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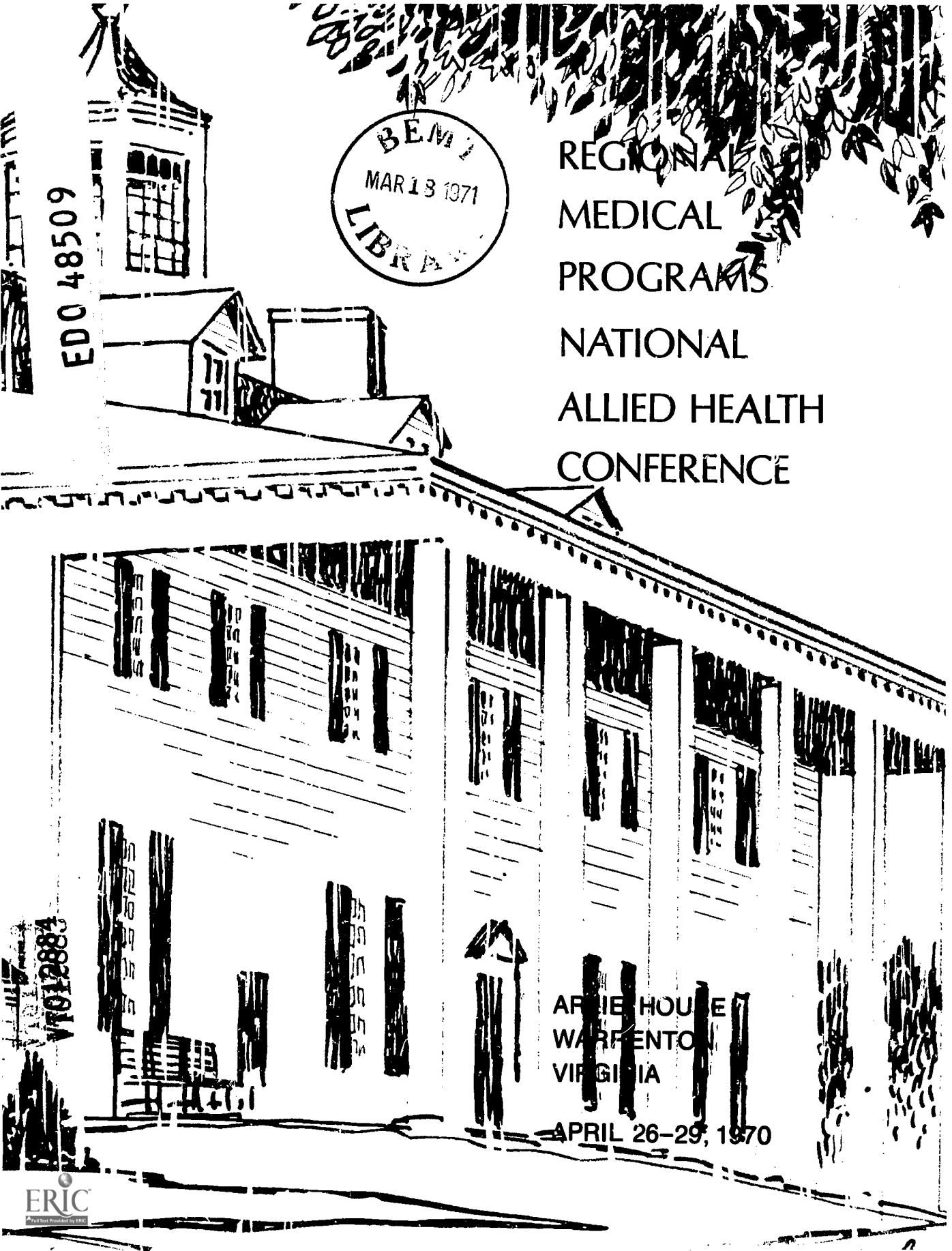
ABSTRACT

A total of 174 representatives of 14 health professions from 54 Regional Medical Programs attended a 4-day conference to discuss means by which allied health professions can make a maximum contribution to the health service system through Regional Medical Programs. Conference activities included two panel presentations, reports of 10 task forces and five special interest groups, and these major presentations: (1) "Changing Perspectives in the Delivery of Health Care" by Ray E. Brown, (2) "The National Health Scene" by Irving J. Lewis, and (3) "Potential for Regional Medical Programs as Viewed by the Regional Director" by Harold Margulies. Texts of the major speeches and summaries and recommendations from conference activities are provided. (SB)

REGIONAL MEDICAL PROGRAMS NATIONAL ALLIED HEALTH CONFERENCE



ARMIE HOUSE
WARRENTON
VIRGINIA

APRIL 26-29, 1970

REGIONAL MEDICAL PROGRAMS

NATIONAL ALLIED HEALTH CONFERENCE

Warrenton, Virginia . April 26-29, 1970

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration
Regional Medical Programs Service

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

January, 1971

FOREWORD

The Second National Conference for the Allied Health Professions brought together representatives of fourteen different health professions from fifty-four Regional Medical Programs. This Conference which was sponsored by the Virginia Regional Medical Program at Airlie House, Warrenton, Virginia, April 26-29, 1970, also included resource participants from a number of the major allied health professions' organizations and from several Federal agencies whose objectives parallel or complement those of Regional Medical Programs. The major purpose of the meeting was to provide an opportunity for interprofessional discussions of the ways in which the allied health professions can make a maximum contribution to the health service system through Regional Medical Programs.

The following proceedings of the Airlie House Conference include the full texts of the major speeches, the panel presentations, and the Reports of the Task Forces and Special Interest Groups. The Report to the National Advisory Council which follows this Foreword is a summary of the findings and recommendations of the Conference.

ACKNOWLEDGMENT

The Regional Medical Programs Service takes pleasure in expressing appreciation to the Virginia Regional Medical Program for serving as the HOST REGION for this second Regional Medical Programs National Allied Health Conference, and for the excellent management of organizational details which contribute to the efficiency of the Conference and to the comfort of its participants.

CONTENTS

CONTENTS, Continued

REPORT TO THE NATIONAL ADVISORY COUNCIL
ON THE
REGIONAL MEDICAL PROGRAMS NATIONAL CONFERENCE
ALLIED HEALTH PROFESSIONS
Airlie House, Virginia
April 26-29, 1970

The Airlie House Allied Health Conference Planning Committee presents this report to the National Advisory Council so that the Council might be informed on the proceedings and recommendations of the Conference.

THE AIRLIE HOUSE CONFERENCE

This second national RMP conference for Allied Health Professions was sponsored to provide an opportunity once again for representatives of the many health professions associated with Regional Medical Programs to discuss crucial health care issues. The three-day conference attracted one hundred sixty individuals representing fourteen different health professions from fifty-four Regional Medical Programs. Among this group, were resource participants from a number of health professions organizations (AMA, AHA, ANA, APTA, etc.) and from several federal agencies (BHME, OEO, SRS, etc.) whose objectives and interests parallel or complement those of Regional Medical Programs.

Key papers were presented by Mr. Ray Brown, Mr. Irving Lewis and Dr. Harold Margulies. The major portion of the program was devoted to task force discussions of the health care crisis. Attention was focused on the ways in which the allied health professions can make a maximum contribution through the concepts embodied in Regional Medical Programs. The ten task force assignments were identical and broad in nature in the belief that such an approach would lend itself more readily to productive discussion by groups representing a variety of professions. In addition to the recommendations which these groups would generate, the intent was that the discussions would serve for the participants as a model of multiprofessional intercommunication. The Task Force Group met for eight hours during the three-day conference. The following summary represents a distillation of the ten reports.

SUMMARY

TASK FORCE REPORTS

The consensus among the multiprofessional Task Forces was that the ultimate goal of all health professions is the establishment of a health care system organized to provide comprehensive services of equal quality and access to all citizens. And, further, that this system - shaped by a fundamental regard for human dignity - will manifest its comprehensiveness through four essential elements: health education, personal prevention services, diagnostic and therapeutic services, and rehabilitation and restoration services. The task forces identified as broad major deficiencies--the inaccessibility of health services at the primary care level; the lack of attention to prevention; the failure to fully appreciate and utilize existing health manpower; and the general absence of innovation in the current approach to health care delivery.

THE POTENTIAL IMPACT OF REGIONAL MEDICAL PROGRAMS

The task forces characterized Regional Medical Programs as essentially Agents of Change. They expressed Regional Medical Programs functions in such terms as "to motivate," "to coordinate," "to collaborate," "to evaluate," "to cooperate and communicate with," and "to provide moral support." In assessing the overall potentialities of the 55 Regions, the task forces concluded that the individuality of the Programs makes it unlikely that all will be of the same nature, but in varying degrees among all Programs some intensification of effort in bringing about needed changes is in order. The task forces also viewed the ideal Regional Medical Program as representing a "coalition of health professions" which brings within the Region's orbit the organizations which the professionals represent; the institutions in which they are educated; the agencies where they practice, and the communities where they live. There was general agreement, however, that the cooperating health professions are functioning within many Regional Medical Programs in a characteristically hierarchical and competitive fashion, although there has been notable progress in many Programs in establishing inter and intra professional relationships so that there is communication and participation where none existed before. The Task Force reports with some degree of consistency, referred to the unique characteristics of Regional Medical Programs which shape their ultimate potential in improving the system. Among those which were underscored are:

> Regional Medical Programs are "owned and operated" at the local level where needs are most acutely felt; where local and regional differences can be identified and where a forum exists for discussion and negotiation. Furthermore, the task forces emphasized as a most important characteristic that because Regional Medical Programs are regionally focused they have established and developed close relationships with Comprehensive Health Planning and other community agencies, thus providing for consumer communication.

- Regional Medical Programs are "institutions" made up of providers in the health care system who exercize influence of considerable magnitude on much of the manpower sphere--its training, the scope of its practice, its utilization, and its distribution.

- Regional Medical Programs, more than any other single program, can address themselves to the traditional schism between education and service. These programs are in a unique position to utilize existing cooperative arrangements with the institutions where health personnel are trained, with the agencies where they practice and with the communities in which they live. They can thus promote programs, projects, and activities where there is true articulation between community needs, educational curriculums, professional practice, and health care.

- Regional Medical Programs are uniquely equipped to improve the existing manpower pool. Through its legal mandate "to generally improve the health manpower available to the nation," RMPs are investing extensively in continuing education of health professionals. Improvements have essentially been in the area of updating of knowledge among health manpower, by an extension of existing skills, by an expansion of roles, and by the retraining of those who have been inactive and in the development of new health occupations.

TASK FORCE RECOMMENDATIONS

The ten Task Forces identified and recommended many strategies and solutions for Regional Medical Programs. The underlying theme in all reports revolved about the interdependence of the health professions in the planning, delivery, and evaluation of health services. Disappointment was expressed that the recommendations of the first Conference at Asilomar in 1969 which primarily referred to greater allied health involvement have not yet been fully realized. The following recommendations of this second conference continue to reflect this unmet need.

Recommendation I Allied Health Professions

- that the degree of allied health professions participation in the structure of Regional Medical Programs at the regional and national level be increased--on planning committees; on Regional Advisory Groups and other review bodies; in operational projects; and on core staff--to insure maximum productivity by RMPs in reaching the goal of comprehensive health care accessible to all citizens.

Recommendation II Communications

- that lines of communications and functional relationships be established within and between the health professions, and with

the organizations, institutions and agencies concerned with the education and service of health personnel, including a provision for consumer communications.

Recommendation III Continuing Education

- that Regional Medical Programs encourage the development of: (1) multiprofessional continuing education activities on the basis that health care providers who learn together are likely to function more effectively as a team in the delivery of health services, and (2) uniprofessional and multiprofessional activities which focus on patient care needs rather than provider interests and in which there is continued evaluation of the impact of such activities on patient care.

Recommendation IV Health Services Research

- that experimentation with new models for the delivery of health services be promoted by Regional Medical Programs in a number of different settings and geographical locations utilizing new types of health manpower.

Recommendation V New Health Occupations

- that Regional Medical Programs promote the rational development and utilization of new or expanded allied health occupations which will serve the evolving health care system.

DEVELOPMENT AND ORGANIZATION OF THE AIRLIE HOUSE CONFERENCE*

INTRODUCTION

Good evening ladies and gentlemen. It is a pleasure to see you here, and I look forward to linking faces with names as opposed to reviewing the participant roster which has been so much a part of my life during these past several weeks.

The program titles me to talk about the development and organization of the Airlie House Conference. In reality, I am here to give you the details as to whom we all are and why you are here. Or, in the words of the youth of today, I am going "to tell you like it is."

Many of us in this room this evening at one time or another have been members of a Conference planning committee and are personally acquainted with the planning process which covers such things as preparing participants for the Conference, designing its conceptual and educational framework, organizing the program, getting the participants involved in the work of the Conference and helping them use, back home, what they have learned.

THIS CONFERENCE

This Conference evolved out of a major recommendation of the California Committee for Asilomar which was responsible for planning and sponsoring the first National Regional Medical Programs' Allied Health Conference. Formal planning for this Conference commenced early in the fall of 1969 with the appointment of a National Planning Committee, members of which are listed in your Conference program. The first meeting of the Committee was held in October 1969 in Atlanta, Georgia. Since that date, the Committee has met as a total planning group on two occasions and as an east-coast subcommittee on four occasions. In addition, many meetings of the headquarters staff and VRMP staff were held in an effort to coordinate planning and to work on specific management assignments.

DECISION MAKING

An initial decision of the Planning Committee was that the Airlie House meeting should be a working conference in that it should attempt

*Presented by Elsa Nelson at the Regional Medical Programs' National Allied Health Conference, Warrenton, Virginia, April 26-29, 1970.

to secure the active participation of every regional delegate in working on identification and solution of health problems, in developing recommendations for future action, and in learning new ways of working together. Members repeatedly emphasized that the Conference should not be an end in itself but should be a device, a means for accomplishing some larger aim. Its goal, therefore, would be change -- not only to forward the progress of Regional Medical Programs as an organization but to contribute to the participants own growth and development.

With these thoughts in mind, the Committee struggled through the process of establishing the overall purpose and objectives of the Conference which follow: For the purpose of exploring ways in which the allied health professionals can make a maximum contribution to the delivery of personal health care through Regional Medical Programs, the objectives are:

- To develop understanding about the current crisis in delivery of health care.
- To explore opportunities and develop strategies for Regional Medical Programs to improve the delivery of health care services.
- To encourage interprofessional approaches for the solution of health care problems.
- To stimulate participants to develop optimal community relationships.

Several constructive suggestions evolved through the process of evaluating the Asilomar Conference which when reviewed by the Airlie House Planning Committee prompted change in the design of this Conference. For example --

- Participants, some thirty-six of you, who attended the last Allied Health Conference will note that programming for this one will bring you fewer formal working papers and thus more opportunity for personal participation.
- More time has been allocated to task force sessions which the Asilomar participants concluded were most stimulating and productive in that they allowed for interchange between delegates of individual Regional Medical Programs and were highly rated as valuable for the purpose of gaining new knowledge and/or information.
- All task forces are multidisciplinary in membership by deliberate design for the purpose of encouraging interprofessional approaches in the solution of health problems.

- All task forces will focus on a similar assignment. Reports on task force achievements will be given on Wednesday morning, the final day of this Conference.

- The task force assignment is intentionally broad in scope in the belief that a broad approach would lend itself more usefully to refinement in accordance with the Conference objectives and the professional background, experience, and program responsibilities of group members.

- One evening of the Conference has been left unstructured or free to allow more time for informal communication between delegates.

- Resource participants of professional organizations and societies are present in this Conference to assist our understanding about current issues in the allied health field.

- Finally, representatives of Federal Health Programs, allied to Regional Medical Programs, in the sharing of related national health goals are present to increase our knowledge concerning ways of utilizing the resources of these programs.

"VITAL STATISTICS"

Now for a brief look at the "vital statistics" of the Conference membership.

- Conference registration for task force participation totals 163 people.

- Delegates are present from all of our 55 individual Regional Medical Programs.

- Our membership represents 14 different health professions.

- We are pleased that included in our membership are 5 representatives of individual RMP - Regional Advisory Groups.

- We feel fortunate that representatives of 5 university schools of allied health professions are present.

- We are pleased to welcome 13 program coordinators of individual Regional Medical Programs.

