at regionalization have generated planning activities which cross the borders of adjacent Regional Medical Programs. Mostly these reflect the identification of hospital service areas or the firming up of long standing functional relationships between communities. There seems to be no reason why these border adjustments cannot be accomplished between the regions involved. Some difficulties might arise when funds from other than the RMP, such as county or state funds, are required. Our experience has indicated that county commissions are extremely careful with their money. Also, there may be some problems with reports and statistics, particularly those compiled on a state basis.

Concern is growing over the coordination between RMPs, especially those serving the same geographical area, interregional programming, and the mechanisms for handling interregional projects. Much of this depends upon core staff interrelationships. The forthcoming guidelines for the implementation of Section 910 of the new RMP law (HR 15758) may clarify this to some extent. However, a number of potential problems can be foreseen. One coordinator has found that the attitudes of public officials or official agencies are not always conducive to interregional planning, particularly between states. Also, if interregional projects must compete within a region with the other projects which the region has generated

independently, and particularly if tight money causes advisory councils to have more and more rigid criteria for determination of project priorities; they might fare less well than they deserve. Thus, it may be necessary to establish a separate funding mechanism for interregional projects.

The growing need for interregional activities necessitates a serious review of core staff organization and functions. Productive interregional relationships will relate directly to staff input -- and few if any of us have made provisions for this in our present staff organizations. Other unanticipated demands upon core staffs have accentuated the problem. Many of these demands require the availability of skills and knowledge which are not readily available. One possible mechanism for the resolution of this situation is the availability of consultant services between regions and the sharing of staff members with special skills.

We have had an interesting experience in this regard. A year ago we began to make consultative services available to community hospitals in the areas of design, equipping, and operation of Coronary Care Units. This was done in collaboration with the medical schools, the North Carolina Medical Care Commission (Hill-Burton) and the Duke Endowment, which long has acted in an advisory capacity to hospitals. As this service became more popular, it emerged that one of the major needs was for expert architectural and engineering consultation. It turns out that there are no available guidelines for the proper design of these units and for the elimination of the various hazards which can be of catastrophic consequence. The part-

time architect-engineer whom we retained, in conjunction with the Medical Care Commission, and who now has acquired a considerable amount of expertise, has been able to properly advise hospital authorities, and in so doing he has saved them well in excess of $100,000.00. So important has this service become that we are in the process of employing the architect full time providing him with further opportunities to expand his knowledge and expertise, and among other duties, to have him prepare the guide lines and standards which are necessary. These, as well as the architect services could be made available to other regions.

An expanded role also is forseen for the liason officers of the Division since they can be immensely helpful in the resolution of many of the problems relating to interregional planning and operations.

INTRAREGIONAL ACTIVITIES

Probably the major concern within regions is the accomplishment of an optimal degree of cohesiveness among participants in program planning and operations. More and more this has become a core staff responsibility, and yet a willingness to cooperate on the part of participants is essential.

A variety of factors contribute to this problem. One is that the participants have not had much experience working together, and at least at the onset have been inclined to fall back upon their more firmly established patterns of operation when they contemplate the nature of their Regional Medical Program involvement. Thus the medical schools, not accustomed to service responsibility at a community level, have tended to prefer to conduct educational

and demonstration activities within their walls and to maintain independent planning staffs. This attitude prevails more strongly at a departmental level than in the Dean's Office. Community hospital boards, administrators, and staffs have found it difficult to think in terms of regional services, even though they have depended for years upon referrals from within their service areas. They also are intensively preoccupied with their own needs and problems. State and County medical societies, curiously, seem to have been excluded from a large number of organized health planning efforts in the past and consequently find it difficult to suddenly be in the mainstream. The universities, community colleges, technical institutes, State Boards of Higher Education, or Divisions of community colleges, though involved in health education have not coordinated their efforts and thus find it difficult to look at the total array of health manpower needs within a region. State health agencies, particularly Boards of Health, first were caught in the confusion of a change in their federal funding from categorical to block grants, and then in trying to decide how they might relate to both Regional Medical Programs and Comprehensive Health Planning.

Slowly but surely, however, these and other groups are becoming more comfortable in this new situation and are beginning to work more effectively together. However, experience is demonstrating that meaningful participation per se requires a sustained investment of time and effort by participants which they are not organized or staffed to provide. Thus there emerges a certain

"cost of togetherness" which hasn't yet been specifically identified in dollars and cents but which the realities of the situation require be recognized.

