rangements in meeting the needs of the people in the Region. The Law requires that these groups be broadly representative of the major health resources of the Region. It also insists that members of the public familiar with health needs be included. The Law makes their approval of applications for operational grants a condition of Federal grant support.

To carry out the full intent of the Law, the *Program Guidelines* and the National Advisory Council have stressed the importance of the continuing role for the Regional Advisory Group and the necessity for independence of its functions. As evidence that the advisory group is performing its role and is not a *pro forma* or subservient group, an annual report is required from the Advisory Group itself giving its evaluation of the effectiveness of regional cooperative arrangements.

The importance and composition of these Advisory Groups have been given further attention in a recent policy statement of the Secretary of the Department of Health, Education, and Welfare on "Medical Care Prices." This policy calls for special emphasis to be given to adequate and effective consumer representation in the administration of Regional Medical Programs. The Regional Advisory Groups are a logical locus for that representation.

Continuing Education for Patient Care

Continuing education is an essential component of Regional Medical Programs. It contributes in a most direct way to the primary purposes of the Regional Medical Programs. Improvements in patient care require the primary participation of practicing physicians and other members of the health team in their daily practice. Therefore, if the advances of biomedical research are to be made available to patients, the means must be provided continuously to update the performance of all health professionals and supporting personnel.

However, Regional Medical Programs are not exclusively nor even primarily a continuing education effort. Continuing education is one of a number of means of working toward their total objectives. Continuing education projects, no matter how meritorious, are supported from Regional Medical Program grant funds only when they are part of integrated, comprehensive approaches of enhancing regional capability for the diagnosis and treatment of heart disease, cancer, stroke, and related diseases.

The accelerating rate of advance in the biomedical sciences and related technology makes the problem of keeping current increasingly difficult for all involved in health care. Regional Medical Programs are providing new opportunities to develop the essential linkages between education and practice, as an important means of diminishing professional obsolescence which is the inevitable consequence of rapid scientific advance. Studies of better ways of providing health services, demonstrations of patient care, and educational and training for all types of health personnel are joined together in a unified effort. In continuing education, as in other components of the program, attention is focused directly on the question, "Will this effort change behavior and will this change result, in fact, in the patient receiving the benefits of advances in heart disease, cancer, and stroke?"

Progress reports show Regional Medical Programs are proving to be a strong catalyst to the entire field of continuing education and training of the health professions. They are providing mechanisms for the cooperative relationships that can make continuing education more effective in improving patient care.

Latest Advances in Diagnosis and Treatment

Section 900(b) of Public Law 89–239 states that the Regional Medical Programs are to help the medical profession and the medical institutions of the Nation make available to their patients "the latest advances in the diagnosis and treatment" of heart disease, cancer, stroke and related diseases. A narrow and rigid interpretation of this section would seriously hamper the effective accomplishment of the purposes of the program. Improved health for patients threatened or afflicted with these diseases requires emphasis on prevention and rehabilitation as part of diagnostic and treatment processes. It requires dissemination and widespread use of all relevant knowledge in order to achieve the benefits of the "latest advances."

The Public Health Service has encouraged the Regions to consider health functions as a continuum and not a set of isolated functions. This continuum involves the environment of research and teaching, where the latest advances in diagnosis and treatment are most readily introduced, as well as the other institutions and groups involved in preventing and caring for victims of these diseases. To overcome existing gaps, it is necessary to overcome problems of organization, distribution, manpower, cost, attitudes of the public or the health professions and evaluation of the effectiveness of activities in

changing the health status of the population.

Limitations on Institutional and Personal Commitments

A practical issue is raised by the initial authorization of the program on a 3-year exploratory basis. If the program is to succeed, institutions and organizations must commit themselves to participation in regional cooperative arrangements which may involve some lessening of their independence of function. Many of these institutions are under continuous financial pressures. Full commitments to new patterns of relationships involve changes in attitudes. For these reasons it is very difficult to obtain this full commitment on the basis of a limited authorization of the program.

Similar problems apply in recruiting talented manpower. High caliber people are reluctant to make career changes when the permanency of the program is under question. The degree of commitment already achieved in the initial phases of the program is the basis of hopeful expectations. However, it will be difficult to obtain a valid trial on which to base judgments of the ultimate effectiveness if the nature of the program authorization does not encourage voluntary and serious commitments of institutions and personnel.

Relationships to Other Programs

The great trends of accelerating scientific advances and rising public expectations in health have generated many new activities and programs to stimulate and support concerted action for health across the Nation. Regional Medical Programs are part of the response to these forces. Other major actions relate to financing the costs of medical care, education for the health professions, delivery of mental health services in the community, strengthening public health services and planning and construction of hospitals and other facilities.

In the preamble to the most recent of the major Federal enactments, the Comprehensive Health Planning and Public Health Services Amendments of 1966 (Public Law 89–749), the Congress made the following statement of national health purpose:

"The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living;

"that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations;

"that Federal financial assistance must be directed to support the marshalling of all health resources—national, State, and local—to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry and related healing arts."

The many and diverse health programs, both nationally and in the Regions, States and communities, all contribute to these goals. However various thrusts must be interrelated to achieve maximum impact and effectiveness. Utilizing resources wisely in the many promising avenues of health activity calls for planning and cooperation at many levels and the recognition of the preponderance of nonfederal financing for the total health function.

Two fundamental principles, both implicit in the Congressional declaration of purpose just cited, govern the Federal participation in health programs.

The first is a commitment to local, broadly based initiative and planning. A diversity of patterns and priorities, determined by the people of a Region, State, or community can help to match programs to particular needs. No master plan imposed by a central authority can be sensitive or responsive to the multiplicity of local conditions and requirements. Planning is to aid foresight and rational action, not dictate solutions.

The second is that decisions involving health involve the whole of society, not just a few public or private agencies. Rather all those affected by these programs—providers and consumers, public and private groups, educators and practitioners—must participate actively in decision making. Division and fragmentation impair progress and effectiveness.

These two principles are demonstrated with special clarity in two major new Federal programs designed to pull together a number of efforts whose impact has been diffused in the past: the Regional Medical Programs, and the Comprehensive Health Planning Program authorized by Public Law 89–749. The first seeks to stimulate the development of cooperative arrangements for programs directed toward enlarging the availability and enhancing the quality of care provided for major disease problems on a regional basis; the second seeks to stimulate effective planning

for the use of all existing resources and the sound further development of health resources by the States, metropolitan areas and local communities. The two programs are in concept complementary and mutually supportive.

A policy statement has been issued concerning these two programs which outlines general areas of relationship and support. (Exhibit XI) Practical operating methods under these concepts are now being refined. Discussions are taking place throughout the country, at the levels where the coordination must be put into practice. These are the most critical decisions of all, for, as Secretary Gardner has pointed out: "We are beginning to understand that much of the problem of coordination must be solved at the local level. If the Federal Government tried to coordinate all its programs at the Washington level, it would end up imposing a pattern on State and local government. More important, only State and local leadership has the knowledge of local needs and resources that will enable them to put all the programs together in a way that makes sense."

Arrangements are being made to insure close coordination between Regional Medical Programs and other Federal activities. Continuing liaison is maintained with the National Heart Institute, the National Cancer Institute, National Institute of Neurological Diseases and Blindness, National Institute of General Medical Sciences, National Library of Medicine, National Center for Chronic Disease Control and the National Center for Health Statistics. Working relationships are being developed with the new Bureau of Health Manpower and plans are being made for collaboration with the proposed National Center for Health Services Research and Development. Similar cooperation is being developed with agencies outside the Public Health Service, such as the Vocational Rehabilitation Administration, the Veterans Administration and the Department of Housing and Urban Development. This partial listing of the programs whose missions relate to that of the Regional Medical Programs is an indication of the magnitude of the coordinating task.

The need for and responsibilities of Regional Medical Programs to identify the most effective ways of linking programs at the regional level are emphasized in the *Program Regulations* and *Guidelines*. These indicate, that in awarding grants, the Surgeon General will take into consideration "the extent to which the applicant or the participants in the program plan to coordinate or have coordinated the regional medical program with other activities supported pursuant to the authority contained in the Public Health Service Act and other Acts of Congress including those relating to planning and use of facilities, personnel, and equipment, and training of manpower."

Relationship Between Federal and Nonfederal Financing

Regional Medical Programs can serve as an integrating force to bring to bear all the resources required to reduce the toll from heart disease, cancer, stroke and related diseases. Grant funds under Public Law 89–239 will necessarily provide only a very small fraction of the total funds necessary to meet all the identified needs. The costs of these diseases constitute a large portion of the Nation's $43 billion health care expenditures. The full application of medical scientific advances in the diagnosis and treatment of heart disease, cancer, stroke and related diseases will require additional support from many public and private sources. Regional Medical Programs will in fact provide only a minor share of financing for the full range of activities relevant to accomplishing the purposes of the Law, even though formal matching requirements are limited to construction aspects of the programs.