- 84% of our Conference registration on analysis breaks down into 5 main categories as follows: Nursing-36%, Education-20%, Medicine-15%, Administration-10%, Medical Communications-3%.

- 16% of the Conference registration is representative of allied health specialists as follows: Physical Therapists-6%, Social Workers and Medical Technologists-3% each, Nutritionists-2%, and Medical Records Librarians and Occupational Therapists-1% each.

- In analysis of the data reported on your Conference registration forms, it has been determined that 95 individuals serve on committees which are part of the organizational structure of Regional programs, as follows: Continuing Education-39%, Nursing-16%, Health Manpower-14%, Categorical Diseases-11%, Nursing and Allied Health-5%, Regional Advisory Group-5%, Community Programs-4%, and Functional Committees such as overall planning, coordination, and liaison-3%.

- 108 or 66% of the registrants of this Conference serve as core staff members of individual regions and project staff representation in the Conference amounts to 19%.

MAJOR PROGRAM RESPONSIBILITY

Analysis of the returned data on your registration forms has documented what has long been known that staffs of Regional Medical Programs share several functions in common. A sampling of stated responsibilities follows:

- Administration and organization of the allied health component of core staff.

- Development, organization, and implementation of continuing education programs for allied health professionals.

- Teaching of selected courses for allied health personnel.

- Liaison function to community agencies, organizations, and institutions.

- Consultation to Allied Health professionals on program problems of field staff.

- Coordination of training courses and educational programs and activities.

- Development, organization, and utilization of allied health manpower.

- Consultation and development of operational project proposals, and

- Review and assessment of program proposals and activities.

CONCLUSION

The charge to the participants of this Conference as described in the objectives is a broad and difficult one. The achievement of the objectives of this Conference in two and a half days will require the maximum efforts by all gathered here together. The expected output of this Conference normally would require about two months of work by individuals on full-time employment. It is unlikely, however, that individuals working independently, no matter for how prolonged a period, could parallel the productivity of these two and a half days of concentrated effort by representatives of a number of health professions. Such a wide spectrum of health professions is not found in many local settings, and it is the interaction of the many professions rather than the independent activity of any one individual which lends unique substance. In actual fact, the success of this Conference depends on what happens from here into the future.

Thank you!

PROGRAM

CONFERENCE PURPOSE AND OBJECTIVES

For the purpose of exploring ways in which the allied health professions can make a maximum contribution to the delivery of personal health care through Regional Medical Programs, the objectives of the Conference are:

- To develop understanding about the current crisis in delivery of health care.
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- To encourage interprofessional approaches for the solution of health care problems.
- To stimulate participants to develop optimal community relationships.

SUNDAY

2:00 p.m. Registration
Lobby, Airlie House Conference Center

3:00 p.m. Meeting of Task Force Leaders and Recorders

5:30 p.m. Social Hour

6:30 p.m. Dinner

8:00 p.m. Program Session
Presiding
Faye L. Peters, Conference Chairman

Welcome
Eugene R. Perez, M.D.

Transition from Asilomar
Veronica L. Conley, Ph.D.

Development and Organization of Airlie House Conference
Elsa J. Nelson, Conference Coordinator

8:30 p.m. Task Force Sessions

MONDAY

Presiding
Eugene R. Perez, M.D.

9:00 a.m. Announcements

9:05 a.m. CHANGING PERSPECTIVES IN THE DELIVERY OF HEALTH CARE
Ray E. Brown

9:35 a.m. THE NATIONAL HEALTH SCENE FOR THE 70's
Joseph T. English, M.D.

10:05 a.m. Discussion

10:30 a.m. Break

11:00 a.m. Task Force Sessions

12:30 p.m. Lunch

2:00 p.m. Task Force Sessions

5:30 p.m. Social Hour

6:30 p.m. Dinner

8:00 p.m. Special Interest Groups

INTEGRATING COMMUNITY RESOURCES FOR COMPREHENSIVE HEALTH PLANNING
Chairmen--Miss Dorothy E. Anderson
T. F. Zimmerman, Ph.D.

EXPANDED ROLE OF THE NURSE PRACTITIONER
Chairman--Mrs. Rose Heifetz

PHYSICIAN SUPPORT PERSONNEL-PHYSICIAN ASSISTANT
Chairman--Ralph Kuhli

NEW HEALTH OCCUPATIONS
Chairman--Israel Light, Ed.D.

RMP PROGRAM EVALUATION MODELS
Chairman--Mrs. Phyllis Higley

DEVELOPING MULTIPROFESSIONAL EDUCATIONAL PROGRAMS (2)
Chairman--William Stucker
Chairman--Marian E. Leach, Ph.D.

TUESDAY

Presiding
Mrs. Forrest E. Mars

8:30 a.m. Announcements

8:35 a.m. REGIONAL MEDICAL PROGRAMS RELATE TO THE COMMUNITY

Moderator--Mrs. Florence R. Wyckoff

- A Sociological Overview
  Robert Wilson, Ph.D.
- The Hospital Community
  Barry Decker, M.D.
- The Rural Community
  John W. Gerdes, Ph.D.
- The Urban Community
  Henry M. Wood
- Community of Educational Institutions
  Mrs. Laurene Gilmore
- Community of Health Agencies
  John S. Hirschboeck, M.D.

10:05 a.m. Discussion

10:30 a.m. Task Force Sessions

12:30 p.m. Lunch

2:00 p.m. Task Force Sessions

5:30 p.m. Social Hour

6:30 p.m. Dinner

WEDNESDAY

Presiding
Mack I. Shanholtz, M.D.

8:30 a.m. Announcements

8:35 a.m. Achievements of Task Forces

9:45 a.m. Break

10:00 a.m. CHALLENGE FOR ALLIED HEALTH IN REGIONAL MEDICAL PROGRAMS

Moderator--Richard F. Manegold, M.D.

- A Program Coordinator's View
  Donald W. Petit, M.D.
- An Allied Health Coordinator's View
  Eleanor E. McGuire
- A Dean's View
  Robert K. Bing, Ed.D.
- The Regional Medical Programs Service View
  Veronica L. Conley, Ph.D.

11:00 a.m. Discussion

11:30 a.m. POTENTIAL FOR REGIONAL MEDICAL PROGRAMS AS VIEWED BY THE DIRECTOR
Harold Margulies, M.D.

12:15 p.m. Conference Closure
Faye L. Peters

12:30 p.m. Lunch

NATIONAL CONFERENCE PLANNING COMMITTEE

Miss Ruth H. Bryce, Memphis Regional Medical Program

Miss Loanna E. Biers, Kansas Regional Medical Program

Miss Marie T. Del Guercio, New Jersey Regional Medical Program

Mrs. Betty J. Dietrich, California Regional Medical Program

Mrs. Lucile M. Dismukes, Georgia Regional Medical Program

Miss Lydia Holley, North Carolina Regional Medical Program

Mrs. Edna Langholz, Oklahoma Regional Medical Program

Mrs. Laura G. Larson, Mountain States Regional Medical Program

Miss Edith V. Olson, Rochester Regional Medical Program

Eugene R. Perez, M.D., Virginia Regional Medical Program

Mrs. Faye L. Peters, Conference Chairman, Virginia Regional Medical Program

Veronica L. Conley, Ph.D., National Advisor, Regional Medical Programs Service

Miss Elsa J. Nelson, Conference Coordinator, Regional Medical Programs Service

ACKNOWLEDGMENT

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PROGRAM SPEAKERS

Miss Dorothy E. Anderson, Assistant Coordinator for Community Programs, California Regional Medical Program, Area V

Robert K. Bing, Ed.D., Dean, School of Allied Health Sciences, University of Texas Medical Branch, Galveston

Ray E. Brown, M.B.A., Doctor of Humanities (Honorary), Executive Vice President, Northwestern University Medical Center, Chicago

Veronica L. Conley, Ph.D., Head, Allied Health Section, Continuing Education and Training Branch, Regional Medical Programs Service

Barry Decker, M.D., Program Coordinator, Northeast Ohio Regional Medical Program

Joseph T. English, M.D., Administrator, Health Services and Mental Health Administration, HEW-PHS

John W. Gerdes, Ph.D., Deputy Regional Director, Mountain States Regional Medical Program

Mrs. Laurene Gilmore, Assistant Director of Education, Alabama Regional Medical Program

Mrs. Rose Heifetz, Director, Nursing Activities, New York Metropolitan Regional Medical Program

John Hirschboeck, M.D., Program Coordinator, Wisconsin Regional Medical Program

Frank L. Husted, Ed.D., Associate Dean, School of Health Related Professions, State University of New York at Buffalo

Ralph Kuhli, Director, Department of Allied Medical Professions and Services, American Medical Association

Israel Light, Ed.D., Dean, School of Related Health Sciences, University of Health Sciences, Chicago Medical School

Eleanor E. McGuire, Associate Coordinator, Education Section, Connecticut Regional Medical Program

Richard F. Manegold, M.D., Associate Director for Operations and Development, Regional Medical Programs Service, HSMHA

Harold Margulies, M.D., Acting Director, Regional Medical Programs Service, HSMHA

Mrs. Forrest E. Mars, Member, Regional Advisory Group, Virginia Regional Medical Program

Elsa J. Nelson, Office of the Associate Director for Program Operations and Development, Regional Medical Programs Service

Eugene R. Perez, M.D., Director-Coordinator, Virginia Regional Medical Program

Mrs. Faye L. Peters, Nurse and Allied Health Officer, Virginia Regional Medical Program

Donald W. Petit, M.D., Area V., Coordinator, California Regional Medical Program

Mack I. Shannoltz, M.D., Chairman, Regional Advisory Group, Virginia Regional Medical Program and Member, National Advisory Council, Regional Medical Programs

William Stucker, Coordinator, Allied Health Program, University of Missouri

Robert Wilson, Ph.D., Chairman, Department of Mental Health, School of Public Health, University of North Carolina, Chapel Hill

Henry M. Wood, Urban Health Coordinator, New Jersey Regional Medical Program

Mrs. Florence R. Wyckoff, Member, National Advisory Council, Regional Medical Programs

T. F. Zimmerman, Ph.D., Director, Department of Health Manpower, American Medical Association

CHANGING PERSPECTIVES IN THE DELIVERY OF HEALTH CARE

Ray E. Brown
Executive Vice President
Northwestern University Medical Center

It is a pleasure to participate with you in this Conference, because I really do believe in Regional Medical Programs. I believe that much of what is being said about the confusion between Regional Medical Programs and Comprehensive Health Planning simply reflects a lack of understanding of what Congress intended and of how Regional Medical Programs are developing. CHP is a planning program, but for the nation, Regional Medical Programs are our only hope for an action program. In other words, we must have some group that can help package the parts and help see that the needs are met. At the present moment, the only agency we have nationally, which has been regionalized, is Regional Medical Programs.

Then, again, it is a pleasure because I really believe that the allied health professions are our only hope in being able to have the necessary personnel to build a system of medical care that I am going to be talking about in just a few minutes. Now, if I seem a little hesitant and uncertain in my presentation, it is probably because I am.

I look at the people here and see Lester Evans, who may be the oldest member, sitting with some of the younger ones who are attempting to reorient and restructure the system of medical care. Again I emphasize the terms "reorient" and "restructure," rather than "to do away with it" because I am afraid that we have reached a point in time when those who have real idealogical motives are scared. Those who have more interest in taking the system apart than they have in helping to knit and repair it where needed are listening to the self-criticism that the field is engaging in, and are using the self-criticism in a way that I think is totally unfair to the system itself. For example, the American Medical Association which everybody says is so monolithic and so arch conservative that it does not change is now beginning the same sort of restructuring that others of us have advocated. It is a

field that has been perfectly willing to examine itself and criticize itself. Just look at the criticism of the public health care field! We are not going to do away with the programs that we have had in medical care in this country. We are not going to allow the system itself to be destroyed.

My assignment is to look at some of the criticisms and some of the ineffectiveness of the field and see what some of the answers may be. I think the answers do come out in the criticism. All of this I find applicable to my assignment before a Regional Medical Programs audience. In the thirty minutes allowed I can obviously do little more than touch on some of the major problems or criticisms.

The first criticism is that the system of medical care in this country has been much more means-oriented than ends-oriented. In fact we say that no system in our society has been more "means-oriented" than the medical care system. It has become a fabulous system in terms of its capabilities. Vast programs of research have been established to increase and enlarge its technology. Great support has been provided for the education and training of doctors and other specialized professionals required in the implementation of this new knowledge. Its hospitals have become "many splendored things" with a highly sophisticated set of facilities and highly trained personnel. But the medical care system has become better and better, only to serve narrower and narrower ends. Its success has been measured more by the complexity of its resources than by the comprehensiveness of its services. The purposes of the system have been organized around its resources, rather than organizing the resources around the purposes.

Second, medical care and hospital system has been much more producer-oriented than consumer-oriented. The "seller's market" that has prevailed for several generations in the field of medical and hospital care, because of conditions of scarcity and low sophistication of the buyer, has enabled the medical care and hospital system to develop its services to suit the physician and the hospital, rather than the patient and the public. The services have been provided and organized in terms of what physicians and hospitals decided patients should have, what physicians and hospitals wanted most to do, and what best suited the aspirations of the physicians and hospitals. The hospital has keyed its policies and practices to increasing its own internal efficiency, rather than to change with the needs of the market it is supposed to serve. It has set the specifications for its product and asked the consumer to fit those specifications. The hospital has set the conditions under which its services are available and, to a large extent, ignored the conditions that were left untended.

Third, the system is much more self-centered than community-centered. The perspective of the medical care system in relation to community health needs has been too passive and introverted. It has been so busy keeping in step with medical advances, that it has lost step with the medical needs of the community. It has been so preoccupied with what the mailman brought, that it has not looked to see where the mail came from. The medical care system has done an excellent job on the things that is has done, but it has been much more concerned with the things it was "doing" than with the needs those things fulfill. Too little concern has been shown about what ought to be done, but an obsessive concern has been exercised about how to do it. The public is demanding that the medical care system reverse its provincial or parochial outlook and approach; that its posture and perspective be outward rather than inward. In other words, the public is asking that the medical care system serve the patient where the patient is -- symptomatically, economically, psychologically, and geographically -- that it move the system within reach of the individual. We can say this in another way. The system has given much greater priority to the search for solutions than to the quest for progress.

Fourth, the system is more parts-oriented than program-oriented. Charges even have been made that we have no medical care system in this country. Some of the critics say that we have a "non-system" of medical care. While this is an invalid and highly exaggerated indictment, it is true that the system is marked more by its diversities than by its unity. It has lacked an overall program; its program has been the sum of the individual aspirations, perspectives and capabilities of its parts. This has led to serious gaps and duplications in programming services. These gaps and duplications are proving to be highly expensive in both economic and social terms as medical care becomes increasingly more complex, more costly and more committal.

Next, the hospital and the medical care system must become more of a continuum rather than a conclusion for the profession. Here we are simply talking about the lack of continuity that marks the system today. In many ways, the criticism is that it is an episodic system, that it does a tremendous job for those who get to a point where their medical condition is showing to their neighbors. When it comes to continuous care, when it comes to all those things that individuals need done that do not require them to get between the bedsheets of their local hospital, the system simply does not maintain a sense of continuity for the patient or for the family.

The chief indictment against the system is that the public has become medically disengaged. Not only the ghetto, but among the middle class there are people who are no longer able to use the system because they are not plugged into it. They are not latched into it; they are simply medically disengaged. They are looking for a port of entry. They are not interested in a system which they can get on only at the end of

the line. They are looking for a system that they can work simply by finding some doorway or some telephone that gets them into the system immediately when the need is there. What we are going to have to provide (and I think this is where Regional Medical Programs can do its best job) is a coupling of all members of each community into a system. (We will talk later about coupling all the systems together.) But at this point we are simply looking at the recipients of medical care. We are looking at those persons that the medical care system is supposed to serve, and at their inability to run a medical maze that doctors themselves, in many instances, cannot run or cannot work. Suggestions have been made (I made one myself) that individuals probably in the end would have to join a system or a hospital (since it is, in my opinion, the staging area or the host that is best known to the public).