Crucial to the productivity of these new ties is the availability of a competent and adequate core staff. There must be some mechanism to bring plans or concepts into reality, to manage the countless number of administrative details necessary to assure smooth operation, continuity and evaluation, and to interprete these properly to the Advisory Council.

More and more, the position of the Regional Medical Program becomes that of a way station between the medical schools and medical centers on the one hand and the system of delivery of health service on the other, interposed for the purpose of catalyzing stronger and more meaningful ties, of trying to determine how scientific knowledge and resources can be used more effectively to meet patient care needs. Concern with patient care needs rapidly leads to an identification and understanding of those individuals, organizations, and agencies which in one way or another are involved in ministering to them. Concern with the medical schools, medical centers, and other academic institutions allows for a sharper identification of the resources available and those that must be developed . Only with these two bodies of information can effective and coordinated operational activities be generated.

It is not beyond the realm of possibility that this unique role of the core staff will become one of the major Regional Medical Program contributions to the improvement of our health care system.

Much of all this points up the increasing complexity of core staff functions. As these are more clearly identified, their documentation would be particularly helpful in better acquainting advisory councils, planning groups, participants, and project directors with the mechanics of Regional Medical Program operations.

Money, of course, is and always will be an issue.

One concern has to do with the projected fiscal potential of the Regional Medical Programs. More specifically, this could be expressed by asking what can we expect to be able to support three, five, and ten years from now.

Clearly, the longer range potential will depend upon what the program produces----how well it attains the objectives of Public Law 89-239--with appropriate concern for economics, organization and administration. The shorter range concerns are more pressing, and yet they have relevance to what might happen in the more distant future. Each Region, in order to mount a visible operational program, has begun cautiously by undertaking limited feasibility studies or pilot projects. In these early stages, visibility, solidification of cooperative arrangements, and a beginning impact upon the improvement of patient care have taken precedence over the amount of money available. Very soon though, the point is reached where tested projects should be expanded,and an increasing number of new project proposals are submitted, reflecting to a large extent the success of efforts to stimulate participation and planning. It becomes important at this stage for those responsible for decision making

to know how close to the belt they must operate, how restricted a priority range they must adopt to stand a reasonable chance of funding. With limited availability of funds, it becomes the tendency to support the winners ------ to put one's money on the favorite. However, Public Law 89-239 encourages innovation --- and innovation is the untested, unproved -- very often the long shot. Restricted funding at too early a stage is apt to discourage innovation and thereby seriously limit the programs potential. Certainly there never will or should be unlimited funds, but it must be hoped that sufficient money will be available to enable regions to adequately explore and evaluate new and innovative approaches and to determine how those that are successful can be incorporated into the health care system.

Eventually, it will be possible to free up funds by terminating unsuccessful projects and by devising measures by which good projects can be self supporting. However, as experience increases, project design and relevance to objectives should improve. This could necessitate some very hard choices by Advisory Councils, should limited availability of funds force a choice between continued support of a good project or recommended support of a new one that looks better. Some recourse might be provided by the availability of other than Regional Medical Program funds. To a large extent, this might depend upon how well federal health programs are coordinated from now on.

On a more simple level, a need has emerged for the clarification of a mechanism for a large number of small, short term fiscal

transactions. The original guide-lines indicated that the involvement of community hospitals should be accomplished by a letter of affiliation which would make the hospital a participant. Also, they provided for participant faculty and staff involvement on a part time salary basis, and not as consultants.

Becoming a participant requires conformance with certain Bureau of the Budget regulations, it also makes indirect costs available which in turn eliminates such items as rental charges. This is fine for the long term, permanent type of participation. Thus far, however, most of the transactions with community hospitals have been short term affairs involving small sums of money -- for which the letter of affiliation is not practical. Fortunately, the new guide-lines provide a mechanism to purchase necessary services in much more acceptable manner.

In a similar vein, there are some faculty members with long term committments to the Program who can be employed part time. However, the need is increasing for a reimbursement mechanism for occasional or limited services.

Concern has also been expressed over the most practical and realistic manner to deal with equipment that is provided to cooperating hospitals and other institutions. Existing government regulations are directed to a large extent to the established situations where equipment remains under the direct supervision of the grantee. Such will seldom be the case with Regional Medical Program equipment for it must be placed in the field where it will do the most good.