Federal grant funds, while they can provide only partial support, must be adequate to stimulate the continuing technological and social innovations to translate the latest scientific advances into the daily practice of medicine at the community level. The "venture capital" for such innovative efforts must, in large measure, be supplied initially from public funds. The potential return is high and will accrue to individuals throughout the Nation. A relatively small amount of new money, wisely and flexibly applied and fully coordinated with related efforts, can help assure that benefits from the "cutting edge of science" are realized both now and in the future.

As noted previously the impact of this program on medical care costs has yet to be ascertained. If the benefits of this program do result in warrantable additions to health services costs, the extent to which such costs can be met by normal financing methods versus direct Federal support through Regional Medical Programs will require careful examination.

The Role of University Medical Centers

Public Law 89–239 does not specify the role of the university medical centers in the development of Regional

Medical Programs. Yet the nature of the functions to be carried out by the Regional Medical Programs has made the university medical centers a vital resource in most areas for accomplishing the objectives of the Law. In many Regions the university medical centers have played leadership roles in initiating the development of the Regional Medical Programs.

Some medical leaders have seriously questioned whether the university is an appropriate focus for the leadership of these cooperative efforts. These doubts are raised from several points of view: (1) Some medical school faculty members and administrators have concerns that Regional Medical Program responsibilities might divert medical school resources from carrying out their teaching and research functions. (2) Other health representatives have expressed concern that medical school leadership will result in domination or absorption of other health resources by the medical schools to serve their educational and research interests. (3) Questions have been raised from many sources about the capacity of university medical centers to expand their administrative frameworks to encompass the planning and administrative implementation of a major effort involving the total health resources of the Region with an ultimate focus on improving the quality of patient care.

Since university medical centers have played prominent leadership roles in the initial development of most of the Regional Medical Programs, these concerns about diversion, dominance, and administrative capacity deserve careful attention. Solutions to these problems require new forms of relationships between the university medical centers and the other health resources of the Regions.

Coordination and Leadership

Various mechanisms are being tested for administering and coordinating regional efforts: (1) the development of new administrative frameworks within the university and formalized administrative relationships with the other primary health resources; (2) the use of executive coordinating committees representative of major health interests which can serve as decision-making bodies closely related to day-to-day operating problems, reserving for the large Regional Advisory Groups a more general advisory and policy-making function; (3) the utilization of existing nonprofit corporations as frameworks for administration of the cooperative program; (4) the establishment of new nonprofit corporations with boards of directors representative of the major health interests and having as their major responsibility the planning and administration of the Regional Medical Program.

The creation of new administrative structures outside of the university medical center framework, as developed in a number of Regions, seem to offer a most attractive solution to the problems noted. These new entities, however, create other problems related to the provision of sufficient status and stability to attract the high caliber personnel required for the planning and administration of the Region Medical Programs. If these innovative approaches to the administration of cooperative health activities prove effective, they may be a useful mechanism for broader health purposes. They may, in fact, provide a useful prototype for relating the resources of the university to broader social needs without undue diversion of the university's attention from functions of teaching and research.

Regional Medical Programs will continue to contend with this array of problems listed, as they continue their development. The resolution of most of these matters will derive from the increasing sophistication and experience gained in the course of full program operations. Others will require further evolution of national health policies and attitudes. Certain are dependent upon clear executive or legislative action and form the basis of the recommendations contained in the following section.

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Conclusions and Recommendations

SECTION FIVE Conclusions and Recommendations

On the basis of the initial experience in the implementation of Public Law 89–239 certain conclusions and recommendations are indicated.

CONCLUSIONS

☐ An effective beginning has been made in the creation of cooperative arrangements among the health resources on a regional basis for implementing the purposes of the Law.

☐ The regional cooperative arrangements being established and the plans being developed and implemented show great promise for providing the benefits of the advances of medical science to persons threatened or afflicted with heart disease, cancer, stroke, and related diseases.

☐ The Regional Medical Programs will be seeking to accomplish their mission during a time when many major problems beset our health professions and institutions. The Regional Medical Programs seem to provide a relevant and useful tool in the search for better solutions to these health problems.

☐ The extension of this program and the indication of substantial further national support are needed, to sustain and nurture the individual and institutional commitments as well as the enthusiasm which give vigor and substance to the regional cooperative arrangements. These initial efforts require an environment of stability and status in which permanent effective cooperation can flourish.

☐ The initial progress provides solid evidence for continuing the program without modification of its essential nature and purposes.

☐ A more effective means for meeting the special space needs generated by this program is requisite to the full achievement of the purposes of the legislation.

RECOMMENDATIONS

Extension of the Act

As discussed in the earlier sections of the Report, the sum of experiences in the development of Regional Medical Programs throughout the country demonstrates the validity and potential of these new cooperative arrangements in both planning and action. The needs are pressing and the opportunities promising for making available the benefits of medical research advances. The establishment of the Regional Medical Programs as continuing instruments in the health field will contribute significantly to the fulfillment of these opportunities.

Many groups and individuals initially expressed uncertainty and doubt about the Regional Medical Program concept. Most have been reassured on the value of this approach as major regional interests have come together to determine locally the most appropriate and effective ways of moving the program forward in their Regions. Groups throughout the Nation are coming to recognize that through Regional Medical Programs, local planning, decision-making, initiative, and capabilities to meet the needs of patients with heart disease, cancer, stroke and related diseases can be enhanced significantly.

Individuals undertaking regional planning have reported that uncertainty about the program's future is a serious obstacle in recruiting well qualified persons for leadership and key staff positions. Some institutions and agencies have been reluctant to embark upon a course of action, whatever its promise and potential, without reasonable assurance that the program will be continued. Therefore, extension of the program will prevent a loss of momentum and enthusiasm already achieved and will provide a firm basis for strengthening and building upon the beginning efforts. The importance of this momentum and enthusiasm for the success of a voluntary cooperative endeavor should not be underestimated.

A 5-year extension should attract the long-term commitment of the kind and quality of people, and the full participation of all affected institutions which are essential to the program's success. This requirement calls for an authorization that, in both its duration and its level of funding, will indicate a national intent to maintain this effort until the job is done.

Funds for Regional Medical Programs can be a critical factor, even though they are only a small fraction of the total national expenditures for heart disease, cancer, stroke, and related diseases. For these funds, effectively used, can be a fulcrum in raising the quality of care generally throughout the country as well as in significantly enhancing the diagnosis and treatment of these diseases.

Experience gained thus far indicates that the annual cost of operation for each Regional Medical Program may be as much as $10 million or more. There are several bases for this estimate. The initial operational grants and the plans being developed around the Nation indicate that there are myriad opportunities for improving the diagnosis and treatment of heart disease, cancer, stroke, and related diseases by bringing the latest advances into the daily practice of medicine in all parts of the Nation.

The number of potential participants—institutions, groups, agencies, and health personnel—is very great. All must contribute if the benefits of the programs are to be widely available to the population of the Nation.

Frequently, sophisticated and expensive equipment is required because of the high order of technological innovation entailed by many recent medical and related advances. This equipment will advance clinical, communication and computing services. Many technological innovations should be rapidly introduced to bring to patients the benefits of the advances. This will require effective regional planning with the cooperative involvement of full-range medical resources. It will also require sources of funding to be spent on the basis of regional priorities which do not have to compete with pressing needs of the individual institutions.

It is recommended that the program be established on a continuing basis.

New Construction of Essential Facilities

The original Administration proposal to the Congress in 1965 requesting legislative authority for Regional Medical Programs included grant assistance for construction of new as well as the renovation of existing facilities. It thus identified the need for facilitating construction in the successful development of Regional Medical Programs.

In enacting Public Law 89–239, however, Congress amended that provision to limit construction authority to "alteration, major repair, remodeling and renovation of existing buildings" during the initial period of authorization. In so doing, the Report of the House Committee on Interstate and Foreign Commerce stated: "The lack of this authority for new construction should create no serious problems during the three years authorized in this legislation and when a request is made for extension of this legislation in the future, the committee will review this question again."

The lack of authority to assist new construction has not presented serious obstacles to the initial planning and development of Regional Medical Programs. Thus, the early judgments of the Congress have been confirmed. Experience, however, has identified several areas in which authority to assist new construction will be essential to the full development of Regional Medical Programs.

Specific construction needs essential to the work of Regional Medical Programs have been more clearly defined and documented during the initial planning phase. Information obtained from Regional Medical Program Coordinators and key staff, Regional Advisory Group Members, and others involved with these programs at the regional level indicates that there are major needs in a number of areas. These inadequacies will hamper activities within the next several years as Regional Medical Programs move into the operational phase and their range of activities increases. The likelihood of significant limitations on Regional Medical Program activities from space shortages is increased by the overwhelming demand for new health facilities generally in the years immediately ahead. The demands of an expanded population and its desires for high quality medical care, the expansion of medical education facilities, and the backlog of demand for health research facilities all indicate very great competition for funds to finance the necessary facility expansion.

The types of construction needs described below, defined according to regional priorities, will have great difficulty in competing successfully with the immediate and overwhelming construction needs to house adequately the basic functions of the participating institutions. Construction of facilities needed for the purposes of the Regional Medical Program is likely to be delayed until these urgent institutional needs are met. Since the lag between identifying a need for construction and the availability of the facility is so great, this competitive position might seriously delay the implementation of the Regional Medical Program.