In the future, people will need to join a hospital just like they join a church. That is, if they move from one town to another, they will need to scout around for a hospital just as they scout around for a church. I do not see why this would not work with medical care. Every newcomer in a city should decide which hospital they would like to become the responsibility of and then find out if that hospital could take them on. Then whenever there was any sort of medical need, that would be the doorway they would go through. This is, again, not such a radical notion, because that is actually what people are doing. However, they are doing it in a very disorganized, disorderly fashion. Here I simply point out the exponential growth in the hospital emergency room where tragically most of the people are entering the health care system, especially in our larger cities. They know that the doorway is always open. They know that behind it lies doctors, nurses -- an organized way of getting medical care. Unfortunately, it is the sorriest place that they could pick to get medical care. The emergency room, if it is properly set up for emergencies, is not set up to handle the nine out of ten who go there who are simply trying to find their way to a doctor or into the medical care system. The emergency room treats the typical symptom which they bring, and probably turns them away with more things and worse things wrong with them than the particular condition that they treated at that moment. Then, of course, no continuity of care is provided as far as the patient is concerned. What we need to develop in this nation is a system of hospital-based practice. I do not see why the medical staff of a hospital could not be the group assuring the public that there was an organized system of care within that hospital, which would provide a comprehensive range of services. The patient, thus, who reached the hospital would know that either at that hospital or somewhere in the chain of medical care situations, these services would be available to him immediately.

For the planners this would be, I think, of great value. At long last hospitals and doctors would know whom they were responsible for. As it now is in any of our larger cities, we are asked to plan for hospital care, but we never know just exactly what our planning goals are. What are our responsibilities? If all individuals were going to their chosen hospital, if they were considered as being regular responsibilities of that medical staff at that hospital, at long last we could bring some real sense into the planning of the individual parts. There are many other things I could say about this need for a coupling device between the patient and the medical care system of the community but time will not permit. Again I think one of the great criticisms hurled at the system is not its cost, but the frustration the average person feels about the fact that he simply does not have a continuing link with the system. He does not know how to work it. He has to hunt his doctor in some high office building or over some corner drug store where he sits behind his own shingle. We must create through both geographic location and the use of specialized professionals other than the doctor, a composite system of a composite doctor (so to speak). Then circumstances must be also organized so that the patient does not have to work the system himself, but simply appears at the appropriate spot and the system takes over.

We must have greater emphasis on horizontal spread of medical advances rather than vertical spread. And here I think I am saying the same thing President Johnson said when he created Regional Medical Programs, we must get on with the business that will give the greatest advantages to the largest number of people of all of the wonderful things that are coming out of the laboratories and out of the experiences of doctors. There are other reasons why I think we are going to have to look at the horizontal spread. The great pay-off in the quality of health of the American people actually will come more from a horizontal spread than an ever more expensive, narrower vertical use of the science we have. For instance, right now I believe that if we just spent a fraction of what we are spending on some of the more exotic surgical procedures, such as heart transplants, in establishing well baby clinics in every hospital in this country, then we would much more significantly affect the quality of the nation's health. And further such care would effect the quality of later performance of well cared for children as citizens. So many children are now more or less doomed by the medical care system to whatever it is that the environment might do to their health without the corrective measures that could be taken by the medical care system.

The next would be the fact that we have got to give more impetus to the medical care system as a social instrument, as well as a medical instrument. I think that all of our important institutions in society today must look upon themselves, first of all, as social instruments. In the case of medical care, it is a social instrument with a medical

orientation. Now I am not pleading, like some intellectuals, that we get away from scientific medicine. I think we must do everything we can to protect scientific medicine. At the same time, we must realize that in a society such as we have, all things have to be gauged first in terms of their social value, their social contribution. It is not going to do us any good to buffer the demands of society. We are going to have to realize that medical care is a component of every other program and see to it that the medical component is properly carried out in all of the other programs. Here again, I simply point out that there has not been a major bill passed in the last decade, other than for the Defense Department, that did not have a medical component. Whether it is legislation relative to Appalachia, Office of Economic Opportunity, or many others, each of these do have a medical component. The medical care system must see to it that the social demands made upon medicine through all these programs and approaches are met.

Next, I think that greater rationalization of the medical care and hospital system must be done; I am talking of a better plan and a better organized system. Yet I am hinting at an aspect of Regional Medical Programs' assignment which you will attempting: to tie the parts together both at the local level and through vertical integration with the major hospitals and medical centers of the Region.

There simply is no argument with the fact that the present system was developed for a different purpose and has become a highly separated, fragmented system of medical care. The facilities part of the system we know grew up under a different ordering than it is now supposed to serve. The hospitals are not very old, and started developing in this country around the turn of the century. Their purpose simply was to bring people into the facilities where they could get certain amenities -- such as food, sanitation, care -- which they could not afford or could not provide at home. But in the twenties the whole nature of the hospital changed because the doctor did develop himself a science, and today we have a hospital system that was developed for congregating people. The basic purpose now is not just to congregate people, but to congregate under a set of arrangements the very expensive, highly trained personnel, the very expensive and sophisticated hardware that the science of medicine now has imposed upon the medical care system. So we are trying to operate a system of hospitals whose purpose is entirely different from what it was just some two or three decades ago. Changing this system to meet current needs involves the investment of literally billions of dollars. That kind of money is not available to do an overnight restructuring of the facility system. We are going to have to see to it that step by step as things occur, the system becomes restructured; that it begins to make more sense in terms of economics of scale, in terms of the qualitative aspects of having a sufficient patient census with a particular condition so that a team can remain well practiced, well experienced in that particular condition. Regional Medical Programs have to play a vital role in trying to help restructure, over a long period, a system that is very awkward in the way it is set up and is very troublesome as we try to make

it work more effectively. We are going to have to have legal sanctions that allow the public and its representatives, which you are, to get into such things as hospital franchising. The latter must come so that the aggressive hospital, (and I hope they always remain aggressive) which cannot respond naturally to public demand, will respond to the substitute of legal sanctions.

There are a number of other points. I will briefly mention two more. Next, we are going to have a continuing redefinition of illness because redefinitions are coming very rapidly. We are going to have a redefinition of what it is that this system can do for people, as well as a redefinition of when a person is ill. As an example, I simply point out the pressures that are being put on the system in recent months to recognize addiction as an illness, to recognize alcoholism as an illness and the great growth in the treatment of emotional disturbances. As you do your thing, as you try to latch these services to arrangements under Regional Medical Programs, then you have to remember that the things you are latching together may not indeed be the larger things ten or twenty years from now. Demands are going to be made upon the medical care system as many groups move in to force hospitals and medical staffs into a recognition of illnesses that they previously did not accept as being their legitimate or appropriate responsibility.

Finally, let's look at that old bugaboo -- hospital and medical care costs. I see no end to the increase in these costs. I just do not believe the myth that somehow or other we are going to use the advancing technology of electronics and the systems experts from the almost bankrupt space contractors to say how the system can operate a lot cheaper. I think, by and large, if you look at the economics of this system, it is doing an awfully good job. If it meets the criticisms that I have expressed, it is going to cost more money because people are not so worried about the economics as about the effectiveness of the system. So I think that we can only look toward an ever-increasing unit cost or an ever-increasing total cost -- two entirely different things which the medical journals like Fortune and the Wall Street Journal and Business Week have not recognized. To talk of the nation's medical care bill is an entirely different thing than talking of the operating cost per unit of service, whether a doctor-visit, a day in the hospital or the cost of an X-ray. Both are going up, but on the other hand, if Regional Medical Programs achieve their supposed result, then a lot more people will get into the system than ever had access to it before. If we redefine illness in the way I mentioned, a lot more people will be coming into the system than ever came in before. So that if the system accomplishes its purpose, there must be an ever-increasing cost. The answer is not to starve the system, not to do violence to the system by a government takeover, but rather to see to it that there is a repayment mechanism that spreads across

the total population. I dare say that in the next few years we will have some form of universal insurance. I hope it will not be a government program. I think the government can accomplish all that it needs to simply by mandating that all employers have coverage for their employees, and that the Federal government establish the minimums of the benefits in such coverage. If it does this, the Federal government then would have achieved its purposes because it would have spread the burden across most of the population. In the meantime, if the government does what it should have done at the start, namely, to make provisions for the disabled to receive Social Security medical benefits and to put the unemployed under Medicare, the main population lapse now would have been employed laborers. I refer to mandated programs in which the employer chooses the underwriter. The Federal government does not do the underwriting but rather indicates what the underwriting has to cover in the way of benefits for the individual. Under these circumstances, we would have forced the underwriters into a competition they have not had before.

As it stands now, their actuaries have actually designed the system of care in the country by leaving out the benefits that might have proven to be most adverse to the underwriter. The benefits are the ones whose absence the employers and the unions would not notice as much as the more dramatic ones covering acute hospital care. Such an approach would allow the Federal government to inject social policy into the health care system. We could have a national policy that was made explicit because the great problem of the medical care system resides in the fact that there is not money down the avenues towards which the system should be worked. As a hospital administrator, I can frankly admit that the only sign that made any difference to me was the dollar sign. You put a dollar out there where there was a service and not only would I go after it in a hurry, but so would my colleagues in the hospital field. Obviously, we could not go anywhere if the dollar was not there -- it would be suicide, because we do keep the score in dollars and cents in our economy, and we do face up to paying personnel and equipment manufacturers. The only way the system will ever be turned around will be by someone putting the dollars where they want the system to go. This is the only way that the system can actually go that way. If there were a mandated insurance program for all of the employed and their dependents which provides hospital care, home care, and all of the other much discussed programs, then national policy would be injected into the system by forcing the underwriters and employers to provide the benefits. This would put the money at the end of the road -- so that all of us would be going after it. Not because we love money, but because we like to increase the size, the prestige, and the influence of our institution. And, further, because we know that we have to get to that money if we are going to survive as an enterprise.

THE NATIONAL HEALTH SCENE

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When we talk about the health care scene in America we cannot ever forget that Americans devote $60 billion of the gross national product to various functions of health. With a Federal contribution to that $60 billion in 1971 of about $20 billion, we must understand that health cannot be nonpolitical. Therefore, the way in which problems get solved in the last analysis involves some political answers. Otherwise, one has great difficulty in understanding why his proposals do or do not have any particular result. If it is true, as I am quite certain it is, that the Federal Government cannot ignore the political aspects of health care in the '70's, I have to talk a little bit about the Nixon Administration, and how the political levels of government are going to be looking at health.

The first things we have to know are the overriding themes of the Nixon Administration. I am a career official, so this is not a partisan assessment. Political decision makers do have a method to their madness, though it may sometimes be difficult to discern. Of all the broad themes and strategies the most dominant is control of inflation. This is the primary target. The strategies for its control determine many other strategies in the Nixon Administration.

Within the framework of control over inflation the first major unifying strategy on the domestic scene has been called the New Federalism. It is not just rhetoric. It represents a conscious effort to establish a division of labor between levels of government as to how to solve social problems. Social problems are not public problems until the levels of government decide to pick them up. For example, a principal subtheme is the distinction between income support, on the one hand, and services on the other. Payments that transfer funds to support people in their daily lives are regarded as a Federal function, while rendering of services to people is seen as a function of state, local and metropolitan governments and of other public organizations. An obvious example is the new Family Assistance Plan. The services programs within that program would be run by other than Federal levels of government, while the Federal Government would pick up the

check for income. Another subtheme is decentralization. An example is the President's Manpower Training Program proposal, which involves a selective but far-reaching delegation of power to state and local governments. This critical subtheme also goes by the name of intergovernmental relations. To establish service programs at the state and local levels, New Federalism has another subtheme, namely, revenue sharing. Revenue sharing is based on the twin assumptions that the Federal fund raising efforts are better than those of state and local governments, but that state and local governments are in a better position to determine how the revenue should be utilized. This theme is not a minor innovation and it has bipartisan support. In time it could involve a shift of some $4 billion from the Federal sector to the local sector. The Family Assistance Plan will involve increased Federal expenditures of a minimum of $4 1/2 billion. With expenditures of this magnitude to back up New Federalism, it can hardly be seen as only rhetoric.

A second major theme is the nature of the income strategy itself. The Family Assistance Plan involves supporting about 23 million people as compared with about 10 million today because it does strike at the problem of the working poor. Another aspect of the income strategy is to de-emphasize "in-kind" programs, such as Medicaid and food stamps. In time the Administration will try to phase out "in-kind" programs and substitute cash payments instead. This change rests on the principle that people themselves can make the best choice of their daily expenditures. This extends to areas of service such as day care. I am not judging the theme; I am simply trying to set it out. A lot of people are astonished to think there is a market concept in buying Head Start care, but there is.

A third major theme is to the rationalization of Government. The field of health offers many examples of a bewildering array of programs, none of which is fitted to others. Each was designed to fulfill some specific, narrowly gauged if legitimate and worthy purpose. But they were not adopted in relation to each other. Outside the field of health there are the same phenomena. One way by which rationalization is achieved is by grants consolidation and simplification. This ties in to the earlier strategy of decentralization and the fact that state and local governments carry out the service programs. Another way of rationalizing programs is to set the same eligibility criteria for more than one program. In the welfare and food stamp programs, for example, which are administered by different departments, there is an attempt to establish the same eligibility criteria. The Family Assistance Plan has that concept built in.

Finally, another broad theme firmly announced is emphasis on what the President calls the "quality life." A better environment ranks very high on his priority list. We can anticipate a lot of

disagrements as to how to achieve it, but I believe that this Administration will make many attacks on the environmental front.

It is my view that initiatives in the health care field through the '70's have to take account of these themes and broad strategies. I am not prepared to say whether the strategies are directly applicable to health. I am not sure that the complex private-public mix that characterizes health can be fitted into them. In Congress and in the Executive Branch there will be a debate to see whether the private-public mix in health problems is reconcilable with the strategies or whether it requires a different strategy.

One of the fundamental problems with designing new health care initiatives is that we do not really know what they ought to be. We wish we did. If we had our professional druthers, and if people were automatons, we could fix up the system, but within the political system we really do not know what the initiatives ought to be. We do not know where to put out our money in order to deal with the so-called health care crisis. When a President surveys the Federal budgetary scene, given the fact that his number one target is control of inflation, I do not think it ought to surprise us that he might well put the limited money available in the area of environment where he can see more precise and immediate payoffs in terms of response to health needs of the American people than in what we call the area of health care.

Those are a few general thoughts about the so-called general health care crisis. It is a health care crisis, but until it is a political crisis there is not going to be any governmental action.

In the past, as we looked at the health crisis our first response was to see the response of the consumer. Why are people not receiving the benefits of what we know today? The consumer wonders why our Nation is fifteenth in the world in infant mortality and twenty-second in life expectancy for males. The mothers of half of the babies born in public hospitals have had no prenatal care. A poor child has four times the risk of dying before thirty than does the nonpoor. The big question is not how much money should go into health. After all, who can say what life is worth? The big question is whether, as the expenditures rise, we will be better off at $100 billion. I doubt that we will without great changes.

To understand where to go in the future, we ought to understand where we came from. We have to know about history if we are to understand what we could do in the '70's. We have had several mythologies about what to do with health. After the failure of the National Health Insurance proposals under President Truman in the late 1940's, we embarked on a major effort in biomedical research. There was a

popular view that massive governmental support of biomedical research would set in motion a chain of events that would automatically improve health care for all. We had privately supported research and a number of brilliant advances in science and technology resulted. We helped shape the medical schools, for good or ill. We helped shape the hospitals by the way in which we held out our dollars. In the process we have produced a technology which is extremely costly. But then as we moved into the '60's, we found the Other America which we had not been looking at. We began to think about our middle class selves, and we realized that the massive advances in biomedical research by themselves were not going to bring about health for those who needed it most. They were not necessarily going to bring the advances even to people who could pay for it. So we succumbed to a second myth: if the only thing standing between the Other America and the best in health care was the lack of money, we would pour our resources and our good intentions into providing money tickets into the system through programs like Medicare and Medicaid. These programs account for the largest part of the increase in Federal expenditures.

In 1955 expenditures for health for this country were $17 billion; in 1965, $37 billion. Now they are $60 billion. By 1975 the estimate is $100 billion. The significant point is that Medicare and Medicaid account for most of the increase. There are several key disastrous elements in the present financing programs.

First, they have overburdened the capacity of the system to respond. This overburdening has been one of the major causes of the price rises in the medical market which hurts the middle class every bit as much as it hurts the poor.

Second, the present financing arrangement through money tickets actually inhibit better and newer methods of health care delivery. They even produce reimbursement barriers to innovative methods of health care. The Watts Neighborhood Health Center may not be the best center in the world, but it is a $5 million operation that effectively serves the poor. Although the group includes 30% Medicaid eligibles, less than 10% of the Watts budget is reimbursed by Medicaid because of the nature of the Medicaid financing system.

Third is a most important point. We have shortchanged the youth of America. Sixty-five percent of the Federal health budget goes to the aged, all of Medicare and a substantial part of Medicaid. Only 10% of the Federal expenditure of close to $20 billion can be said to go for children and youth. Sixty-eight percent of Medicare goes to institutional care. The essential point is that the financing systems of the Federal Government, primarily Medicaid and Medicare, but also the Defense Medicare program, like private third party

payments, fundamentally do not address themselves to anything other than the payment of the bills for services that somebody may be able to obtain. We have learned to our bitter regret that in many places entrance into the medical care system does not exist and is as much a problem for the middle class as for the poor. The added purchasing power of Medicare and Medicaid has led to the dilution of quality of care. It has increased cost and moved more people into the hospitals and institutions in the health care system.

For the Federal Government to get at the basic elements in the health care scene there must be a goal, a sense of purpose. There is need for more all-embracing programs than the Federal Government has set in motion. It is useful to have in mind the necessary basic elements of the health care system. It is not difficult for health experts to define these. They include at least these elements:

1. The health care system ought to provide for comprehensive services ranging from preventive to long-term institutional care, and it ought to provide continuity.

2. Medical care systems at local levels ought to be dealing with defined populations.

3. The systems ought to provide for integrated management of a variety of institutions and individuals.

4. There ought to be broadly based risk sharing, achieved through insurance mechanisms in one form or another, heavily weighted in the direction of per capita prepayment or payment.

Opponents of health insurance, public or private, too often take a simplistic approach. They say the system is not ready to respond, we have to wait until the system has the capacity. If we do that, in the long run we will all be dead, and the system will never be able to respond. I would suggest a concept of investment as opposed to consumption, which is what the present Medicare-Medicaid systems are. More important, the concept would establish firmly what too many advocates of national health insurance have not recognized: that the system is not capable of responding and that the financing systems cannot be allowed to go on independently of the capacity producing systems.

If we are to move in the direction of some of the elements, including broad risk sharing, the financing system must include within it the basis for investment. We can improve the management of our financing systems. We can offer all sorts of incentives to increase efficiency and to lower costs, but as long as we live in a reasonably

affluent society we should not assume that incentives alone and tinkering with financing systems will bring about the kind of change we are talking about. Creating a health care system is no minor fix-up operation.

What is investment? It is the diversion of resources from current consumption in order to achieve the benefits in the future of the investment. We may have to put our financing first into investment, into programs such as Regional Medical Programs as an institutional device for bringing the changes about. This kind of program might even have to be financed out of payroll taxes. I say hurrah because it is such a departure from traditional methods of budgeting.

The Federal budget for health in 1971 will be $2 billion higher than it was in 1970, and it will be all in Medicare and Medicaid. We need the concept of investment in the capacity-producing side of the health care system, but we do not have that concept linked firmly to our financing system to pay the bills. Blue Cross and the insurance companies do not have it; the Federal Government financing systems do not have it. We will not get there overnight just by knocking on President Nixon's door saying we would like another $100 billion. To get this kind of concept adopted there has to be a strategy of investment which will insure that financing mechanisms will get the hospital to move into ambulatory care. Investment is needed to produce the ambulatory care service.

To get there, a number of fundamental questions bearing on institutional problems have to be faced. A lot of people are still moving away from these questions. Here are a few of them, as I see it.

In the light of national health care needs and resources, can we cling to the principle of fee for service as a general rule? This is not a question of medical care administration for just the experts to work out. It is a fundamental political and social problem for the American people.

Can we in our legislation follow the freedom of choice principle as far as we would like to?

Can we leave such programs as Medicare and Medicaid uncontrolled?

Can a community hospital continue to operate its "business" on the basis of just filling its beds, or must it reach out to organize and serve community ambulatory needs?

Investment means more than just money for services. Unfortunately, no social or political body has real authority to plan and manage the

organization and delivery of health on the community scene. I deliberately stress "no real authority to plan and manage." If we are to effect change and not have a nationalized system like that of Great Britain perhaps the most critical requirement is the creation of a new community organization and investment to support it. We have a bewildering array of individuals, agencies and institutions, an equally bewildering array of government programs which support the disparate efforts of all these autonomous entities. We do not have a responsible focal point for exercising community trusteeship of health resources and there is no consensus in society that we ought to have one.

The nature of the missing institution is not well defined but some of its ingredients are clear. It has to be a private-public mix with strong consumer involvement. It has to be based on a principle of geographic responsibility. It must be authoritative enough to exact from the medical resources of the area (physicians, hospitals, and others) the performance of defined health care functions on a geographic basis. That sort of body gets right into the battle as to whether planning and regulation are to be combined into what is the mission of the Federal Government in the health area. There is confusion as to whether or not the Federal Government has a mission to organize and create a health care system to meet the needs of all. The debate in the American society has not yet focused on such a mission for the Federal Government. Although society does not yet say that ought to be the mission of the Department of Health, Education, and Welfare, I have some personal views that it ought to be.

The level of debate has moved from the question of paying bills to the question of how society organizes and delivers health care. How do we make sure that the $94 billion, which economists project will be going out of the gross national product for health in 1975, will not be just a transfer of payment which is what Medicare and Medicaid have been up to now, but will actually be an expenditure by American society to bring about changes in the system and delivery of a larger quantity and higher quality of service? The two or three years ahead are essentially years of increasing debate such as is going on in this meeting, rather than the arrival at solutions. Regional Medical Programs were a response to a particular need at a particular time as were Comprehensive Health Planning, Mental Retardation Programs, Community Mental Health Centers, and so on. In the meantime, the Federal Government tries to develop a uniform policy to cover all programs.

Several main legislative initiatives have been taken, and it even looks as if we knew what we were doing. Under the present system we deal with a host of different committees: House Ways and Means Committee, the Senate Finance Committee, and House Interstate and

Foreign Commerce Committee and the Senate Labor and Welfare Committee. In the Department of Health, Education, and Welfare we developed a set of bills dealing with financing, facilities, planning, organization and delivery of health services. The financing amendments are called the Health Cost Effectiveness Amendments of 1970, the President's economy measure or message, and facilities, mainly in the Hill-Burton Amendments of 1970. Planning, organization and delivery are in the Health Services Improvement Act of 1970 and the Community Mental Health Centers Act. All are designed to get at particular health care problems without actually taking on the institutional settings involved.

Here are some problem indicators. In the urban core in 1943 we had one doctor for every 500 persons. In the suburbs we had one doctor for every 2,000. Today we have one doctor for every 10,000 in the urban core and in the suburbs we have one doctor for every 500. People can shoot holes in the statistics but this is a little like arguing with Michael Harrington a few years ago when he said: "Don't argue with me as to whether there are 40,000,000 or 30,000,000 poor people; you know there are a .... of a lot." The statistics may be a little off, but the essential thrust is there: the urban core does not have the doctors, the suburban core does. You have to provide for redressing that imbalance. You have to provide for institutional arrangements working on capacity. Regional Medical Programs are hopefully trying to bring the doctors where the people live, stressing the ambulatory as opposed to in-patient care.

The Health Services Improvement Act established that Regional Medical Programs, Health Statistics and Health Services Research and Partnership for Health have common objectives--improved organization and delivery. We also proposed a variety of model systems. So we went before one committee with the Health Services Improvement Act with requirements as to the planning agency. Then when we came to the Hill-Burton Amendments we tried to stress ambulatory care. We tried to encourage alternatives to acute in-patient care. We tried to change the emphasis from grants to loan guarantees because there is $300 or $400 million coming to hospitals now out of the Medicaid-Medicare Program which was not coming during the period of big grants. We tried to do the same sort of thing in the Community Mental Health Programs to provide incentives and better matching arrangements not only to continue those facilities which had been organized, but to move them into the poverty areas where the facilities are not being afforded.

The Health Cost Effectiveness Amendments provide incentives to states to control costs. Under the new proposals there are incentives to all sorts of organizations including profit-making ones to provide ambulatory care. The Health Maintainance Organization proposal cannot

be divorced from the proposal that states be given a higher matching ratio for services which are rendered in an ambulatory care setting as opposed to services which are rendered in an institutional setting. They all link together with the proposal under the Health Services Improvement Act that we try to develop model systems of health care for which a certain amount of money is reserved. It has both the reality and the illusion that we knew in going before the different committees that all the three linked together, but they do have within them these common linkages.

In concluding, I would like to ask: "Is health care an entity in itself?" Are we ultimately concerned only with the prolongation of life and the improvement of physical and mental health, narrowly defined? Such purposes may well motivate the individual researcher, or the practitioner, but society's vision, and I think yours collectively, should be greater and move to a higher plane. I would suggest that our ultimate purpose is to enhance the quality of living in all its dimensions. Everything we do should be viewed in this context.

An increasingly prevalent and corrosive characteristic of the spirit of the American citizen of today is his real or apparent despair or lack of confidence that he can deal with the problems of society. Citizens affected by this spiritual condition are most unlikely to work to improve health, education, and welfare because they do not believe that such improvements are possible. This lack of individual confidence extends to the efforts of government and to many other organized efforts as well. I believe that the restoration of trust in optimism, in confidence that the citizen is not helpless, and that progress is possible is an undertaking that has to engage the entire nation. Government for its part needs to develop and carry out, if it has the capability, strategies that will advance the rebirth of the necessary sense of individual pride and progress. Placement of responsibility for health services programs in the community, where the people are, represents a portion of these strategies. In the last analysis, the people in the community must answer many of the hard questions, face the awesome decision, and effect by political action the changes that society demands of them in a democracy.

POTENTIAL FOR REGIONAL MEDICAL PROGRAMS AS VIEWED BY THE DIRECTOR

Harold Margulies, M.D.
Acting Director
Regional Medical Programs Service

I suppose you would like to know what kind of things we are thinking about in the Regional Medical Programs and what the whole activity looks like from the Federal point of view. You might be a little curious over who I am and what I represent and what my interests may be and whether this new voice signifies any changes in the Regional Medical Programs, whether my appointment is part of some slow slippage or of a grand movement. So, I will talk about the kinds of things we are thinking about and then narrow it down to the area of allied health.

I have looked at Regional Medical Programs and health care issues in this country from a number of points of view. They include private medical practice where, among other things, I discovered that the general quality of medical care provided by our health care system is remarkably erratic. I have looked at the health care system from the point of view of other countries where I have worked, in Asia, Africa and Europe. I saw terrible things going on in countries like Pakistan and India, terrible wastage in manpower, terrible misapplication of resources, huge sums of money spent on the treatment of diseases which would recur a moment or two after they were treated. And then I suddenly discovered as I was looking at these misappropriations of resources that if I looked back at my own country, I saw the same things. As a matter of fact, in some ways they were magnified. In Asia or Africa it is much easier to see how much poverty there is, how much bad medical care and how many people go without the attention they need. Here despair is relatively hidden.

I looked at the health system when I was with the Association of American Medical Colleges, and I saw a great many patient people working hard to change the systems of medical education, to do something about the distribution of health care. I also came to the conclusion, which I still hold, that very likely the greatest stumbling block to the improvement of health care in this country lies in the

medical schools. Even with the great efforts of the deans and some forward-looking people, the rigidities remain and the movements toward addressing the real issues of the day have not emerged. I find people talking so much about what they think they should do and somehow not recognizing the fact that there are people out there who need attention, people who are poor and miserable and do not get health care. Somehow this fact seems to disappear from the discussion.

In February I went to an illuminating meeting of the American Medical Association's Annual Conference on Medical Education. At the same time there was a meeting of the Student American Medical Association. I am most grateful to that group. I think one of the few sources of energy to change the health care system comes from young people and, so far as I am concerned, the more militant, the better. So I met with students in a small hotel room where they were trying to find out what the health care system should be and they said, "Since we are fairly young" (sophomores, juniors and an occasional senior), "let us look at the health care system from the point of view of a patient; let's play patient for a while." And you know, that lasted about 120 seconds, because even at that early point, they were incapable of doing it. So then they said, "Well, we can't really do it; we're already too mired in the system." "Let's take a look at it from the point of view of the way it ought to be." And within ten minutes, they were describing the kind of practice they would like to be in to really serve the community. After about ten minutes of that I said, "You know, you are still not addressing the problem. You are talking about what you as individuals wish to do so that you can do something better as an emanation of your professional skills. Can't you understand that you can be effective only by being part of something much bigger, that you as an individual cannot provide all the strength needed in the system?" Well, they struggled with that for a while, but quite frankly they got no place. Then, we began to talk a bit about some of their doubts and growing cynicisms.

I looked at Regional Medical Programs also from the point of view of the American Medical Association. When I was there I occupied various positions, including being secretary to the Council on Health Manpower and working closely with the Council of Medical Education. I saw efforts being made to bring together the various providers of health care, and I saw that in the American Medical Association it was quite impossible to merge the nursing activity with the other manpower activities. For some reason this could not be done. The issue would come up to the Board of Trustees, and it would come down again. Somehow nurses had to be put in some separate kind of role. Why, I do not understand. Well, I guess I do understand, and it distresses me. When we work with allied health professionals, we suddenly get into situations in which they as organized groups try to deal with the physician groups and somehow they have great difficulty talking with one another.

I also served on the National Advisory Council on Health Manpower and helped prepare its extremely good reports. If you have not read it, I recommend it to you, particularly the second half.

During this time as I kept seeing Regional Medical Programs from various points of view, things began to come together. I suddenly found myself having to take action, with appreciation of what needs to be done. The problems in the health care system are familiar. Medical care costs too much. People do not have that much money. In fact, the country is medically indigent. If it were not for a whole series of supporting activities, including insurance programs, some doubtful, some good, and the expanding activity on the part of the Federal government for the purchase of medical care, the situation would be worse. It is too expensive, it is not available, it is not moving rapidly enough, it is not responsive, but more than anything else there seems to be no place in the health care system where a sensible decision can be made and where action can then follow. We can put ideas together, and we can say that this should be done and that should be done, and yet somehow nothing much does happen. At the present time I would say that without exaggeration the scene at the Federal level regarding health care is one of anxiety moving toward panic.

From the Federal point of view, the uncontrollable costs of services are increasing at such a rapid rate that the opportunities to invest in efforts to redress what is wrong are extremely limited. That means we have to do some things better than we have ever done them before. As I look now at Regional Medical Programs from the point of view of a bureaucrat, I discover that they represent for this country the one access to changes in the health care system which is likely to really mean something. They are the only way the Federal government can deal effectively with the system of health care as it exists; the only method by which it can jump over state, county and district lines and all the archaic prisons we have set up to make it unlikely that we can ever do anything effectively. It also can do some special things for the providers of health care.

Let me have a diversion for a moment, because I keep standing here and looking at this crowd and reaffirming the impression I had earlier in the week. This is a pretty lily-white group. It looks to me like white middle-class America. I saw one black person when I was here the other day, and there is someone else here today. The rest of you talk about the problems of the poor and the blacks, but where are they? I do not see them here, and I do not see them well represented in the Regional Medical Programs. One of the policies of Regional Medical Programs is going to be that if you want to do something about the people who need help, you must be involved with them. Better than that, they must be involved with you. When we go into anniversary reviews and ask Regional Medical Programs to tell us about their activities, we are going to look at what they are doing about

equal employment opportunities. As they develop allied health manpower we want to make sure the disadvantaged and minority groups are included. Then we will look for results. This is going to be very real within the Regional Medical Programs Service and throughout all the Regional Medical Programs. It is something we will measure very, very carefully. Aside from the issue of social justice, about which I feel strongly, you simply are not able to deal with problems about which you are ignorant. You have to involve people who know about them. You can not get the job done otherwise. Then you have entry, skills and effectiveness.