It is also important that the types of needs cited below be given adequate consideration during the general expansion of health facilities of the Nation. Only then will the activities represented by them become an integral part of the functions of the medical institutions of the Regions:

☐ *Space for continuing education programs and training purposes is urgently needed, including classrooms and conference room space, learning center facilities, and medical reference and audiovisual facilities.* This is the need most frequently cited by Regional Programs and other groups, such as the Association of Hospital Directors of Medical Education. It is particularly acute in community hospitals.

In the past there has been a paucity of operational support in both community hospitals and medical centers for continuing education activities. The same situation has been true with respect to capital expenditures. Most of the Nation's 7,000 hospitals, especially the smaller ones, simply do not have existing space that can be converted or renovated for educa-

tional purposes. The same holds true for most medical schools, most of which cannot significantly expand their present postgraduate education programs without additional space and facilities. In the past, as documented by the 1962 survey of the American Medical Association Council of Medical Education, continuing education programs have not been a major responsibility and interest of most medical schools; accordingly, the development of appropriate resources (including related facilities and space) was usually neglected.

In both community hospitals and medical schools, the pressures of rising expenditures for direct patient care have made it impossible to allocate sufficient funds to the continuing education activities that are essential to high quality care. Thus, the potential impact of continuing education and training programs in heart disease, cancer, stroke, and related diseases will be seriously hampered unless essential facilities are constructed.

☐ *There is a critical need for additional space and facilities for patient care demonstration and training purposes.* Intensive care units, radium therapy facilities, and specialized surgical suites are, for example, often necessary in order to provide facilities to demonstrate to practicing physicians, nurses, and allied personnel the use of these and similar advanced tools and techniques for diagnosis and treatment.

Only if physicians and the other members of the health care team learn how to utilize these advances "by doing," and have the required facilities available to them at the community level, will they be able to fully exploit the continuing education and training afforded them, and bring to their patients the full benefit of their learning.

Most community hospitals do not now have such facilities. In the case of older hospitals, adequate provision was not made for the inclusion of such specialized facilities because the underlying advances which make continuing education a necessity today had not yet been made; newer hospitals often were unable to include sufficient space for these purposes because of limited funds (public and private) available for initial construction. Developing these facilities on the basis of regional planning will permit great educational impact at minimal cost.

☐ *Some community hospitals have need for additional space for new or expanded diagnostic laboratory facilities.* Both the introduction of new diagnostic tests and procedures, and the fuller use by practitioners of existing tests, depend upon adequate hospital laboratory facilities. Such facilities will serve as teaching laboratories for medical technologists and other supporting personnel.

☐ *The establishment of integrated data banks and communications systems for the storage and rapid transmission of diagnostic information, patient records, etc., requires space to house the computer and communications facilities. Similarly, television and radio transmission of continuing education programs will require new space and facilities.*

Most Regional Medical Programs are undertaking inventories of existing facilities for both educational and specialized clinical care activities relating to heart disease, cancer, stroke and related activities. These planning efforts are being closely coordinated with State and area-wide hospital planning agencies. Experience in administration by the Public Health Service of other recent programs, such as the construction of community mental health centers and mental retardation facilities, has developed patterns and procedures that can help assure necessary coordination of effort.

The construction of new facilities for Regional Medical Programs must be limited to facilities that are essential, carefully selected, and designed to meet regional needs. Each such request will need to be approved by the Regional Advisory Group which represents the major health interests of the Region. This review and approval process will ensure that an excessive amount of attention and funds are not devoted to construction, and that no construction is undertaken exclusively or primarily for the benefit of any single institution or group in the Region.

Most community hospitals, medical schools, and other institutions would have serious or insurmountable difficulties in raising matching funds for construction of facilities needed for continuing education and demonstration essential to meet regional needs. The regional nature of the program may make it especially difficult for any individual agency to obtain substantial funds for this purpose. The current matching requirement of 10 percent applicable to renovation and alteration of facilities, requires a local commitment without impeding progress. A larger matching requirement at this time in the development of this pioneering new program could be self-defeating.

It is recommended, therefore, that adequate means be found to meet the

needs for construction of such facilities as are essential to carry out the purposes of Regional Medical Programs. Priority should be given to facilities required for continuing education, training, and related demonstrations of patient care, particularly in community hospitals.

In meeting these needs, the following considerations should be taken into account:

1. Construction undertaken for Regional Medical Programs should be directly supportive of the operational programs and should be broadly distributed for maximum impact. This might be done by (1) limiting the amount available for construction to no more than 15 percent of the total appropriation for operational activities; and (2) restricting grants for such construction to no more than $500,000 for any single project.
2. The special space needs of the program can be met either through additional authority to aid new construction as part of grants for Regional Medical Programs under Title IX of the Public Health Service Act or through other mechanisms, such as amendments to Title VI and Title VII of the Public Health Service Act (Hospital and Medical Facilities and Health Professions Educational Facilities Construction Programs).

Support of Interregional and Other Supporting Activities

The present Act authorizes grants for the planning and operation of *individual* Regional Medical Programs. No consideration was given during the development of the legislation to support for other activities which might contribute to the implementation of the Regional Medical Programs. These activities include both cooperative efforts among several Regions and other activities supported centrally which make available to all or several Regions specialized skills and resources which are not generally distributed throughout the Regions.

The desirability for extensive cooperation among Regional Programs was foreseen. However, the extent of and rapidity with which cooperative arrangements among Regions would develop was not fully anticipated. Nor, in turn, was the corollary need for additional funding for this purpose apparent.

During the first year of the program, individual Regional Medical Programs devoted considerable attention to coordinating their efforts with other Regions. Interregional cooperative efforts involving several Regions have already evolved in a number of areas throughout the country. In some instances, these arrangements are still informal; in others, interregional agencies are being established.

These interregional activities have arisen in response to real needs. Regions have identified a number of objectives that can be best served and activities carried out in this way. Among the principal potential benefits are the following:

☐ To facilitate communications among Regions, including exchange of information on approaches to and problems in planning and program development.

☐ To help in defining responsibilities and coordinating efforts in "interface" areas between Regions.

☐ To foster consistency in approaches to the conduct of planning studies.

☐ To achieve comparability in data collection and program evaluation.

☐ To develop and apply better and more comprehensive methods of program evaluation.

☐ To utilize more effectively skilled manpower, specialized facilities and resources.

☐ To help achieve compatibility in communication networks and computer systems.

☐ To plan and conduct joint epidemiological and research studies.

☐ To develop jointly common educational programs and materials.

☐ To orient and train staff personnel.

A somewhat similar situation has been identified with respect to certain specialized needs common to all or a number of Regions. The support of a limited number of facilities and programs is needed to develop techniques and prepare personnel to facilitate the work of individual Regional Medical Programs. The support of such activities in agencies that can serve a number or all of the Regions will avoid unnecessary delay and duplication of effort and make the best use of specialized facilities. Central support for these activities will enable the Division of Regional Medical Programs to make available to some regions skills and resources which are not available within the Region. This assistance at a crucial time in the development of a regional program could improve the quality and accelerate the pace of the region's activities.

For example, continuing education and training programs will require

significant numbers of specialized professional personnel (e.g., education specialists, communication and information specialists). Many of these categories of personnel are in scarce supply and the facilities in which they can be trained are limited.

There are also numerous studies and demonstrations that need to be carried out in such areas as motivation, learning theory and evaluation affecting both continuing education and other aspects of Regional Medical Programs. In many instances, these studies will call for resources in one Region to study these issues in a number of Regions. These interregional efforts, too, will substantially assist and expedite work of the individual Regional Medical Programs.

It is recommended that an effective mechanism be found for the support of interregional activities necessary to the development of Regional Medical Programs. This assistance will facilitate the work and implementation of individual Regional Medical Programs.

Referrals by Practicing Dentists

Section 901(c) of the Act provides that "no patient shall be furnished hospital, medical, or other care at any facility incident to research, training, or demonstration activities carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician."

In certain instances, in carrying out the programs authorized by the legislation, a dental practitioner may assume responsibility for the referral of a patient. For example, a patient with oral cancer may be diagnosed by a dentist and referred by him for treatment and rehabilitation. It is desirable to clarify the Lay to cover this type of situation.

It is recommended that patients referred by practicing dentists be included in research, training and demonstration activities carried out as necessary parts of Regional Medical Programs. This modification is in line with the original intent of the legislation in this regard and would correct the original oversight.

Funding of Activities In Federal Hospitals

Veterans Administration and Public Health Service Hospitals in many areas have been involved in the planning of Regional Medical Programs. The participation of these institutions has been particularly helpful and desirable in light of their significant role in providing diagnosis and treatment services to many residents of the Region. The effectiveness of the programs operated by Federal hospitals can be enhanced by close cooperation and sharing of effort and resources with other health facilities in neighboring communities.

The Congress recognized and endorsed this principle in enacting the Veterans Hospitalization and Medical Services Amendments of 1966, Public Law 89–785, enacted November 7, 1966. Among other provisions, this legislation authorized the Veterans Administration to enter into cooperative agreements for the sharing of medical facilities, equipment and information with medical schools, hospitals, research centers and others. The Law required that, to the maximum extent practicable, such programs should be coordinated with Regional Medical Programs. A somewhat similar provision is included for Public Health Service Hospitals in legislation now pending before the Congress.