When I first came to this position, a lot of people did not know whether to offer congratulations or condolences, which outside the fact that it is a tired old wheeze, was interesting to me. I was not sure myself until the end of the first twenty-four hours. After that I was very sure it was congratulations, because I think I have a tremendously exciting opportunity. One of the things which most convinced me was the quality of the staff I found around me - people who really want to get things done, not only within the Regional Medical Programs but in Health Services and Mental Health Administration. I have never seen anywhere a group as consistently well motivated and strongly turned toward the issues of the day as I have found in the Federal government. I will match the staff against any, and as a matter of fact, it will stand superior to most. I have not consistently found a similar kind of devotion in the other organizations in which I have been involved. If we have that kind of energy, why do people send you condolences? I think partly because many individuals really do not know what Regional Medical Programs are about, what they are going to be, what they are for, what the legislation means, what regionalization means, where are we going, what we hope to do.

After pondering these questions a while, I realized most people would be unhappy if I did enunciate a policy. In the first place it would be wrong. In the second place, if correct, it would remain correct for only a short time. Instead of policies, there must be action. I can give you some nice statements about the role of the Regional Medical Programs, regionalization and cooperative arrangements and so forth. You have heard all that, but let us talk about what kinds of things are going to get support, and what kinds of things I am going to hope for from Regional Medical Programs. Maybe that is what is meant by policy.

A top level responsibility of the Regional Medical Programs is to improve the health manpower situation in this country. This is major. After talking with the House Appropriations Committee, I can doubly assure you of its importance. They asked about allied health manpower, about physician assistants, about ties with Junior and Community Colleges; how are we going to move in that direction, and is

this really what we want to do? Unfortunately, in the course of the discussion I also discovered that those who are keenest frequently have some delusory ideas. One is that the responsibility for improving the health care system is a matter of adjusting and improving what is going on. I fully support those who say that is not enough. I see nothing in the present organization of the health care system which cannot be questioned and, if necessary, changed. There is nothing sacred about a system that is doing as badly as this one is, even with its tremendous costs. So any effective change in the organization of the system that provides better health care for the people is fair game. If you want to be a little disruptive, be disruptive. Part of the illusion which I hear expressed is that our health care manpower needs can be met by adding more people to the system. That is what we have always done; that is how we got into this mess. The problem is that there are too many people, costs are going up and health care is badly organized.

What is the answer? People say, let us have physician assistants, orthopedic assistants, pediatric assistants. Where do most of them come from? Right out of the same health care system but moved into another place. If we can bring people out of retirement, if we can take advantage of ex-corpsmen (a grossly exaggerated asset in terms of numbers), if we can do it - fine. But what is the real issue? The real issue is in having the people presently in the health care system do more than they are currently doing. How can more and better quality health care be provided without adding to the numbers? It would be simple to double or triple the number of physicians or nurses or technicians. This would result in a great increase in the cost of medical care and medical education. What now is described as a crisis would become a debacle. Quite clearly that is not the way to do it.

I suspect that if we were to reassess the needs of the nation, we could convince ourselves that there is no shortage of health manpower. Even with the maldistribution, we could provide vastly better medical care and lower per unit costs by doing more with the kinds of people who are already there, and doing the job more capably. How is this to be done? One of the ways is for people like yourselves to change your character. I have always been struck by the fact that people in the allied health fields take a secondary position to the physician. They keep waiting to see what the physicians are going to do, and then decide whether they are for or against it. They are responsive. You represent more people with more direct involvement with the health care system, more capacity to think as a group. In fact you are the ones who work as a team, not the physicians. I have practiced medicine. I know what this is all about. When I was on the Council of Health Manpower I used to listen to arguments about how we had to watch those physical therapists. The physical therapists are going to be independent.

They are going to license themselves, and they are going to want to run their own show. Then during the coffee break I would say to a physician:

> What do you do when you have a stroke patient? You are not an orthopedic surgeon; you're not a specialist in this field? What do you do with that stroke patient when he needs physical therapy?
>
> He would say: I send him down and let the physical therapist take care of him.
>
> And how often do you see him?
>
> Well, if they call me I try to get down and visit there once in awhile.

Now this is really the way a lot of the teamwork functions. There is no real necessity for the physician to be the leader of the team; that is nonsense and you know it does not happen. There are places where he should, can and must be the leader, but it is not always an absolute necessity.

Moreover, there is no reason why physicians or any one group should call the turns for what we are going to do. If you cannot mount your energy and devise changes in the way health care is to be provided, then it is not likely to be done in the foreseeable future. If we are to do it, what is the role of the Regional Medical Programs?

I have some ideas about how we might get more money, and that would be nice. I think we are going to do quite well during the coming year, and I suspect that we will be the only program which is going to start out as strongly in the next fiscal year as it did this. Instead of $73-1/2 million for grants at the beginning of fiscal year 1970, I think we will have $93-1/2 million for fiscal 1971. If you think that shows loss of confidence in Regional Medical Programs, you do not count well in the millions. Well, I cannot count very well in the millions either, but I can recognize that difference. There are other opportunities for money, however, which extend beyond that. Regional Medical Programs have to begin to tap other available funds. For example, the Manpower Development Training Acts has been unable to spend more than half the money specifically designated for health manpower. Every year they hit about half their goal. Yet we have been wondering why we cannot get money to train health manpower and upgrade skills.

What do they want to do? Exactly what we want to do! They want to have money available to provide employment opportunities for those who ought to enter the health care system. They want to have money available to upgrade the skills of those who are already in the system. Regional

Medical Programs have never identified those sources of funds, never worked with the agencies that can make them available, even though they are in every state and area, and funds are available year after year. Again this year Regional Medical Programs went begging. That makes me uncomfortable. It is the kind of thing I think you should give attention to because they are sources of money, which is the fuel we need for energy.

Indeed, if we are going to get more effective use of allied health manpower (and by effective use I mean having allied health people do their maximum and reduce to a minimum what must be done in an institution, or at the more expensive hands of a physician) if we do that, we are going to raise another big issue: the quality of care provided if somebody other than the doctor is tapping the knee. If we are going to address the issue of quality it will have to be through the eyes of the providers of health care. Who else is in a convincing position to say what represents adequate medical care unless it is done with the combination of skills, talent and people available in Regional Medical Programs? Only we can do it. So, I would say that the Regional Medical Programs must address the issue of quality in the health care system, particularly in these trying times when all the patterns of health care are being challenged and many changes are being carried out. If we can establish the fact, and I think we can, that care now being provided by a physician can be provided by allied health people; if we can establish the fact that better organization of services increases the number of services available, and if we can at the same time prove that this provides good quality medical care, then we shall have moved our cause farther ahead than by any other venture.

These are some of the major moves that I am talking about. I emphasize these points partially because you are an allied health group, and also because they underscore another strong feeling I have: that we will flounder, fail and be miserable if we do not identify what we can do and do it, and eliminate or not attempt what we cannot do. Some regions have great capacity for planning and for influencing events and institutions; some do not. They have the access, they know where they are, and they know how to deal with them. Some have other kinds of capacities. The one thing we are not is a system of managers. We are not experts on insurance. Some people may be, but in general that is not what we are. We represent the profession of medicine. We represent the facilities and the people who are involved in medical care, and if we stray from that particular asset, then the total effect of what we do will be less useful than it should be.

This, therefore, leaves open the question: what about all the other issues? What about the mess of Medicaid? What about the Health Maintenance Organization to assist in setting up competitive health care systems? What about the problems of liability insurance? What about the problems of licensure? And so forth. What are we going to do about all these? Quite clearly some people are going to be working

on these problems. Sometimes it will be a special agency, sometimes it will be Comprehensive Health Planning. It will vary in different settings. If core staff and coordinators of Regional Medical Programs are unable to devise effective ways of influencing, guiding, counseling and working with complementary groups then the efforts I have described are not going to be as fruitful as they should be. So, we must have more evidence of energy on the part of core staff, competence to deal with the health care system not only through the specific perimeters of Regional Medical Programs, but through those kinds of shared responsibilities which are dependent upon structures, organized or disorganized.

As I look toward anniversary review and see the kinds of projects that come in, I find a lot of them pretty dull. I look at a little project here and there and somewhere else which I realize may have been necessary to bring Regional Medical Programs together and get people to talk with one another. One thing is clear to me: Regional Medical Programs are not a device for supporting projects in the field. My becoming the director signaled that we are out of National Institutes of Health and into the health care system. I have great admiration for the National Institutes of Health, but their game is not our game. As we move now from what has been a specific kind of project-related activity with the development of some strong core effort, we are going to move towards programmatic thrusts on the part of Regional Medical Programs. This is going to give Regional Medical Programs the opportunity to do many things which they have not done in the past. It is going to give them some freedom and, as with all freedoms, it is going to give them some increased risks. Regional Medical Programs that can move the nation farther towards what needs to be done are going to get good support. From the Regional Medical Programs point of view, the competition is going to have to be programmatic. It is going to have to be meaningful and you have to decide what your job is and get it done. I believe we at Regional Medical Programs Service have done too much interfering with what happens out in a Regional Medical Program. I think individual Regional Medical Programs have to develop greater autonomy, self-sufficiency, and the opportunity to be right or wrong. I will defend as vigorously as I can effective innovations which change the direction of events within a region, so long as the effort is real. If that is to be done, people are going to have to play the game. They are going to have to give us the information we need. They are going to have to make effective use of the resources we can supply. In the meantime, we are at the point of reorganizing Regional Medical Programs so that we are doing things differently than before. The whole grant mechanism needs reorganization, and we will move in that direction to make it much more efficient with more continuity and less delays and uncertainties.

The other major move which I am concerned with has to do with the development of a different kind of professional and technical function

within the Regional Medical Programs Service. Continuing education in the form of the one-day conferences, periodic lectures and getting together to find out about the latest technical device is not going to do these days. If you are talking about continuing education which will change both the ways in which people perceive their functions and how they operate within those functions, then you are talking about something we are interested in. We are going to have a hard look in evaluating what all of these activities in Regional Medical Programs mean. We want to know if a program really addresses the issues we have talked about. If there is a coronary care unit, or multi-phasic screening program, what difference does it make? What does it matter who got the priority? If the priority is health care for the poor, better use of health manpower, control of costs, lowering the dependence upon institutions, better utilization of facilities - if these are what you set up as your goals, then let us find out whether these goals are really being met by the devices you have introduced. If some are good, and many of them are, then it is our responsibility to make sure you know what has functioned well elsewhere and have an opportunity, with our assistance, to find out whether it will function well for you. So, innovation as a naked, isolated act is not going to be very helpful. Innovation which becomes generalized and effective in a broad way is much better.

I think we are joined in a common interest. I know that without the kind of effort we have talked about we are not going to do what needs to be done. Although it is a bad cliche, the concept of a health crisis in this country is truly an agonizing reality. It is here. It is not going to be resolved by old ways. If we are going to devise new ways, we will make some mistakes and we will get hurt in the process. If you are ready to be disruptive, if you are ready to get bruised, if you are ready to challenge the way things are and try something different, and will work very hard for it, then I will be here to help you. And I think I can say with some assurance that I will be here to help you for a long time.

PANELS

REGIONAL MEDICAL PROGRAMS RELATE TO THE COMMUNITY

Moderator--Florence R. Wyckoff

CHALLENGE FOR ALLIED HEALTH IN REGIONAL MEDICAL PROGRAMS

Moderator--Richard F. Manegold, M.D.

THE COMMUNITY : A SOCIOLOGIC OVERVIEW

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Any observer of American communities, whether his purpose be analysis or action -- or in the best of all worlds conjoint analysis and action -- faces a series of exceedingly difficult problems. I shall discuss very briefly four such problems as they appear to a sociologist concerned with the domain of health. They may be conveniently grouped as problems of definition, structure, process, and value.

1. Problems of Definition

Explicit in the content of today's symposium is the idea that there are several ways of conceptualizing "the community." Thus, we have before us a geographical conception, as in the rural community, and an institutional conception, as in the hospital community. Of the six definitions listed in the Random House dictionary, all seem to rest on either or both of two criteria: spatial propinquity and shared interest of some kind. Hence, we should have to say that a community is a collectivity of persons or groups that hang together in some determinate ways; it is more than a mere aggregation. This hanging together is usually based upon a variety of sharings: shared life patterns, in which people interact with one another in the life-space more frequently than they interact with those "outside" community boundaries; shared customs and values, in which people follow certain ways of acting, feeling, thinking in common, in which they know how to identify one another and what to expect from one another; shared consciousness of kind, in which they feel themselves members of one another and inhabit the same "community of fate." I think we can then conclude that the community is characterized by organization, a more-than-random patterning in social space and time, and by sharing of resources, needs, and criteria for meshing resources with needs.

The chief point to be made here is not that definition is necessarily complex and messy, that there is no single authoritative concept that will serve all goals. It is, rather, that definition is

important, since it determines much of subsequent thought and action. Further, definition should be various and flexible, chosen to be appropriate to what one wishes to do; there are many communities, each as legitimate as the others, but we have to be clear about what kind of community is the referent in our universe of discourse. Otherwise, we are left in a very flabby situation, in which we literally don't know what we are talking about when we throw around the sacred term, "community." And, one should add, the mystical overtones attached to the concept, the notion in all our minds that the community is a "good thing," may blind us to the fact that it may also be a repressive and constraining thing, a brake on both individual creativity and broader social change.

Finally, it should be remarked that in an advanced industrial society, such as our own, any boundaries we choose to draw around our favored concept of community are likely to be both permeable and shifting. If we are perhaps not yet all bound together in Professor McLuhan's "global village," we are, nevertheless, members of an increasingly common culture and an increasingly interdependent social system. Therefore, neither the city as community, nor the health professions as community, is exempt from constant interpenetration with larger environing systems of economics, politics, and consciousness. Whatever community we are talking about is an open system, and we ignore its links to surrounding systems to our great peril.

2. Problems of Structure

I am afraid that in our ordinary usage of the word, "community," we have only the vaguest idea of something out there, something incredibly complex with which we hesitantly cope. But the community is not a huge undifferentiated beast; it may be analyzed, broken down into component systems of action, personalities, places. When so analyzed, we can often determine which components are essential to our understanding of a given situation or our possibilities for fostering a given line of action. Unfortunately, thorough comprehension of a community may demand a depth and subtlety of knowledge that can only be achieved by painstaking study for which there is no time or money. Central to this issue is the immense variability among American communities in size, population composition, political and economic history, and so on; we cannot make the easy assumption, for example, that the locus of power or the distribution of population sentiments regarding health matters will be congruent between cities A and B.

Failing the opportunity to attain that detailed knowledge-of-acquaintance that characterizes the social anthropologists' grasp of the community, we may yet find the rough outline of structure within our reach if we can be sensitive to the primary, recurrent features

of the social system. What are these features? A community profile should include the contours of local institutions and agencies: economic, political, educational, religious, health and welfare, and communications. That is, we ask what are the stable, requisite mechanisms by which people are brought together to do in concert the things they cannot do as soloists? (My listing is clearly only suggestive, not exhaustive.) Our profile should also include a sophisticated mapping of the chief features of the population: the patterns of formal and informal leadership, the distribution of people by occupation, income, social status, race and ethnicity, and neighborhood groupings. Very importantly, of course, in the present framework we must have reliable knowledge of the population's health characteristics. This should embrace not only the familiar epidemiological baseline data describing states of health, but also the most accurate possible description of peoples' health behavior and beliefs. Harder to dig out, especially in a brief sketch of the community, is the constellation of values and attitudes that guide men's habitual style of life. Yet the community's action or inaction in matters of health is crucially dependent on the totality of life circumstance and on peoples' preferred version of the nature of man, the nature of society, the goals of living a life.

3. Problems of Process

If we have succeeded in defining a target community and erecting a minimum outline of its main aspects, we then meet what is probably the most recalcitrant set of problems: understanding process, or community dynamics. How do things happen in this community, what must be done to get anything accomplished? The flow of local decision-making is not only fiendishly hard to chart, but this flow may (and usually does) change with changing topics of interest. Nevertheless, the best single predictor of future performance, in communities as in race horses and students, is past performance. Therefore, we should be concerned to get a first reading of local process of reviewing the history of the community and, in particular, its decisional history. The way this system has behaved on the issue of school bonds or downtown renewal, or on some previous health matter, yields some evidence as to how it may behave on the issue of immediate interest. The attempt to identify an enduring leadership cadre, to which I have alluded above in discussing "structure," may also be furthered by an analysis of recently-made decisions; those who have been influential in the past are likely to be influential in the present, always with the qualification that leaders may often be issue-specific. (That is, the individuals and organizations that have been interested and effective in urban renewal are not necessarily the ones who will take the same posture toward health.)