While the staffs of Federal hospitals may now participate directly in planning Regional Medical Programs, those institutions are not eligible to receive funds from the grants authorized by Public Law 89–239. Thus, a technical modification is necessary to authorize Federal hospitals to receive such funds on the same basis as other hospitals. In this way, programs can be developed in these facilities when such an approach is identified as the most desirable way to strengthen the total Regional Medical Program. As in the case of all other projects proposed for support as part of Regional Medical Programs, such requests must be part of the overall regional program and will need to be approved by the Regional Advisory Group and the National Advisory Council on Regional Medical Programs.

It is recommended the Federal hospitals be considered and assisted in the same ways as community hospitals in planning and carrying out Regional Medical Programs. This modification will, in effect, increase the flexibility, discretion and capabilities of Regional Programs.

Regional Medical Programs in Action

"One of the strengths of the bill is that it provides the flexibility necessary to accommodate the many different patterns of medical institutions, population characteristics, and organizations of medical services found in this Nation."

Excerpt from the Report of the House Committee on Interstate and Foreign Commerce on H.R. 3140 (P.L. 89–239)

SUPPLEMENT Regional Medical Programs in Action

Regional Medical Programs are best defined by the particular actions and activities being undertaken across the country. In this Chapter, outlines of a number of individual Programs are presented.

☐ Four reports summarize what has happened in the *planning* of the Iowa, North Carolina, Washington-Alaska, and Western New York Regional Medical Programs. They summarize salient developments in the preliminary and initial planning phases and the interaction among various institutions and groups that has occurred.

☐ Two reports indicate the nature of the initial *operational* activities of the Intermountain and Missouri Regional Medical Programs. They highlight how these activities will benefit the practicing physician and his patients.

☐ In addition, excerpts are presented from the *annual progress reports* of the 10 Regional Medical Programs for which the first grants were effective July 1, 1966—Albany (New York), Connecticut, Hawaii, Intermountain, Kansas, Missouri, North Carolina, Northern New England, Tennessee Mid-South, and Texas. These excerpts provide further insights into specific aspects of the Regional Programs.

Collectively these reports reveal, in some detail, the accomplishments and problems of individual Regional Medical Programs. It is through these individual efforts and actions that Regional Medical Programs will be more precisely defined and ultimately will serve the needs of the Nation's medical professions, institutions and patients.

PLANNING GRANTS

Iowa Regional Medical Program

The Iowa Regional Medical Program, like a number of others, is built on a significant base of past regional activities. Extensive interrelationships between hospitals and practitioners have developed over the last 50 years. By an interchange of patients, physicians throughout the State have become, in effect, integrated with the activities of the staff of the University of Iowa Medical Center. Continuing education programs have been developed over the last 30 years and include courses at the Medical Center, programs at community hospitals, and closed circuit television educational programs between the Center and a number of these hospitals. As a result, it has been possible to move forward in a number of directions since the receipt of a planning grant in December 1966.

Even with this previous experience of cooperative arrangements, however, there was need to plan for an Iowa Regional Medical Program. This preliminary planning involved cooperation between the Medical Center and three other major health planning groups—the Health Planning Council of Iowa, a voluntary agency organized to coordinate statewide health care planning; the Council on Social Agencies of Des Moines; and the Des Moines Health Planning Council. Other localities are also organizing planning groups that will be related to the Regional Medical Program.

The Regional Advisory Group, designated to guide the expanded effort now being embarked upon, is broadly representative of all of the Region's health professions and agencies. It includes the Dean of the College of Medicine, the Commissioner of Health, Past Presidents of the Iowa State Medical Society, Heart Association, Cancer Society and League for Nursing; also included are representatives of the Iowa Hospital Association, Society of Osteopathic Physicians and Surgeons, Dental Associations, Nursing Home Association, Nurses Association, State Department of Social Welfare, rehabilitative groups, and members of the public. This Group has met seven times through March—or almost monthly since its creation in mid-1966.

The goals which the Iowa Regional Medical Program has set for itself, with the advice of the Regional Advisory Group, are to: (1) augment present education and training capabilities; (2) improve continuing education programs; (3) expand research programs; (4) broaden regional communication to promote dissemination and interchanges of knowledge and techniques; (5) develop programs for public education; and (6) develop demonstration units and systems.

To accomplish these goals, the Program has been organized into four sub-areas: an Education Program, a Research Program, a Comprehensive Patient Care Program, and a Communications Program.

Within the Education Program, for example, studies have been initiated to develop basic 2-year curricula for post-graduate education on heart disease, cancer and stroke. These curricula, once developed and tested, will be taught through a coordinated program of the College of Medicine and regional hospitals, utilizing live conferences and video-taped materials. Extension of this endeavor to

the community level for individuals or small groups of physicians using kinescope presentations is also contemplated.

Other planning activities or projects in the other program sub-areas have also been initiated. These involve a number of different agencies or groups. For example:

☐ The Iowa State Department of Health is planning program elements which concern public health generally, professional and public communications, disease entity reporting and health manpower.

☐ The University of Iowa Department of Economics is involved in research on the economic structure and performance of the medical care industry in Iowa. One of its first projects is the delineation of the Iowa Medical Care Region, considering economic and demographic factors, traditional service areas, and political boundaries.

☐ The Iowa Central Tumor Registry is providing planning information and analysis guidance concerning disease registries.

At the same time, the participation of the Colleges of Dentistry, Nursing and Pharmacy of the University and other health care and educational institutions is being developed.

North Carolina Regional Medical Program

In North Carolina, as in many other states and regions in the country, planning for regionalized medical and health programs has been underway for over twenty years. However, limited resources and other local factors have resulted in incomplete implementation of these plans. Passage of the Regional Medical Program legislation provided an opportunity for North Carolina to move ahead quickly and build upon its past experiences in developing a Regional Medical Program.

The Program was established with the award of one of the first planning grants effective on July 1, 1966. Even before the legislation was signed into Law, the deans of the three medical schools in the State met with the President of the Medical Society to form an Executive Committee to make preliminary plans. The Executive Council of the Medical Society approved the plans for cooperation from which emerged a new, non-profit organization to carry out the purposes of the Program. The Association for the North Carolina Regional Medical Program was officially established in August 1966, and is made up of the three public and private medical schools in the State, the University of North Carolina School of Public Health and the Medical Society of North Carolina. It has adopted Articles of Association, and established a Board of Directors which has been actively working with the Program Coordinator and Advisory Council.

To provide leadership and overall direction to its Program, North Carolina selected as Program Coordinator, Dr. Marc J. Musser, a physician with extensive experience in medical education, medical research and administration. His prior position as Deputy Chief Medical Director of the Veterans Administration and his previous 25 years as Professor of Medicine at the University of Wisconsin School of Medicine provided background and stature invaluable to the Program.

A 25 member Advisory Council, representing the major relevant health interests in the State, was organized to provide overall advice and guidance to the Program. Its Chairman is past president of the State Medical Society and its membership includes the Director of the State Board of Health, the Directors of the North Carolina Public Health Association, Heart Association, and Cancer Society, other voluntary associations, the current President of the State Medical Society, the State dental, nursing, pharmaceutical, and other allied health professional associations, practicing physicians, the North Carolina Health Council, the deans of the three medical schools, a leading hospital administrator, and members of the public. They have met monthly since August 1966, and have conducted intensive reviews of project applications.

Subcommittees of the Council have also been organized to focus on and provide expertise in specific problem areas, such as heart disease, cancer, stroke and dentistry. Represented on these subcommittees are all the leading organizations and experts in the respective fields in North Carolina. For example, the Subcommittee on Cancer is composed of representatives from the Cancer Society, all the official relevant State agencies, practicing physicians, the experts from the North Carolina Division of the American College of Surgeons, the medical schools, and the State Medical Society. Their discussions immediately revealed the need for a state cancer registry which would augment, coordinate, and make more effective use of the several on-going independent cancer registries in the State. This led to recommendations of a project proposal which was submitted to the Advisory Council, coupling the resources of the Regional

Medical Program with the on-going cancer registry activities of the other health agencies. Financial contributions from many of the participating agencies were also anticipated as part of the Program.

In the field of heart disease a similar process took place which resulted in a feasibility study now underway to develop a regional plan for providing on-going educational services to coronary care units. Other programs underway in North Carolina include planning for a statewide diabetic consultation service; planning for education and research in community medical care; studies and surveys of education program needs and resources; surveys of relevant health professions needs and resources; and studies of patterns of illness and care.

The impact of the Regional Medical Program is already being felt in the health affairs of the State. With the State Medical Society taking an early leadership role in developing the program with the medical schools, practicing physicians are actively involved in the planning phase. The channels of communications which have opened up at all levels and among all health groups are quickly leading to fruitful discussions on a multitude of problems. The Dean of Duke University School of Medicine described the phenomenon when he said: "Channels for cooperation for many endeavors have now been opened. Although we have talked together a great deal before, we now have available more effective channels of communications and financial resources to implement such programs, not only with other medical schools but also with all other health agencies." As the North Carolina program moves ahead, it will be a program conceived, designed and implemented by and for the people of the State. As one leading official of a voluntary health agency put it: "We hope to weave it so that it won't be your program, or my program, but our program."