In our studies of process for the National Commission on Community Health Services, we discovered that the two most significant elements

in moving a community toward health action were, first, the presence of some one individual who had both organizational skill and a zestful urge for getting a thing done and, second, an involvement of economic leadership in the effort. Similarly, a current study by one of my doctoral candidates finds that a key factor in instituting family planning programs in North Carolina counties is the existence of some individual who is passionately interested in the subject, and prepared to push.

In health, as in so many other regions of civic life, the chief foe of concerted planning and action is probably apathy. Thus, our problem is not only how to study process, or how to take advantage of process, but how to stimulate the kind of commitment and interplay among individuals and agencies that affords a fighting chance for anything to happen. This strikes me as a very serious question indeed. Unless we are able to cultivate wide awareness, and to devise the mechanisms for joint action that are embodied in the current thrust toward "coalition planning," we may be hard-pressed on the very possibility of survival -- to say nothing of the maintenance of a civilized polity.

4. Problems of Value

In Arthur Miller's play, Death of a Salesman, the unhappy older son, Biff, who has been a disappointment to his parents and to himself, confesses that he has never known what he was supposed to want in life. If large numbers of people in a community are unable to articulate their values, or if they are in the dread state of valuelessness, then there are no stars to steer by, no ends of action that are taken to be ultimate goods in themselves. Why seek health? Health is not, presumably, an ultimate goal for its own robust sake, but for what it enables people to do, to enjoy, to express, to be. And even as an intermediate or proximate value, health can scarcely be considered in isolation from moral, political, aesthetic, or other goals. So we must learn what a community really wants; if, as I suspect, it really wants happiness, then perhaps we are bound to explore in some detail the anatomy of that blessed state of being.

REGIONAL MEDICAL PROGRAMS
RELATE TO THE HOSPITAL COMMUNITY

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It is indeed a challenge to present as complex a subject as Regional Medical Programs and the Hospital Community in 15 minutes. This time constraint demands vigorous selection and an emphasis on overview often at the expense of illustrative detail.

Despite the almost universal aversion to statistics, it seems wise to begin by defining the scope of hospitals. Table I, which summarizes the data for 1968 as reported in the most recent guide issue of HOSPITALS, is self-explanatory. This information, however,

TABLE I

HOSPITALS - U.S.A. - 1968*

CHARACTERISTIC		TOTAL	SHORT TERM	% OF TOTAL	LONG TERM
HOSPITALS		7,137	6,192	87	945
BEDS	thousands	1,663	919	55	744
ADMISSIONS	thousands	29,766	28,954	97	812
PERSONNEL	thousands	2,310	1,880	81	430
EXPENDITURES	billions	19.1	15.8	83	3.3
ASSETS	billions	31.1	24.3	78	6.8

*Hospitals 43:15 August 1, 1969

deserves the emphasis of personalization. One out of every six or seven Americans was hospitalized at an average cost of $640, presenting a bill for $95 to each of us if these costs were shared equally. By far, the majority of this activity occurred in short term hospitals.

The total national expenditure for health services during 1968 was just under 60 billion dollars. Direct hospital expenditures (19+ billion) required about 1/3 of all health dollars for the year. These estimates, however, do not include physician's fees for hospital services. Appropriately adjusting for this independently collected but intimately related component, hospitalization consumed nearly half of the national health dollars during 1968.

The National Center for Health Statistics has estimated a total of 3.4 million health workers present in the United States at the end of 1967. Using this figure as a comparative base, hospitals employed 70% of the country's available health manpower. Finally, the 29-plus million hospital admissions during 1968 comprised approximately 15% of the total population.

These estimates permit the following quantitative summary of the scope of hospital activities:

> Half of the national health budget is expended during hospitalization where three-fourths of the nation's health workers care for the sickest 15% of the population.

Statistics alone, however, do not adequately define the importance of hospitals in the delivery of health care to the nation. A conceptual appreciation of the role of the hospital as an organization is equally important.

Most American hospitals serve a somewhat loosely defined geographic area and often a definable subpopulation within these boundaries. From the viewpoint of most service populations, the hospital has become the central organization for all health activities. The increasing use of hospital ambulatory diagnostic facilities, the growing use of hospital emergency rooms for primary care, the growing legal expectation that hospitals monitor the quality of care, and the expanding use of hospitals as educational institutions all demonstrate this public attitude. There is considerable evidence to document this growing public substitution of the hospital-patient relationship for the earlier more personal physician-patient relationship.

From the professional viewpoint, hospital resources permit the use of complex and expensive equipment. The hospital organization permits the utilization of many different health workers on behalf of

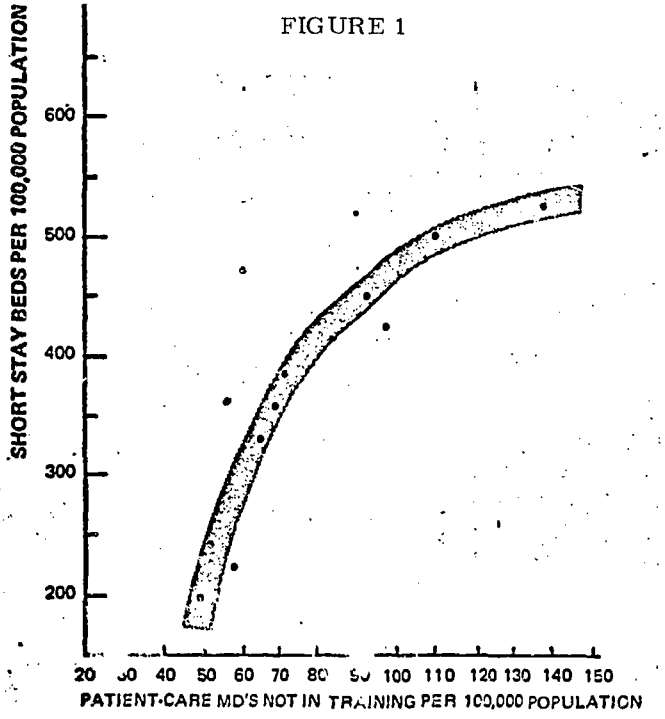
the individual patient. Where hospital resources are themselves inadequate, the hospital serves as a point of entry into a broader referral system or as the financial base for the expansion of local resources. For the professional too, then, the hospital has become the central organization for local health activities.

These insights permit the following conceptual definition:

> Hospitals represent the major existing social organization to functionally relate the activities of many different health professionals, in an orderly fashion, to the health needs of a defined local population.

Let me draw briefly on two recent studies in Northeast Ohio to further emphasize these relationships. Physicians, like hospitals, are important in the delivery of health care and consequently to the goals of Regional Medical Programs. In a recent Northeast Ohio Regional Medical Program study, the number of practicing physicians in each county of Northeast Ohio did not correlate closely with the size of the population, the age adjusted death rates for Heart Disease, Cancer or Stroke, or with the median county income. There was, however, an exceptionally good correlation with the number of short stay hospital beds in each county as shown in Figure 1.

FIGURE 1



It is evident that physicians and hospitals are wedded. True, as in most marriages, there are heated quarrels over who wears the pants and the distribution of funds. Nevertheless the marriage of doctors to hospitals, through the medium of the organized medical staff adds additional muscle to the hospitals importance to local health delivery services.

One might legitimately question the relationship of the Regional Medical Programs categorical diseases to hospital activities in general. Table II describes the hospital experiences of the 2.4 million people living in Greater Cleveland during 1967, studied by the Northeast Ohio Regional Medical Program. As described in the table,

TABLE II

HOSPITAL DISCHARGES BY RESIDENTS

OF GREATER CLEVELAND (2.4 million people)

CATEGORY	DISCHARGES			DAYS OF CARE		
	#	RATE 100,000	% OF STUDY	#	AV. STAY	% OF STUDY
HEART DISEASE	19,812	823	35.8	322,707	16.3	36.1
CANCER	12,652	525	22.9	224,615	17.8	25.1
STROKE	4,509	187	8.1	110,582	24.5	12.4
RELATED DISEASES*	18,370	763	33.2	236,035	12.8	26.4
TOTAL STUDY	55,343	2,298	% of all discharges 16.9	893,839	16.1	% of all days 26.6
ALL DISCHARGES	326,863	13,622		3,359,639	10.3	

* Diabetes Mellitus, Rheumatic Fever, Hypertension, Chronic Bronchitis and Emphysema, Nephritis-Nephrosis-Renal Infection, General Arteriosclerosis

17% of all discharges and 27% of all hospital days of care and inpatient costs were necessitated by diseases of primary concern to the Regional Medical Programs.

The quantitative scope of hospital activities, the major application of these activities to Regional Medical Programs' categorical concerns, the conceptual role of hospitals as a local focus for health resources, and the functional organization of doctors in hospital staffs all serve as a priori justifications for the importance of hospitals to the Regional Medical Program. Stated simply:

> Regional Medical Programs cannot represent the community of health providers without major incorporation of hospitals in its decision making process; Regional Medical Programs cannot influence health care without major impact on hospitals as a program target.

Thus far in this presentation, hospitals have been described, dissected and found critical to the goals of Regional Medical Programs. It is now appropriate to concentrate, at least briefly, on the entry points and objectives for Regional Medical Programs-Hospital interaction.

The involvement of hospitals in the management of Regional Medical Programs can follow several models. In Northeast Ohio, institutions and agencies are not formally represented on our Regional Advisory Group or committees. Nevertheless, by choice, 10% of the total membership of RAG and committees includes knowledgeable hospital administrators, 19% full-time medical staff from community hospitals, and about 5% hospital based nurses or allied health professionals. In many other Regions the formal structure of their RAG includes members appointed by their state hospital association, local hospital councils and individual large hospitals. Another common device, best illustrated by the Georgia Regional Medical Program, is the development of hospital based local advisory committees in each of the state's community hospitals. Finally many Regional Medical Programs, such as Metropolitan Washington, have appointed a full-time core staff hospital coordinator. Each of these models permits hospitals to have a significant voice in generating local Regional Medical Program objectives; stimulates interest in Regional Medical Programs by the virtue of involvement; and encourages the necessary use of hospital resources toward the accomplishment of Regional Medical Programs goals.

Unfortunately, the involvement of hospitals in Regional Medical Programs is more easily discussed than the purpose of hospital involvement; specifically, the objectives for Regional Medical Programs' impact on hospitals. The first, most important and perhaps only goal of Regional Medical Programs is to improve the quality of health care

delivered to the population. It should be readily appreciated, however, that the highest quality care delivered to a selected few does not yield high quality care for the population. Regional Medical Programs unique emphasis on the quality of health care must, then, necessarily include significant concerns for the quantity of services and its relevant distribution to various subpopulations. Approaches to the quality, quantity and distribution of health services through hospitals are generally summarized in Table III.

TABLE III

METHODS	AREA OF HOSPITAL IMPACT	PRODUCTS	
		INTERMEDIATE	FINAL
"Cooperative Arrangements"	Networks: for shared facilities; for educational support	Attitudinal Change	Higher Quality Services
	Research: systems; automation; new personnel		Greater Quantity of Services
Education	Data: physician & hospital self-audit; community evaluation of resources applied in relation to need	Direction for further Research and Education	Relevant Distribution of Services

The methods and products for the Regional Medical Programs-Hospital interaction, as described in Table III, are conceptually simple and presented only to illustrate logical relationships. Networks either to share facilities and scarce resources or for educational support represent the main current thrust of most Regional Medical Programs. Research in new or modified delivery systems, in automation and in the use of new categories of manpower represent the ideal future thrust for which most Programs are now preparing. Regional Medical Programs and hospitals can and should play a major role in

research and education on the use of individual automated patient records and computerized summaries of hospital discharge data. Proper use of these media permit professional and hospital self-auditing of performance and results to direct needed education or the search for better ways of responding to specific needs. Lastly, Regional Medical Programs and hospitals should define the statistical tools to study the comparative use of hospitals by specific communities in relation to their use of other medical delivery services. This approach, which has been started in Northeast Ohio, permits a population based evaluation of the application of medical resources to medical need in relation to health results. Detailed illustrations of the specific projects to implement these Hospital-RMP impact areas are beyond the scope of this brief presentation, but will hopefully surface in the forthcoming discussion groups.

The preceding discussion of the RMP-Hospital interaction emphasized the mechanics of possible impact areas. A few further words on the desired "attitudinal change" are necessary. Hospitals, once developed in response to community needs, have grown sufficiently to substitute their own organizational needs as prime goals. Such administrative goals as more beds and a balanced budget, or such staff goals as the development of more highly specialized services and the competitive recruitment of house staff often supersede the hospital's proper concern for the health of its defined service community. These are classic, and perhaps not unexpected examples of "Peter's Inversion," which result ultimately in the excessive flow of national health resources into secondary and tertiary medical care at the expense of primary care.

The main "attitudinal" objective for the RMP-Hospital interaction is to re-channel the hospital's attention on its primary goal of serving community health interests. This does not mean beds, cobalt units and successful residencies, but rather a programmed approach to the demonstrated gaps in community medical services measured against demonstrated results in community health.

I agree with Anne Sommers that appropriate modification of hospitals is the best route to the solution of the current health delivery crisis. This attitude, which makes Hospitals the keystone of future planning, reflects an appreciation of the hospital and its medical staff as the primary local focus for the delivery of health services. This attitude reflects an understanding of the existing investment of national health dollars and manpower in hospitals. In those areas where de novo organizations for the delivery of health care must be developed, appropriate relationships with hospitals still need to be developed in order to deliver comprehensive health care. The proponents of major new non-hospital systems of health delivery, including oversophisticated hospitals who wish to place "snub-nosed" medicine elsewhere, must recognize that the manpower and dollars for

new health organizations must in good part be retrieved by a restriction of hospital activities. It is apparent, then, that the approach to improved health delivery, which is the goal of Regional Medical Programs, must be built on or at the expense of hospitals which remain the key to this critical national dilemma.

THE RURAL COMMUNITY

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THE SETTING:

Currently it is good style in health circles to discuss problems of medical care delivery in terms of the needs of an urban population. If one lives in an urban center, that is the self-evident problem. One sees it every day as he goes from home to work. Without any effort, it is comfortable and easy to assume that the health problems of the urban ghettos are by far the most complicated problems among all others in the field of delivery of health services. Until one lives in a rural area, that view is a reasonable one.

A rural exposure can quickly convince you that the problems of a sparse population, of distance, of lack of professional services, of inadequate tax support, indeed, the vanishing American, the rural physician practitioner can become problems of such magnitude that it makes the problems of the urban ghetto pale by contrast. I concede that there is a vast difference in terms of numbers of people. Justifiably, this factor alone has a great impact in formation of national policy. However, from the point of view of solving problems of delivery of service, those found in rural areas are as complicated and as difficult of solution as can be found anywhere in this country.

My comments will reflect experience in an area of the Mountain West that is known for its tremendous distances and sparse population. While these rural qualities differ from other states, primarily in the number of miles between urban centers and in the urban population concentration, the problems of accessibility to service and in the willingness of health manpower to work in rural areas are much the same throughout the United States. The differences are matters of degree. "Rural Pennsylvania" can mean a ten to fifteen mile distance to a hospital or physician. The problems are essentially the same, though differing in distance and concentration of people.

The town of Challis, Idaho, with a population of 732 (1960) is 77 miles from the village of Arco, Idaho, which has a 12-bed hospital and one physician. In another direction, patients must drive 66 miles on a winding, serpentine road to Salmon where there are four physicians and a 39-bed hospital. It is not uncommon for a Challis patient to travel to a larger center in Idaho Falls, 138 miles away. Heavy mountain snow and long winters add a significant complication to the distance.

While the example just referred to is inclined toward the extreme, it can be duplicated. Distance, coupled with a sparse population, characterizes much of the rural West, where the population density of the four states in the Mountain States Regional Medical Program ranges from 3 to 8 persons per square mile. This compares with the United States average density of 55 persons per square mile.

THE ATTITUDES:

The difficulties of delivery of health services in rural areas and the development of personnel to meet those needs should be discussed in the context of our society with its many forces vying for the public's attention. We cannot separate the public's interest in "health" from the total spectrum of our society's interests.