Washington-Alaska Regional Medical Program

Although the Washington-Alaska Region previously had little regional health activity, Alaska, which has no large medical center, is naturally related to Washington by transportation, communication, economic and social ties and traditional patterns of medical referral and consultation. The joint Washington-Alaska Regional Medical Program is being developed on this basis.

Here, as in many other regions, there was widespread participation in the preliminary planning and preparation of an application. An initial conference, held only one month after Public Law 89–239 had been enacted, included some 35 members of the University of Washington Medical School faculty, approximately 50 practicing physicians, and representatives of the Washington Hospital Association, State Department of Health, and the Seattle-King County Department of Health.

Though the planning proposal that eventually resulted was formally submitted by the University of Washington Medical School, it had the approval of the Governors of both Washington and Alaska, the President of the University of Washington; the Washington and Alaska State Medical Associations, Dental Associations, Nurses Associations, and Heart Associations; the Washington and Alaska Divisions of the American Cancer Society; the Washington Health Department, Alaska Department of Health and Welfare and the Divisions of Vocational Rehabilitation in both States.

Many of the health institutions in the region are being involved in the Regional Medical Program. Representatives from virtually all of the 130 hospitals in the region have been contacted. Interest has been expressed by the Heart Associations and the Cancer Societies of both Washington and Alaska; their programs of research, professional and public education, community service, traineeships and direct patient services will be coordinated in a joint effort.

The Program Coordinator for the Washington-Alaska Regional Medical Program, Dr. Donal Sparkman, assumed his position on March 1, 1966, six months prior to the beginning of the planning grant. Thus, the Program has had the benefit of overall administrative direction since its preliminary planning phase. Dr. Sparkman has had extensive experience in the practice of internal medicine, in teaching at the University's School of Medicine and with the State Department of Vocational Rehabilitation.

Other key staff, including a coordinator for Alaska, an associate director, a cardiologist, a hospital administrator, and a systems analyst, have been recruited since the Region's planning grant was awarded, effective September 1, 1966. In addition, a wide variety of consultants, including epidemiologists, statisticians, economists and communications specialists, are being utilized.

The Program strategy of the Washington-Alaska Region is to concentrate first on the following:

☐ Assess the existing disease problem in the region.

☐ Delineate resources and needs in patient care, education, training and research.

☐ Investigate the effectiveness of current programs and how they can be improved by regional planning and cooperative efforts.

Initial planning studies now underway are focused on identifying needs of physicians, particularly needs for continuing education and the best use of medical consultants visiting smaller communities. Particular attention is being given to physician manpower needs in Alaska as well as transportation and communication patterns in that part of the region.

Planning studies relating to the coordination of coronary care facilities and services, a post-graduate preceptorship program, and the establishment of a regional medical library system have also been inaugurated. Other planning studies soon to be initiated will concern methods of pooling data from cancer registries, a feasibility study of open channel television, a survey of physician and nurse participation and interests in continuing education, and the early detection and care of coronary disease.

Western New York Regional Medical Program

Western New York is a comparatively small and compact but heavily populated Region. It is essentially urban and dominated by metropolitan Buffalo. There had been relatively little regional and cooperative activity among the health resources and interests in this area in the past. Substantial and rapid progress has been made in creating a regional health organization and framework for decision-making since the enactment of Public Law 89–239.

The development and creation of a Western New York Regional Medical Program has been characterized from the very beginning by the widespread participation by nearly all of the major health institutions, groups, and agencies in the eight-county region covered by it (Allegheny, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, and Wyoming Counties in New York, and Erie County in Pennsylvania). The Regional Medical Program has been received by the practitioners with unexpected enthusiasm following the well-publicized interest of the State University of New York at Buffalo (SUNYAB), Roswell Park Memorial Institute and other major hospitals in the area to build on and strengthen the existing good relationships.

In November 1965, following passage of Public Law 89–239, an Interim Coordinating Committee composed of key people concerned with health and health care was formed to study the bill and "to promote as rapidly as possible regional interest in the establishment of a regional program" for heart disease, cancer, and stroke. The committee, as initially constituted, included the Dean of the Medical School, Director of Roswell Park, the Executive Director of the Western New York Hospital Review and Planning Council, the Past President of the Erie County (N.Y.) Medical Society, Erie County Health Commissioner, and the Regional Officer for Western New York of the State Health Department.

In January 1966 this committee called together representatives from the medical, hospital, and other health-related professions, practicing physicians and voluntary health agencies. From each of the eight counties came the health and hospital commissioners, the medical society representatives, chairmen of the Boards of Supervisors, the hospital administrators, and the American Cancer Society and Heart Association Chairmen. Individuals from social welfare agencies, public health and nursing representatives, as well as education personnel were also present. A total of 78 persons representing 70 organizations, institutions, and groups attended.

This group, originally invited to participate in the formation of the program, evolved into the Regional Advisory Group. This was no simple task. For the first time in the history of Western New York, an assemblage from the above groups met *with a common objective*. In an atmosphere paralleling that of a town meeting, each force presented its particular point of view. As the day wore on, a unique spirit of understanding and cooperation evolved. It was unanimously agreed that *it is the patient who must benefit from the Law*. Wholehearted support was expressed for a Western New York Regional Medical Program.

Several meetings were held by the group during the spring of 1966. The outcome of these meetings was the formation of a new nonprofit organization called Health Organization of Western New York, Inc. (HOWNY) and the designation of its 111 member representatives as the advisory body.

Their initial grant application, looking toward the development of a sound and workable proposal, in-

corporated a six-point planning program.

☐ A coronary care unit feasibility study

☐ The feasibility of multiphasic screening in Western New York

☐ Health care team planning

☐ A medical communications study

☐ A planning survey for a local consultation program

☐ A health care manpower survey

By the time a planning grant was awarded in December 1966, some other important and parallel developments had also taken place.

☐ New channels of communication had been opened among the many diverse health institutions and groups in the region.

☐ A parallel organizational framework was established at the community level. Through these local advisory committees, broadly representative of the health interests in the communities and including public members, the intent and aims of Regional Medical Programs were more fully and accurately conveyed to the practicing physicians and others at the community level. In addition, communities had been prompted to examine their own needs.

☐ Perhaps most significant was the decided change in the attitude of the practicing physicians in the region. Initially they had been quite wary and somewhat suspicious of the medical centers and the "cooperative arrangements" approach embodied by Regional Medical Programs. This view has altered with their increasing involvement in and better understanding of the program, so that now, in the judgment of many, including the Regional Advisory Group Chairman, who is himself a private practitioner, a majority of them support it.

Since the award of its planning grant, the Western New York Regional Medical Program has obtained a full-time Program Director, Dr. John R. F. Ingall, formerly an associate cancer research surgeon at Roswell Park. The Director has begun visits to all the medical communities, large and small, to explain the regional concept of the program and to stress the need for coordination. He aims personally to discuss with physicians and the health service agencies the aim of the Regional Medical Program to support all involved in giving medical care; the patient is most important and his needs can only be met by action in concert. The patient in turn, as consumer, is being informed by radio and television of the objectives of the Program. The health care manpower and coronary care unit feasibility studies had already been launched prior to his appointment; the remainder of their proposed planning activities have gotten underway since then.

The HOWNY Board of Directors, with members from each of the participating counties—one representing the county medical society, the other usually from a health related field—as well as SUNYAB, Roswell Park, the Western New York Hospital Association, the area-wide hospital planning group, and official public health agencies, has already set up procedures for reviewing proposed pilot projects. These include, in addition to a number of tentative proposals generated by local communities, proposals for the establishment of a regional hematology reference laboratory and a regional blood bank communication system.

OPERATIONAL GRANTS

Intermountain Regional Medical Program

The initial operational activities of the Intermountain Regional Medical Program will provide the following opportunities to a medical practitioner in this Region (which encompasses Utah and parts of Colorado, Idaho, Montana, Nevada and Wyoming) to improve the care of his patients:

☐ He will have available at his community hospital a communication network, including radio and television facilities, which will provide education programs and opportunities for interchange and discussion with consultants at the medical center.

☐ He will have available at his community hospital for himself, nurses and other personnel, a training program in the resuscitation of patients with heart disease, and the necessary equipment to make it possible to carry out these techniques. He will also have on call a medical consultant who has been specially trained to head hospital cardiopulmonary arrest alert programs.

☐ He may have tested at his hospital the feasibility of a system that transmits, in a 24-hour day operation, physiological information on heart disease patients to a computer facility in Salt Lake City and transmits promptly back to stations within his hospital information for diagnosis and treatment.

☐ He will be able to attend training courses in the intensive care of heart patients and will have available for consultation medical and nursing spe-

cialists who have completed such training.

☐ He may participate in seminars led by local, regional and national experts in order to better understand trends which are influencing medical care practices as well as new methods of maintaining and extending his medical skills.

☐ He will have available at his hospital both continuous 24-hour consultation by telephone and visits by special consultants knowledgeable in the latest information in the diagnosis and treatment of cancer.

☐ Through the use of a computerized tumor registry, he will be able to analyze and compare his own cancer patients with local, regional and national standards.

☐ Consultants will visit his hospital (if it is in a community with less than 10,000 persons) periodically, to assist him in the diagnosis and care of heart disease patients by working at the bedside of his patients.

☐ He may apply for a special clinical traineeship in cardiology that will involve specialized training at 5 cooperating medical institutions in programs designed to meet the individual interests and problems of the participating physicians.

☐ He will have available a communication and information exchange service that will provide information on the prevention and control of these diseases to public groups as well as to professional and allied health workers.

☐ He, along with other health workers and members of the public, will have opportunities through a formal feedback system to communicate with the planners and leaders of the Regional Program to indicate his reactions, needs and recommendations for developing new program activities.

Missouri
Regional Medical Program

The initial operational endeavors of this Program are "oriented toward maximizing the amount of diagnosis and care which can be delivered in the . . . community by the physician and the local medical resources while maintaining and improving the quality of medical effort. . . ." As the program is implemented in the future, a medical practitioner in the Missouri Region may have the following opportunities available to assist in the care of his patients:

☐ He will benefit from the development and demonstration of a comprehensive health care system that is being tested in Smithville, a suburban-rural community north of Kansas City, with a view to eventual replication throughout the Region. This project is exploring the benefits to practicing physicians of having available automated clinical laboratory testing for multiphasic screening and a computer fact bank displaying the results to him audio-visually; an automated patient history system providing him with a patient's complete medical history before seeing the patient; an automated EKG service connected with the University Medical Center for rapid, accurate transmission, receipt and interpretation of electrocardiograms; specialists consultation from the medical center by telephone; and an integrated continuing education program at his hospital for himself and the allied health personnel supporting him.

He may, through the connection of his community hospital with the Medical Center's Department of Radiology and computer facility, obtain computer aided radiologic diagnosis that will help improve the accuracy and reliability of his diagnosis of bone tumors, gastric ulcers, and congenital heart disease.

☐ He may, after a period of pilot testing and validation, have at his disposal an automated patient history acquisition system through which he can obtain a complete medical history of a patient before seeing him. Presently this requires an amount of time not normally available to the busy practitioner.

☐ He will, if the result of experiments being initiated are successful, have direct access by means of computer terminals in his office to a Computer Fact Bank providing the best and latest information concerning the diagnosis and care of stroke patients. This information will not only be available for application to individual patients while in the physician's office but will make possible discourse with the computer so that the experience constitutes an integral part of his continuing education.

☐ He will have the use of a multiphasic screening center to be established to provide him and his patients with 11 blood chemistry tests, complete blood count, urinalysis, stool guaias, and Pap smear.

☐ He and his colleagues in the Ozark area will have available at St. John's Hospital in Springfield, and later at other small hospitals, a refined and more comprehensive cardiovascular care unit that will demonstrate the feasibility of an intensive care program without house staff.

☐ He and others will have available to them as a result of the establishment and sampling of population study groups, more current and accurate information about the true

rates of disease incidence and prevalence in the Region.

☐ He and his patients will benefit from an operations research and systems design project aimed at (1) improving early detection of heart disease, cancer and stroke and (2) optimizing the utilization of the resources committed to these diseases in terms of the effectiveness of the medical services provided.

☐ He and his patients will benefit from improvements in bioengineering techniques utilizing sensor-transducers for early detection of heart disease, cancer and stroke.

☐ He and his patients similarly will stand to benefit from studies of the Program Evaluation Center, a multidisciplinary research unit of the Missouri Medical School, dealing with the problems of the distribution of health services and medical facilities. Priority will be given to developing instruments for evaluating the quality of care and level of health, both individual and community-wide.

☐ His patients will be the ultimate beneficiaries of a communications research project aimed at better understanding public attitudes, opinions, and knowledge about heart disease, cancer, and stroke, in order to enhance prevention and early detection.

☐ He and the community service agencies and others will be provided with a directory of the names, services and addresses of all medical and paramedical services in the State to facilitate the referral of patients between agencies and the full use of available resources.

EXCERPTS FROM
ANNUAL PROGRESS REPORTS

Albany
Regional Medical Program

"In our Operational Grant Application it was mentioned that 'there is no question but what the development of the Albany Regional Medical Program has produced very important effects, both in the surrounding medical communities and at the Medical Center. The predominant attitude is one of interest, enthusiasm and cooperation. Relative to need the program is ideally timed. An early addition of operational support should allow us to take full advantage of the momentum of our rapid initial progress. . . .'

"To this statement should be added the fact that the April 1, 1967, approval of our operational grant request allows us to intensify the continuous planning activity as the conduct of our Pilot Projects reveals additional planning opportunities. We believe the most effective planning will result as we relate the planning to the conduct of our operational program. . . .

"However, since the initial projects of our operational program are not intended to result in a complete program, it will obviously be necessary to continue planning supplemental projects which will further increase the capability for diagnosis and treatment of heart disease, cancer and stroke. In particular, we contemplate extensive planning of continuing education and training for medical and allied health professions.

"The purpose of the Albany Regional Medical Program is to utilize research, education, training and demonstration care in an organized cooperative and effective approach to the prevention, detection and management of heart disease, cancer and stroke. Although leadership and the dissemination of scientific information are among the important responsibilities of the Medical College, the intent is to promote interrelationships among all relevant institutions, agencies and individuals in a manner which will produce a sustained effort by the citizens of each local community. The intent is to strengthen community medicine and thus improve patient care. . . .

"The Albany Medical College was involved in a great deal of advanced planning in anticipation of its involvement in Regional Medical Programs. This resulted in extensive activities prior to the planning grant award. . . .

"Five mature experienced physicians were contacted relative to their interest in becoming full-time members of the Department of Postgraduate Medicine, which has the primary responsibility for the administrative direction of the Program. . . .

"The needed nonprofessional administrative personnel were sought and excellent individuals were acquired. One of these is now our Director of Community Information Coordinators. He has three coordinators working with him. These men are experienced former pharmaceutical house representatives who have proven their ability to relate well to physicians and be successful in their contacts with physicians. . . .

"Regional Medical Program staff have met with the administrators and staff of many of the hospitals in the Region. To date, 58 hospitals have

been contacted; and formal presentations on the Albany Regional Medical Program have been made to the medical staffs and/or boards of trustees of 25 of these. All of the latter have indicated, by vote, their desire to participate in the Program. . . .

"In general all of the hospital administrators, staff physicians, and board members have indicated their sympathetic agreement with the concepts of Regional Medical Programs. In some instances there were misconceptions about the Program based upon the Report of the President's Commission on Heart Disease, Cancer and Stroke; these were quickly and easily dispelled. The administrators and staff of many of the hospitals expressed the desire, long felt, for a closer working relationship with the Albany Medical College and Center, especially with respect to patient consultations with specialists; increased opportunities for continuing education in the physician's home community; assistance in updating their knowledge and ability to diagnose heart disease, cancer, stroke and related diseases; guidance and aid in the training of more nurses and other allied health personnel; and advice as to whether or not to engage in research activities as well as the nature thereof. . . .

PROGRESS REPORT ON SELECTED PLANNING PROJECTS

Project to Improve and Expand Cancer Detection and Therapy

"A major project preparation has been prepared, involving the efforts of physicians and administration at Vassar Brothers Hospital at Poughkeepsie, New York. The study is directed towards the objective of enabling more effective early diagnosis and treatment of cancer in the Poughkeepsie area. . . .

Vaginal Cytology Screening Program

"This project proposes to develop a model for cytological screening of all female patients in a given community for cervical cancer. Continuing study is underway to establish the most effective coordinated approach to the objective, combining the capabilities of the Regional Medical Programs with the opportunities which other State and Federal efforts provide. . . .

Multiple Hospital Prospective Cancer Investigation Program

"This project proposes to establish a sub-regional and eventually a regional approach to a prospective cancer investigative program which would result in major dividends with regard to research, with regard to diagnostic and therapeutic procedures and with regard to general cancer education. . . .

Cardiopulmonary Laboratory Development

"It is proposed to establish a cardiopulmonary physiology and diagnostic laboratory at the Pittsfield Affiliated Hospitals, Pittsfield, Massachusetts. Such a laboratory would provide accurate diagnostic facilities in heart disease, diseases of the blood vessels and pulmonary disease. In addition, its establishment will lead to improved local physician continuing education in this field.

Cardiac Care Unit at Herkimer Memorial Hospital

"This project proposes the establishment of a firmly based Cardiac Care Unit building upon the hospitals existing embryonic 'homemade' one. Such a unit will permit nurse training in intensive coronary care in this locality."

Connecticut Regional Medical Program

"During the 'tooling up' phase, when the program objectives were being set and the action program was being formulated, the primary work involved the RMP staff, the Planning Committee and the Regional Advisory Board. Good communications were maintained by frequent meetings, which were well attended, and by circulating full follow-up minutes. . . .

"The Planning Design, as finally adopted, is concerned with such fundamental elements as health personnel, facilities, and finances—and their effective blend into a coordinated regional medical program serving all the people of Connecticut. . . .