I am convinced that most of us health workers seriously overemphasize the importance which an "average citizen" attaches to health as a value. The exception to this, of course, occurs in a crisis situation in which an individual or a member of his family is in need of immediate attention. In the valleys between crises, the level of interest in health programs has not been consistently high, in spite of the fact that we are being bombarded by a wealth of articles relating not only to personal care, but to the cost of health services.

Another quality found among most health workers is a missionary zeal to develop programs for consumers based on our conclusions of what they need and what they want. Recently, we have been giving lip service to consumer participation in health planning. In fact, however, the dominance of health planning activities by health professionals is evident in most quarters. Optimal communication suggests a two-way conversation involving talking and listening. Rarely do we make a sincere effort to listen carefully and with complete attention to what the consumer considers to be his needs and desires. We are usually talking, not listening!

As an example, we have generally made the assumption that every citizen should have easy access to providers of health services. A physician and a hospital should be within easy reach. As a matter of fact, however, I am not at all sure that all residents of rural areas

really feel a great need for a physician or a practitioner of another kind to be within easy reach of his ranch, his farm, or his timberland.

As we develop plans for allied health manpower, let us listen carefully to the consumer's views as he appraises his needs. Let us also listen to the front line health professional who may or may not reflect his professional organization's published views. Using those views in conjunction with the views of skilled planners and administrators, let us work together to provide the quality and quantity of care needed in this country.

VIEW FROM "OUT THERE":

What do we see and hear at the grassroots level in the rural areas? In the words of a recent folk song, it is clear that, "The times, they are a changing."

Within the past year, I sense a change in the historical problem of fatigue among the health profession. It is rapidly increasing and becoming acute. The complications presented by malpractice suits and costs and the increase in requests for services associated with the benefits of Medicare and Medicaid are taking their toll as practitioner after practitioner reduces his time in the office or withdraws from practice to preserve his own personal health.

Our crisis orientation toward health is producing strong and bitter feelings about the cost of care when we become patients. Recent, rapid increases in cost have made the public weary of the discussion, particularly since we have great difficulty in implementing effective ways of improving our service delivery system. The pressure is upon all of us to become much more active in experimenting with methods of improving accessibility to services at more reasonable costs.

We sense a changing attitude among some of the strong, stable professional organizations toward the challenge of providing qualified allied health personnel. It is easy to sense in the spring wind a change of attitude at the grassroots among physicians. I think we see a more relaxed point of view, with a willingness to participate and discuss new categories of allied workers who will in some way relieve the intensifying pressure upon the individual practitioner. He is far from ready to surrender the traditional solo practitioner role and adapt to another, perhaps more efficient plan. However, he is discussing ideas more openly and fairly, as he realizes more vividly the complexity and difficulty of his chosen task.

Among the nursing profession one senses a crystallizing, resistant attitude toward the consideration of new allied manpower categories

that evidently appear to the professional nurse as a threat and a loss of identity as a traditional, professional nurse. As a group, they seem more suspicious and less willing to take a leadership role in developing new or different categories. If this observation is correct, perhaps it can be defended as a reasonable position in which the status quo is threatened in some, as yet undefined way. At the same time, it appears unfortunate that the opportunity for developing a leadership role, leading with reason and flexibility appears to be lost to this generation, unless there is a rapid change of attitude.

A few traditional, as well as legal, definitions of relationships among the health profession are in need of serious questioning. They are being challenged by every consideration of a new category of allied health worker. Basic among these traditional concepts is the notion of one category of personnel functioning "under the supervision" of another category of personnel. Initially, the concept of working under someone's supervision implied direct supervision and personal observation. This has been diluted to the place where a written order or a signature on a piece of paper hours or days after the performance of an act is construed to mean "under the supervision" of another category of personnel. In effect, the concept has developed into one which has decreased significance for a patient.

Problems related to this concept have particular meaning in rural areas when a person in the role of a physician assistant, in a town thirty or forty miles from a supervising physician, is compelled to act independently and promptly by the reality of a situation presented to him.

WHAT'S HAPPENING IN RURAL AREAS:

There is a rapidly growing interest in a category of allied health personnel known as physician assistants. The skills involved have a range that is well known to this group with opportunities for education that are equally well known. The Medex program, in its trial stage at the University of Washington, appears to have great success in developing individuals who work with practitioners in rural areas. Reports of acceptance by patients have been excellent. The earning capacity of the Medex appears to be reasonably established at a comfortable, living income level. More than that, the program builds upon already acquired education and military service before the student enters the program.

A nurse living in a small New Mexico town entered a specially planned medical center program to supplement her nursing education and experience, preparing her to serve as a nurse practitioner. In effect, she is the major health resource in a small community located some

sixty-five (65) miles from a metropolitan center. She maintains frequent telephone contact with medical center physicians to obtain constant supervision and guidance as she sees patients in her small home community where she has an office in a former Sears-Roebuck Foundation Clinic building. Supporting services at the clinic are provided by a technician who is a high school graduate further educated in a program specially developed for her by the medical center. Both of these individuals return to a medical center setting for frequent educational opportunities. There is no doubt that their presence in the community is a reassurance to local residents and, increasingly, an accepted pattern of obtaining first-contact care.

Another, long standing example of this category is seen in the person of the Alaska Health Aide. Natives with relatively brief education backgrounds function with considerable independent action. When necessary they have access to physician guidance through a communication system.

We have heard comments from organized nursing expressing deep concern over what the physician assistant type programs mean for registered nurses. As I have suggested earlier, they reflect apprehension over the changes that could develop in the traditional physician-nurse-patient relationships. While organized nursing is reacting, we have also been contacted by individual nurses asking how they can enter the channels that will prepare them to expand their realm of capabilities and service. We find these individual expressions encouraging. They reflect a positive, comfortably aggressive attitude to offer improved services in rural areas.

In each example I have mentioned, the obvious departure is for someone who acts as a first contact resource for individuals entering the medical care stream. Increasingly, in rural areas there is a need for this type of person, who can exercise independent action, but with access to individuals possessing a greater skill, when the occasion requires it.

In another portion of our Region a Regional Medical Program grant is supporting continuing education for individuals who are providing inhalation therapy services in community hospitals. With the rapid sale and distribution of inhalation therapy equipment, a variety of hospital personnel are handling the equipment. Sometimes it is a nurse, sometimes a nurse's aide, sometimes an orderly. Initially, the program was planned to offer a short, intensive course to whomever was providing the service within the community hospital on the premise that it would be years before we could adequately train properly prepared, inhalation therapists. In the meantime, there appeared to be a good chance of reducing the risks associated with service provided by personnel with no training. As the project was developed, we encountered

a resistance from nursing organizations which felt that only nurses should provide the care. Accordingly, the project was modified so that the major attention would be given to nurse applicants, although other personnel would be accepted. Subsequently, as the projects have moved ahead, we have, in fact, had mostly nurses attending the courses. However, we have also had practical nurses and other non-nursing personnel enter the program.

Another example of personnel development through cooperation was initiated through a Regional Medical Program-initiated series of discussions. Four hospitals in three communities, along with a voluntary health association, have joined forces to develop an intensive and coronary care training program for physicians, nurses and licensed practical nurses. The hospitals contributed dollars, facilities and personnel. With substantial support from the local Heart Association and with a small contribution from the Mountain States Regional Medical Program, a training program to staff the coronary and intensive care units of the hospitals of the area is under way. These efforts have resulted in a substantially increased supply of individuals and broadened the categories of personnel being trained for service in those units. Perhaps of greater significance is the voluntary cooperation exhibited by the hospitals and the voluntary health group.

In one of our states we have encouraged development of seven regional sub-centers for continuing education. In each geographically decentralized area a local coordinator, a health practitioner, has been recruited to spearhead development of a continuing education program for the health occupations. Each coordinator was stimulated by a chance to develop a year's program suitable to his own community's needs. As they have emerged, the plans have common threads, but differences as well.

Programs to help health professionals learn how to teach as well as how people learn have attracted the community coordinators and other local health leaders. Just now we begin to see evidence of serious interaction between the local health educators who have attended these courses. Nurses, physicians, technicians, dentists and administrators are showing evidence of planning together to develop interprofessional education efforts.

THE FUTURE IN RURAL AREAS:

We have merely scratched the surface in our search for qualified individuals who can serve in some part of the medical care network in rural areas. It is evident that there is a great need for individuals who have the privilege and responsibility of increased independent action working within well defined limitations to provide an increasing volume of service more conveniently available to the consumer. This

raises the serious problems of licensure and malpractice insurance coverage. There is no doubt that protection of the public from inadequately prepared individuals continues to be an essential part of our societal relationship. It is equally apparent that there is a desparate need for an improved basis for licensure which does, indeed, provide protection of the public but also encourages innovative progress. Efforts to revise our licensing schemes, perhaps focusing upon specific, individual capabilities or skills, rather than focusing on professional, categorical limitations, may point a way to more clearly establishing the limitations of individual practitioners.

To undertake a modification of our licensure system, perhaps working toward national licensure, requires a more reasonable and understanding attitude among existing professional organizations. There is an intense need to sit down and reason together in the interest of providing personnel who can adequately care for the needs of our citizens.

All I have said so far is still focused upon crisis type care. This leaves the unspoken, but evident need for allied health workers to become engaged in providing preventive services. If we are to move ourselves from a defensive to an offensive position, we must offer a substantially greater volume of prevention than has ever been offered. Coupled with this need is the complex task involved in educating citizens to seek preventive care. We are in need of allied health workers who can measure up to this assignment.

These major needs are evident in the rural states of the Mountain West. I think it reasonable to assume they are evident in most rural areas of the United States.

Having outlined these basic needs for the future, I am still left with the haunting concern that no matter whom we train in new lines of endeavor, it may be difficult to persuade them to remain on a permanent basis in small communities of the sparsely populated areas of the West. One is often left with the attitude, tasting of defeatism, that a part of the risk of living on a ranch, on a farm or in a forest is that you may need medical care, but not have it immediately accessible. I have heard more than one resident of the mountain area say it is a risk he is prepared to take. If one looks at the morbidity and mortality figures of our states, one sometimes suspects that there is some support for the choice that the rural residents make.

THE URBAN COMMUNITY

Henry M. Wood, Urban Health Coordinator
New Jersey Regional Medical Program

When I was approached to present this paper I was impressed by the broad latitude available to me in offering this topic and somewhat bewildered by it. Bewildered largely because my personal experiences with the concept of "relating to" have historically meant a means of implying activity and interaction with something or someone, but with no specified procedural definition. This semantic device is particularly effective when one party wants to convey the idea of positive action with another party, but is not yet prepared to make a clear commitment to any specific role. Again, I repeat that this is my personal view of the concept of "relating to," and I have chosen to indicate this introductory view as a means of emphasizing the fact that the strategy of the Regional Medical Program in New Jersey has not been to "relate to" the community -- its role has been far more definitive than mere "relating."

All of you are fully aware of the rather broad mandate of Public Law 89-239, and I am certain that virtually all of you have at one time or another stepped back to look at this thing called Regional Medical Program and wondered...."Are we really doing what needs to be done? Are we really hitting the mark? Are we doing all that can be done? What else should we be doing?...." I would be very surprised, indeed disappointed, if you have not reviewed these questions in your minds. These are questions that any agency committed to concern for the welfare of the public must ask over and over again. They have been asked repeatedly in New Jersey, I suspect that the Regional Advisory Group of the New Jersey Regional Medical Program entertained similar questions when it chose to become deeply involved in the Model Cities Programs of our State.

Early in 1968 a resolution was passed by that body to authorize the placement of Urban Health Coordinators in the three federally designated Model Cities of Newark, Hoboken and Trenton. (It is important to point out that none of the aforementioned cities had made provision for full-time health planners within their initial planning staffs). The Coordinator of New Jersey's Regional Medical

Program then met with the Directors of those programs and worked out very general agreements which called for the Regional Medical Program Urban Health Coordinators to be assigned full-time to the staffs of those programs to work with the elected citizens participation bodies to develop the health components of the comprehensive Model Cities plans.

There is a need to focus on two very important issues that provided the background for New Jersey Regional Medical Program's Urban Health effort. The decision to make the major commitment had been made and staff had been acquired and placed. The Regional Advisory Group had boldly responded to a need within our region and had received the support of the Division, yet the legislation made no clear provision for such action. Although I appeared on the scene at this point, some months after the passage of the resolution, the residue of anxiety was still quite apparent. Secondly, no one really knew exactly what an Urban Health Coordinator was to do. That is, a general mandate had been laid down -- but there was no reference work that would spell out just how such a creation should function.

Strangely enough, if I were to be asked to cite the two most important factors leading to our success in urban health, I would probably name these two issues. Issues that on the surface would appear to be draw-backs to success. Why? Well, largely because strange new ground had been opened by the Regional Advisory Groups' decision. No clear legislative mandate existed for this demonstration effort and, rather appropriately, no clear set of rules governed our actions on the local level. We, in the field, would sink or swim on the basis of our personal strengths or weaknesses, but a significant contributor to our success or failure would be the attitude of our headquarters office. Could we rely on its complete and unflinching support when the chips were down -- could we, in the face of a seemingly paper-thin mandate? Well, we soon found that we could. We found that the total resources of headquarters were available to us each and everytime the need arose. It was this type of back-up that was so essential to our role in the field. And what was the field like? Just what is it like to be fully immersed in that amorphous thing called "community?" First, I would like to attempt to dispel some of the erroneous notions that are rampant about the "community." <u>There is no such thing</u>! There is no such thing in the sense of the manner in which the term is generally used. The term "community" is a form of shorthand -- a symbol of sorts. When it is used, everyone immediately thinks they understand what it refers to. Yet, have you ever come across "the REAL community?" This is the most dreaded of <u>all</u> "communities." This is the group that <u>really</u> represents what you think, the group that you're "relating to" represents. Confusing? Well, this is the type of problem that is an

everyday experience to the Urban Health Coordinator. My pointing it out here is not to suggest that the "community" is not a real thing. It is quite real -- with real power. The problem is too few persons realize that there are varying levels or layers to the community. I think it is safe to say that all of the layers have essentially similar goals, but their approaches tend to vary.

As I indicated earlier, most model cities citizen participation bodies are elected. It is not uncommon, however, for a person -- once elected -- to be relegated to an 'ex-community' status by those who were not elected. Those who were elected, on the other hand, regard themselves to be 'certified community' directly as a result of the fact that they were elected. It is perhaps in this area that the Regional Medical Program has received its severest criticism in the field. Once an Urban Health Coordinator is assigned, his mandate is to work with the "certified community' that has the mandate to plan. It does not really matter the size of the city, the 'community' issue as I have stated is ubiquitous and cannot be ignored. It is a genuine issue on the 'front lines' of urban planning.

How many of you can recall a candidate for public office that was elected without campaigning? How many total unknowns have been elected to key public offices? I am sure that I can safely say, very few. The inner city is no different in this respect. 'Community' elections are generally won by the more vocal, the more visible candidates. More often than not, the candidate that has been visible and vocal for sometime, the candidate that has been overly active. The inner city is full of unvocal unknowns who are just as genuine, if not more so than the elected individual, and it is usually not until he begins to realize that no one is interested in him unless he is heard from that he becomes the vocal 'real community'. Perhaps I have overly simplified the issue, but I do feel that it is important to understand that working with the 'community' is an exceedingly complex and often frustrating process.

Each Urban Health Coordinator had to deal with the multifaceted entity called "community" in his own way. Local issues, needless to say, played no small part in providing much of the stimulus for their activities. A case in point would be the manner by which the Urban Health Coordinator of Newark dealt with the very complex 'community' situation that he was exposed to upon entering that city. I will attempt to set the stage for you.

Two rather turbulent events in the recent history of Newark formed the backdrop for the Regional Medical Program Urban Health Coordinator's activities. First, the City of Newark, like many of the urban centers of our country, has lived over the years in the shadow of a volcano of frustrations and unmet needs, tightly compressed in its ghetto. Having lacked the appropriate mixture of

commitment and resources to deal effectively with the many special and complex problems of large segments of its disadvantaged populations, the volcano erupted in the summer of 1967. Among key issues leading to the riot was the coming of the New Jersey College of Medicine & Dentistry's new campus which was located in the teeming Central Ward of Newark -- causing the displacement of numerous families. But underlying this issue was one fully grounded in health. Newark's health problems have been well documented and delineated so often as to make indicating them here quite unnecessary. The City Hospital (taken over by the New Jersey College of Medicine & Dentistry in July, 1968), which served the bulk of the residents, has been traditionally known in the ghetto as the "butcher shop." The community's lack of regard for this facility as an institution of 'help and care' was graphically demonstrated during the riots when snipers took up positions near the hospital and fired into the emergency room entrance. Subsequent to the riots, a committee of community representatives met with State and College officials to hammer out a unique document entitled "Agreements Reached Between Community and Government Negotiators Regarding New Jersey College of Medicine & Dentistry and Related Matters" (commonly known as the "Newark Agreements") which gave the "community" a participatory role in the planning and operations of the Martland Hospital Unit (formerly the City Hospital).