"It involved the creation of nine Task Forces to study specific components of the Connecticut health care system, to determine deficiencies, to chart action programs and ultimately to work for their implementation. A serious effort was made to have various segments of the health community represented on each Task Force, as well as to obtain a reasonable geographic distribution. Each includes representatives of various points of view appropriate to the topic under consideration, drawn from private practice, education, voluntary agencies, governmental service and the public at large. . . .

"These Task Forces are concerned with the (1) supply and distribution of physicians and dentists; (2) recruitment, training, distribution and

continuing education of nurses and other allied health professionals; (3) continuing education of physicians and dentists; (4) extended care facilities and programs; (5) university-hospital relationships; (6) the organization of special services within hospitals; (7) implementation of a state-wide library system; (8) financing of medical care; and (9) definition of the Connecticut region and its subregions. . . .

"The RMP staff is responsible for assembling the complete information on the health resources in Connecticut needed by each Task Force in its subject field in order to go about its work. To date, preliminary steps have been taken to ascertain what data is available through a number of established health organizations. Fortunately, the assembly of health information by such organizations as the State Health Department, the Connecticut Hospital Association, the Connecticut Hospital Planning Commission and others will provide much of the information needed. It remains, however, for the RMP staff to carry out some special studies and, ultimately, to compile much of the health resources data in a central profile.

"There have been many opportunities to discuss the Planning Design with boards of directors of health organizations, with hospital staffs and with many interested individuals, both from the medical and lay ranks. Thus, the potential of Regional Medical Programs is becoming known in a widening circle; and communications among various segments of the Connecticut health community are improving. . . .

"The Regional Advisory Board has assumed responsibility for the pivotal decisions relating to the development of the Program, e.g. the approval of the planning grant request, the appointment of the Planning Director, the adoption of the Planning Design and the appointment of the Task Force membership. . . .

"It is noteworthy that Regional Advisory Board members are now serving as Chairmen of eight of the nine Task Forces and that every Board member has a position on one of them. This means that Board members will be deeply involved in planning activities, that they will be in good positions to weigh proposals for the operating program one and two years hence, and that they will have the background knowledge needed to push their implementation. . . .

"The most difficult problems encountered to date are the following: (a) the complexity of the subject fields under study; (b) the weakness of communication links between segments of the health system; (c) the shortage of experienced health planners and researchers in the delivery of health care; (d) the overlapping and uncertain jurisdiction of related health planning organizations; and (e) the shortness of time available to achieve measurable results.

"With regard to the complexity of the subject fields under study, it is pertinent that the Connecticut Regional Medical Program is probing questions which have perplexed leaders from the fields of medical education and medical care alike in recent and past years. There are no ready answers, for example, on how to provide family medical care to all citizens in the years ahead, or how to recruit and educate the necessary nurses and other supporting health personnel and make them a part of a true health team, or how to implement effective programs of continuing education for all health practitioners, etc. It is even difficult to structure planning studies to lead to the best solutions to these important issues. Yet, the Program has chosen to concern itself with those very issues in the health field which are of greatest concern to the people of Connecticut. . . .

"It is pertinent that in Connecticut, as elsewhere, there has been relatively little contact in the past between the medical and social sciences in the universities. These need to work together to chart overall social progress in the health field. There has been a considerable 'town and gown' rivalry between clinicians in the university and community settings. There has been too little continuing contact in the past between health spokesmen from the educational and voluntary segments, on the one hand, and from local and state government, on the other. The planning efforts of the Connecticut Regional Medical Program depend in great measure on full collaboration between representatives of the health establishment drawn from education, from the voluntary community and from government. Some of the needed communications links are having to be forged as a part of the Connecticut Regional Medical Program planning process itself. . . .

"Despite the major problems encountered and the enormity of the task . . . a sound organizational framework for planning has been established; broad consensus has been reached on the program's planning design; and a large number of key leaders from the Connecticut health scene have become involved in the planning process.

Hawaii
Regional Medical Program

"The assessment of the overall situation, and the establishment of communication with the participating agencies have been the major items of activity since November 1966, when a full-time Deputy Program Director (General W. D. Graham, M.D.) arrived in Hawaii. Informal conferences with members of the Regional Advisory Group and their represented agencies and with other participants have been held, and the status of the public, private, and voluntary programs in the health field have been studied.

"Local assessment, and the detailed consideration of the content and concepts of programs under way in other regions, lead to the conclusion that tangible progress in the program here is contingent upon projects in continuing education. There is at present no fully-staffed, on-going academic clinical teaching center in Hawaii. Those highly qualified personnel currently engaged in the training programs of the teaching hospital are engaged to full capacity, and are augmented by 'visiting professors'. By locating full-time teaching specialists in teaching hospitals, significant additional support for postgraduate training programs will result and will bring these specialists in close touch with private practitioners. . . .

"Additional programs of particular interest are the Stroke Registry and the Facilities Studies. On March 1, 1967, exploration of the feasibility of the establishment of a Stroke Registry was begun. Consultations with physicians and with medical record librarians have progressed most satisfactorily. Field testing of methodology will commence about May 1, 1967, in selected hospitals. . . .

"The project for stroke rehabilitation education involves a plan to set up a training program for various categories of rehabilitation personnel at the Rehabilitation Center of Hawaii in Honolulu, at outlying hospitals on Oahu and on the neighbor islands, in order to augment stroke rehabilitation capabilities, which are at present at the full capacity of the Center staff.

"The goal of a facilities study by the Hawaii Heart Association is to determine equipment status in facilities which provide diagnosis and treatment to patients with heart disease. A questionnaire has been directed to hospitals and clinics and the returns will be preliminarily evaluated, using volunteer services. Collation, analysis, and subsequent development of the information will require RMP support, and will begin about June 1, 1967. . . .

"Planning is under way for a program directed toward the hematologic aspects of the care of heart, cancer and stroke patients. This will also have components of continuing education, consultative service and laboratory and investigational activity directed toward assisting physicians in diagnosis and patient care.

Intermountain
Regional Medical Program

"Organized efforts to develop a Regional Medical Program for this Region began in the fall of 1965. Efforts were made early to enlist the interest and support of organized medicine. . .

"In October 1965, Dean Castleton and Dr. Castle of the University of Utah School of Medicine met with the Utah State Medical Association Executive Committee to gain their interest and support for a regional program. Subsequent meetings were held with representatives of the Utah, Idaho and Nevada State Medical Associations, and county medical societies in Reno and Las Vegas, Nevada; Grand Junction, Colorado; Idaho Falls, Pocatello, Twin Falls and Boise, Idaho; and Butte, Great Falls and Billings, Montana. Meetings also were held with members of the hospital staff in all the major hospitals in the region. . . .

"On February 26, 1966, a regional workshop was held at the University of Utah Medical Center in Salt Lake City, which was attended by representatives from all six states involved in the proposed region and all professions, organizations and institutions concerned about heart disease, cancer and stroke. The purpose of the meeting was to begin to define a Region which could work together as a unit and to obtain ideas as to regional resources and needs, and how a program should develop. Ideas expressed at this meeting served as a foundation for the planning grant application submitted in May 1966 and awarded effective July 1, 1966. . . .

"Since July 1966, the major efforts in planning have been in recruiting a planning staff, establishing lines of communication with all elements within the region and with other regional programs in the country and developing systems for sustaining active interaction among these groups, explaining the purpose of the program to professional and lay communities, developing methods for collecting data relative to heart disease, cancer and stroke, identifying needs which can be met by Regional Medical Program legislation, and formulation of proper procedures for construction of pilot projects and methods for their review and ap-

proval by reacting panels and the Regional Advisory Group. . . .

"Progress has been made toward meeting all objectives outlined in the planning grant application, but none have been completed and will require an intensity of planning similar to what has been established within the last few months for at least another year. One major obstacle to more rapid progress within the region has been the slow process inherent in obtaining outstanding people to serve in key positions on the planning staff. Although the Intermountain Regional Medical Program has been particularly fortunate in obtaining an outstanding, dedicated, hardworking staff, the process of bringing them into a new program, allowing them time to understand the program and to define their role, has taken much longer than anticipated at the outset. In lieu of people with background and experience in developing the type of program outlined under Public Law 89–239, it has been necessary to recruit personnel with a variety of career commitments and ask them to make major changes in their careers in pursuing this new national program. . . .

"To meet some of the most pressing needs in initiating a Regional Medical Program, specific projects to provide training for personnel and to involve certain institutions, organizations and individuals in an active way were identified early in planning. . . .

"The community profiles developed by the Intermountain Regional Medical Program are being used by the Mountain States Regional Medical Program and the community committees to be formed in Nevada, Wyoming, Idaho, and Montana, will serve as liaison to both programs overlapping these areas."

Kansas
Regional Medical Program

"By the first of the year the position of Regional Medical Programs with relation to Public Law 89–749 and other efforts of the medical school had become somewhat clarified. Dr. Charles Lewis, professor and chairman of the Department of Preventive Medicine and Community Health, who had been active in both the planning grant body and in preparing the operational grant application, agreed to take full-time responsibility as director of the Kansas Regional Medical Program. He assumed this role on March 15, 1967. Since this time considerable progress has been made with regard to a principal staff and development of a formal organizational structure. . . .

"In addition, a Regional Medical Program office has been established in the Wichita area. This was done since this metropolitan area contains 15.75 percent of the population of the state of Kansas as well as 357 physicans and 1,825 nurses. Mr. Dallas Whaley, the previous executive-secretary of the medical society in Sedgwick County (Wichita) was approached and hired. . . .

"In addition to the Regional Advisory Council, two additional groups have been appointed to serve as staff advisory committees. One of these is the Professional and Scientific Review Committee. This is made up of individuals nominated from various organizations and groups, such as the Heart Association, the Cancer Society, the state Medical Society, those from certain sections of the School of Medicine, etc. . . .

"The second group appointed is a physicians' panel. This is composed of a group of physicians selected by stratified random sampling with regard to geographic area, type of practice, and age. This panel of names will be submitted to the president of the Kansas Medical Society. . . .

"The Regional Advisory Council was recently enlarged with the addition of eight new members. This enlargement was accomplished in order to gain further representation of other non-health-related groups within the state and also to increase representation from the Wichita area. . . .

"Considerable discussion has taken place with the Missouri Regional Medical Program regarding cooperative planning efforts, particularly with regard to data pooling and evaluation. Special attention and cooperative planning have been directed to the complex Kansas City metropolitan area which crosses the Missouri-Kansas State boundary and six county boundaries. . . .

"A special Metropolitan Kansas City Coordinating Committee has been established to advise and assist with the planning for this area. This committee, which is made up of representatives of both the Missouri and Kansas Regional Medical Programs, will consider all proposals of either Region which would have an impact in the greater Kansas City area. . . .

"An interregional conference on health manpower data recording and evaluation was held May 22–23, 1967, at the University of Kansas Medical Center. Representatives of the Oklahoma, Missouri, and Kansas Regional Medical Programs participated with outside experts. The purposes of this conference were (1) to define basic core information which must be recorded on all professionals (having decided what disciplines will

be covered) and to develop a common data base for the three Regions for the transmission and comparison of manpower data, and (2) to emphasize the importance of proper evaluation rather than developing artificial indices which mean nothing in terms of health delivery systems. . . .

"It should be noted that feasibility studies will soon be under way in the Wichita regional area. A group representing the hospitals and physicians of that area is now making plans to develop a non-profit corporation in order to seek non-federal financing from private industry to supplement funds from Regional Medical Program resources. . . .

"It is hoped by the first of September that manpower data recording for the state of Kansas will be almost complete. It is also projected that during the summer of 1967—several field investigations will be carried out on consumer and health professionals' attitudes toward current systems of health care. A probability sample of consumers will be interviewed, comparing their attitudes toward medical care. In addition, physicians, nurses, hospital administrators, etc., will be similarly consulted. The purpose of this is to *describe* the system in as many ways as possible and to correlate this with other information regarding parameters of health care, i.e., morbidity and mortality data, utilization of beds, number of office visits, costs, etc. By comparing two or three different types of medical care systems in different parts of the state, we will have a better idea of the means by which we can evaluate changes and variations on the original theme of delivering health care to patients and improving the quality of care for those with heart disease, cancer, and stroke. . . .

"Another development which will be completed before the end of this planning year is the attempt to develop a health data bank. To this end the University of Kansas Medical Center, the Kansas Regional Medical Program, the Kansas State Board of Health, Kansas Blue Cross-Blue Shield, and Kansas Health Facilities Information Service, Inc., have all agreed to pool data on manpower, postgraduate training, resources for health care, facilities, utilization, morbidity, mortality, vital statistics, economic development, outpatient utilization of office visits, etc."

Missouri Regional Medical Program

"Under the leadership, guidance and direction of the Regional Advisory Council, planning for the Missouri Regional Medical Program and development of pilot projects for implementation have proceeded simultaneously during the year. The Advisory Council, with advice from its Scientific Review and Liaison Subcommittees and the Metropolitan Kansas City Coordinating Committee, serves as the governing body, determines policies, and approves (or disapproves) and sets priorities among proposals for pilot projects. The Scientific Review Subcommittee advises the Council relative to scientific problems, including the merit of pilot project proposals. The Liaison Subcommittee serves as a two-way medium of communication between the member organizations and the Missouri Regional Medical Program. The Kansas City Metropolitan Coordinating Committee reports to the Advisory Councils of the Kansas Regional Medical Program and the Missouri Regional Medical Program and works to encourage cooperation and avoid duplication of pilot project proposals among institutions, hospitals and other agencies of Metropolitan Kansas City. All the organizations and institutions represented on these Committees have an active role in planning, and two have submitted pilot projects now under consideration and three are preparing pilot project proposals. . . .

"The Advisory Council made an early and crucial decision to place primary emphasis on maximum use and refinement of present resources. This means learning more about the needs of practicing physicians and other health professions, the consumer, and State and local health resources. Missouri Regional Medical Program aims to assist the practicing physician in providing optimum patient care as close to the patient as possible, with equal access to any needed national resource. Accordingly, Missouri Regional Medical Program stresses prevention and early detection, continuing education, public education and information, and appropriate demonstrations of patient care. . . .

"The Missouri Regional Medical Program staff is confident that the splendid interest, concern and contributions of the Advisory Council are, in important part, related to its decision-making authority. (There appears to be evidence that the contributions of Regional Advisory Groups to a certain extent parallel their responsibility for decisions.) . . .

"Since July 1, 1966, the staff have taken steps to strengthen inter-agency cooperation and communications. The Program Coordinator and staff have made speeches at society meetings, meetings of other health profession organizations and lay groups. The staff has also conducted seven site visits with reference to pilot projects

proposed by various communities; has been in communication with six other communities relative to possible pilot projects; has consulted with numerous official health agencies and other organizations and individuals; has discussed plans, projects and activities with numerous visitors. . . .

"Thus far all agencies, institutions, organizations, and individuals asked to cooperate have responded favorably. . . .

"However, some practicing physicians need to be informed that Missouri Regional Medical Program is primarily patient oriented and not Medical Center oriented, and that Public Law 89–239 emphasizes cooperative arrangements, continuing education, and demonstrations of patient care within the present system of medical practice. . . .

"Missouri Regional Medical Program may face problems when agencies present pilot projects for funding and a choice must be made. However, we are developing Guidelines on which funding decisions will be based and explained to interested agencies. . . .

"The Missouri Regional Medical Program emphasizes the importance of evaluation of results. The Program Evaluation Center for the University of Missouri School of Medicine is being used to develop whatever measurement devices are required and to apply them to the results achieved by various funded programs. The staff's activities have been spent in attempting to conceptualize comprehensive coordinated community health services in terms of 'schemes of action' rather than 'schemes of arrangement.' Thus, the model will be defined in such terms as access, communications, and end points. . . .

"Pilot projects proposed by Missouri Regional Medical Program include built-in evaluative mechanisms. . . .

"A study is being conducted in a rural Missouri community, Glasgow, approximately 40 miles from Columbia, to examine some of the decisions made and the systems used by members of this community in seeking medical care. . . .

"In keeping with the 'scheme of action' concept, this one has looked at (1) routes of access to care which have been used; (2) critical coordination and comunication points in the systems used; and (3) endpoints or reference points in the health service system.

"Missouri Regional Medical Program will continue to coordinate its planning and pilot projects with other health and related programs. This applies especially to Public Law 89–749 and a new State law relating to State and regional comprehensive planning and community development (including health). A new Office of State and Regional Planning and Community Development has been designated by Governor Hearnes for administration of these two laws in Missouri. In order to effect proper coordination between Missouri Regional Medical Program and the Office of State and Regional Planning and Community Development, a new senior staff position (Liaison Officer) has been established. . . .

"Up to this writing, Missouri Regional Medical Program has considered approximately 40 pilot project proposals. Of these, 27 were forwarded to the Division of Regional Medical Programs in the form of three operational grant applications. If current negotiations are confirmed, 15 of these will be initiated during April 1967, as follows:

Smithville Project
Communication Research Unit
Multiphasic Testing
Mass Screening—Radiology
Automated Patient History
Data Evaluation and Computer Simulation
Computer Fact Bank
Operations Research and Systems Design
Population Study Group Survey
Automated Hospital Patient Survey
Program Evaluation Center
Bioengineering Project
Central Administration
Comprehensive Cardiovascular Care Unit (Springfield)
Manual of Services

"Staffing arrangements for these projects are underway and are expected to be completed in major part within the month."

North Carolina Regional Medical Program

"Very early in the consideration of the North Carolina Regional Program it became clear that in order to fully implement the provisions of Public Law 89–239, it was necessary to develop a core concept which would make possible the coordination and augmentation of an already large number of existing health activities, interests, and institutions and in the process enhance the ultimate effectiveness of each component element. This unifying conceptual strategy called for the mobilization, through comprehensive planning and cooperative enterprise, of all health care knowledge and resources for a concerted attack upon the problems of heart disease, cancer, stroke and related diseases. . . .

"The program has the unique opportunity of being in a position to bring together the talents of this hitherto widely diffused leadership