Secondly, the City Government of Newark, through the Community Development Administration, sought designation as a Model City under the Metropolitan Demonstration Act of 1966. Once named, the City went through a grueling eight-month period to develop an appropriate election process to establish its Model Neighborhood Council. When the elections were finally conducted, Newark's model neighborhood residents turned out in record numbers to elect their representatives. When the balloting was completed, Newark had had the most successful election of this type in the nation's experience -- nearly 25% of the eligible voters had cast ballots. It was the beginning of the most legitimate city-community experiment in the history of Newark.

These seemingly unrelated events shaped the dilemma that confronted the health planning efforts of the Newark Model Cities staff and Council. The publicity of the negotiations leading to the Newark Agreements and the conditions of Newark's disadvantaged population outlined during those sessions tended to focus the attention of a wide range of organizations and groups on "helping." Elements of the "community" prevailed upon health service institutions, agencies, and well-meaning individuals to develop projects to meet specific needs or the needs of specific sections of the City. A proliferation of projects and project plans emerged -- at various stages of completeness -- all aimed at "helping."

The Urban Health Coordinator was faced with the task of developing the comprehensive health component of the Model Cities Program. Additionally, he had to address himself to accomplishing several key objectives:

> The health task force of the Model Neighborhood Council had to acquire an effective advisory group to plan with it, and also needed a means of "relating to" a broader segment of the "community";
>
> the Newark Community Health Council (spawned as a result of the Newark Agreements) had to be formed, and an effective method of "relating to" the Model Neighborhood Council's Health Task Force had to be established. (This was particularly necessary since the "Agreements" called for the Council to plan closely with the New Jersey College of Medicine & Dentistry which was being constructed in the center of the Model Neighborhood.)

New Jersey Regional Medical Program's response to this situation was quite innovative. The Urban Health Coordinator wrote, negotiated and received funding for a project -- independent of Model Cities funds -- which called for the establishment of a team of urban specialists that would serve as staff to the "certified community" but who would additionally work directly with all other elements of the lay and professional community to coordinate health planning and provide direct technical assistance to enable all of the planning factions to be able to effectively tie in to the overall comprehensive plan of the Model Cities effort. This Regional Medical Program stimulated effort is unparalleled nationally. Today numerous activities are underway in Newark in the health arena that very definitely "relate to" that Team directed by the Regional Medical Program Urban Health Coordinator. One project currently in the developmental stages is an interim medical facility located in one of that city's largest housing projects that will be owned and operated by a non-profit corporation formed by the citizens of that housing project.

Although I have focused on the activities in Newark for the purpose of this presentation, I must point out that health planning activities in Trenton and Hoboken -- led by the Regional Medical Program Urban Health Coordinators -- are no less startling and significant. Perhaps the most graphic evidence of the effectiveness of New Jersey Regional Medical Program Urban Health Coordinators in those Model Cities Programs would be the fact that the comprehensive plans of each of those cities have been approved by the Department of Housing and Urban Development and all are now operational Model Cities programs. I have centered my discussion on Newark largely

because of its national prominence. The Director of that program once made a statement that carries a special significance to me. That statement being ... "Wherever our cities are going, Newark will get there first ... "

It is difficult to say where the urban health component of New Jersey's Regional Medical Program is going. There are now six additional Model Cities in New Jersey, and New Jersey Regional Medical Program has received approval to assist those additional cities in a manner similar to our efforts in the three first-round cities.

In February of this year a state-wide urban health conference was sponsored by New Jersey Regional Medical Program. The result of this conference was that representatives from the nine Model Cities citizen participation health planning bodies were elected to the New Jersey Regional Medical Program Urban Health Task Force. This unprecedented action now gives Regional Medical Program an opportunity to develop health activities in a regionalized manner utilizing the state's nine Model Cities Programs as the core for planning and demonstration project implementation. We view this development, additionally, as an opportunity to provide a direct link to our State's most troubled urban centers for the basic programming of the entire New Jersey Regional Medical Program mechanism.

Much has been accomplished in addition to what I have reviewed with you here. Needless to say, far more can be done, and I am confident that it will be done. Yes, a direct commitment has been made to "the community" by New Jersey Regional Medical Program. No false promises, no cautious offers of support -- <u>direct action</u>. Perhaps the most encouraging feature that I can cite is the fact that in spite of all that has been accomplished, New Jersey Regional Medical Program is still asking ... "What else should we be doing? ... "

COMMUNITY OF EDUCATIONAL INSTITUTIONS

Laurene S. Gilmore, R.N., Assistant Director of Education
Alabama Regional Medical Program
University of Alabama in Birmingham

The community known to us as education is enmeshed in American Society, not by accident but deliberately -- even though the Constitution of the United States does not provide for it. Since it was not provided for, young Tom Jefferson at the Constitutional Convention questioned its lack of provision and was told that all which was not provided for in the Constitution would become the responsibility of the individual states. This seemed to satisfy young Tom at the time but little did he envision the education community of today.

The explosion of knowledge, e.g., the body of knowledge doubling each eight years, has had an awesome impact on today's education. This is good in that it increases man's mastery over his environment and bad because it makes for greater specialization and militates against our goal of making well rounded citizens in our democratic society. Francis Bacon once said, "I have taken all knowledge to be my province." Poor Francis would find his goal impossible in this space age. Education today is a lifelong process and not a pill which could be swallowed once to gain lifelong immunity. This lifelong learning is probably the most important educational implication of our automated world because it gives meaning and content to the human resources of the nation. As Sir Eric Ashby once said, "A university degree, at least in science, should lapse after ten years unless it is refreshed...Many schools seem to work on the principle that once their pupils escape from their educational embrace, they are lost for good...Adult education should be nearly universal in its scope and attractiveness."

It is this lifelong process of learning to which Regional Medical Programs are committed that makes our tasks challenging.

The Alabama Regional Medical Program has begun its second year of operation at a time when funds are short, but our contribution to the education community must continue to grow.

I would like to give you a few examples of how we are involved in the education world. In December, 1968, four projects were approved and funded for the year beginning April 1, 1969; three were educational projects.

The first is considered a little different than most projects. The sum of $30,000 was awarded to Jefferson State Junior College to assist in maintaining its nurse and medical record faculty. This college has the first Associate Degree Nursing Program and the first Medical Record Program in the State. The nursing program, accredited by the National League for Nursing, is innovative in that nursing courses are offered each term. The ratio of classroom activity to clinical laboratory experience is one to two. It offers several courses not offered in the usual Associate Degree program, one of which is Community Nursing. The course description from the college catalogue follows:

NURSING 260 COMMUNITY NURSING

A course based on identification of community health needs and the means to solve community health problems. Nursing takes place in many environments and this experience requires that the students draw on all previous experiences and logically apply these concepts to all situations. The DeBakey, Medicare and Kennedy Mental Health legislation and other health legislation are studied in order to utilize the intent of the law in terms of services to the American people. Some of the problems studied are those related to tuberculosis, venereal disease, unwed mothers, problems of rehabilitation and disaster, home care of those with cancer, heart disease, and stroke. Since most people with cancer, heart disease, and stroke are in homes, student will learn concepts needed in meeting patient needs in homes.

NURSING 260L COMMUNITY NURSING LABORATORY

This course must be taken concurrently with Nursing 260. Under nurse-instructor guidance, students apply community health principles and concepts to the care of patients in selected agencies such as the visiting nursing association, county health department, private homes, tuberculosis sanitorium, rehabilitation center, and other like agencies.

Site visitors to this program asked, "What makes this education situation different?" A simple response was that education in Alabama ranks low in all educational criteria according to both the Department of Health, Education, and Welfare's Digest of Educational Statistics, 1967-1968 and Academic Media's Standard Education Almanac, 1968. Research Reports of the National Education Association 1969 reported Alabama's per pupil expenditure was $358.00.

Jefferson State College is the largest junior college in Alabama and serves as a proving ground for many health programs. Visitors come from both the State and throughout the south to study the programs. The Alabama Regional Medical Program is proud of its contribution to the institution.

Last fall the College, in a cooperative way, diverted approximately $8,400 of Alabama Regional Medical Program funds to another junior college, Lawson State, to help get its program off the ground. Through the efforts of Alabama Regional Medical Program, Lawson State was able to secure a nurse director. Through our "broker role" the staff assisted Lawson State in writing a grant proposal to be submitted to the Division of Nursing, Department of Health, Education, and Welfare. The consulting role of our staff gave assistance in curriculum planning, organization of an advisory committee representing the community, consultation on library holdings (both book and non-book), construction and renovation and liaison between the Board of Nursing and the State Department of Education. In addition, consultation on developing health technology new entry curricula was given to three other state junior colleges. These curricula related to Pharmacy Technology, Mental Health Technology, Medical Assistants Technology as well as Laboratory Technology and X-Ray Technology. Some of these consultative activities resulted in projects written for other Federal agencies, such as the Appalachian Commission.

The core staff believes that through sound junior college health programs some articulation between the senior college health programs might be worked out. Although there is much verbiage in the state and nation on working out the health curriculum ladder and recognizing student individual differences, little has been accomplished toward this goal in Alabama.

The Regional Technical Institute in Birmingham is unique in that it is part of a health complex and does not offer industrial technical programs. It is fairly young in its growth. The staff of Alabama Regional Medical Program worked with the Institute to work out an arrangement with the State's 17 junior colleges to offer health programs such as laboratory technology courses, radiological technology courses, etc., while the junior colleges offer the general education courses, grant the credit for the health courses and also grant the associate degree. This regionalization activity has been approved, but not funded, by the National Advisory Council.

In essence, the work with the before-mentioned junior colleges and the Regional Technical Institute has been a deliberate attempt to assist with the health manpower shortages. Alabama has fewer practitioners in most health fields than any other state.

The University of Alabama in the Birmingham Medical Center is Alabama Regional Medical Program's fiscal agent. We are, therefore, closely related to administration, deans, department heads and faculty of the rather large complex. Core staff funds have given assistance to the continuing education activities of the physicians and have been responsible for seed money for the Medical Information System via Telephone (MIST) project. Perhaps you have seen this project as described by Time Magazine, Look, and various health periodicals. This latter project has brought together the medical community in Alabama better than most former efforts. The calls range from fairly simple ones, such as a practitioner who could not diagnose his patient and was advised that a platelet count of special nature would be helpful. The practitioner offered to send the specimen to Birmingham but the advising physician told him where it could be done at home. At the other extreme, the practitioner's patient suffering from heart disease had been "given up." The advising cardiologist along with cardiac technicians boarded the University's helicopter and went to the "grass roots" to help. As far as we know, the patient still lives. Not only has MIST been helpful in terms of patients, but it is helping identify the continuing education needs of the practitioner.

We lend some assistance to the School of Nursing and played a minor role in assisting them to employ a full-time coordinator of continuing education. In addition, we have an approved but not funded project for Medical Laboratorians and have worked with the School of Dentistry and the nursing and pharmacy departments of the University Hospital on educational projects. The director of Alabama Regional Medical Program is directly responsible for the School of Medicine's addition of a program in family practice and the development of a Community Health Service Council to serve the State's needs.

Alabama Regional Medical Program has worked with Auburn, our second largest university, and will conduct a study on the potential for health curricula at the University. Other institutions that have asked for assistance also have received it.

As most Regional Medical Programs have done, Alabama has worked with hospitals and the Heart Association on developing coronary care teaching projects. This assistance sometimes is in the form of helping the agency to put their goals into behavioral terms and to work out appropriate methods of evaluation, or to expand their instructional methodologies.

Early in the life of Alabama Regional Medical Program the core staff assisted the Alabama Department of Education in a study of health education in the public school system.

One of our projects, "Reality Orientation," is an educational project offered to nurses, licensed practical nurses, attendants, hospital and nursing home administrators, physicians or families. It is a project which affects the patient and helps him maintain a greater sense of reality than he previously had. The project is housed in a psychiatric facility and enrollment has been filled throughout the year of operation.

In addition, we have worked educationally with organized groups. For example, the 1971 Education Conference of the National Association of Practical Nurse Education and Service will be held in Birmingham. Although our monetary contribution will be small, we have worked out the details of housing and expect to work closely with planning groups on the program. Another group with which we are working closely is the State Ambulance Driver Association. The drivers need continuing education and we are trying to help develop a new entry curriculum for beginners. We have also offered assistance to a new organization for our State, the Alabama Ostomy Society.

The greatest need educationally in Alabama is for teachers of health disciplines to improve their instructional methodologies to do more effective teaching. The core staff is endeavoring to develop a small material resources center directed at this goal. We still hear about "the lecture," "getting across information," and we are still taking lectures out on the circuit in spite of the Kansas Study indicating that in 30 years the department of continuing medical education could not prove even one behavioral change.

In summary, the educational community in our State, as in yours, is enmeshed in formalized senior and junior colleges, in service agencies, and in professional groups. To work with this community in achieving Regional Medical Programs' goals means countless committee meetings, (our own education committee, allied health committee and committees of other organizations) research, travel, writing projects and the like. Sometimes it involves simply speaking to the right person at the right time, but the end results of better health practitioners and, in turn, better care for those receiving health services make continuing education the most exciting frontier of American education.

As Voltaire remarked when chatting with his fellow inmates at Elysuir, "They are, I am told, about to extend the school age in England. They will extend it to seventy, I hope." And, indeed, since Regional Medical Programs is the only Federal program directed at continuing education, the nebulous efforts in Alabama must continue

to grow. The education community, comprised of students, teachers, deans, administrators, and the interested public, will develop a better awareness of our role in education.

COMMUNITY OF HEALTH AGENCIES

John S. Hirschboeck, M.D.
Program Coordinator, Wisconsin Regional Medical Program

Regional Medical Programs are uniquely capable of facilitating collaboration within the health-care system. This is accomplished through the development of formal or informal cooperative arrangements among a wide variety of institutions, including community health agencies.

It was recognized more than fifty years ago that there is a real advantage for community agencies of diverse types to collaborate in fund raising. Community Chests were initially organized to eliminate the multiplicity of fund-raising drives, and at the same time focus the interest of the entire community on the purpose and role of the voluntary agencies. Collaboration in fund raising eventually suggested the possibility of sharing other activities and eventually to undertake long-scale social welfare planning programs. Today the United Funds in most American cities are also attempting to carry out a coordinated program of service. They have been reasonably successful in carrying out this function among those health agencies which share in the United Fund. Those agencies which do not receive financial support from United Fund are reluctant to give up autonomy to submit to budget review and program priority determination by another group, even though the United Fund has broad support and represents the power structure of the community. For this reason, such important agencies within the health system as hospitals, public health departments, comprehensive health planning agencies, educational institutions, professional associations, and others may not be included in those cooperative projects which are organized and financed by United Funds. As a matter of fact, the United Fund's influence may be negligible, because United Funds often deal primarily with social selfare rather than health matters, and community health agencies may not receive the attention they deserve.

Regional Medical Programs, on the other hand, are able to relate to community health agencies directly within the sphere of the health-care system. They provide a means to develop linkages among community health agencies with other institutions in the health-care system on a regional basis.

The Wisconsin Regional Medical Program from its inception has emphasized its role as a coordinating rather than an operating agency. It has encouraged ongoing agencies to plan operational projects which could become units in a coordinated Regional Program even though the projects might not be funded through the Division of Regional Medical Programs. Whenever possible, it has attempted to find ways in which two or more agencies may collaborate with each other in carrying out a project.

Functional cooperation between the Wisconsin Regional Medical Program and community health agencies may be described best by giving several examples.

1. Comprehensive Health Planning Agencies.

The Wisconsin Regional Medical Program and the Comprehensive Health Planning Agency of Southeastern Wisconsin and its predecessor, the Hospital Area Planning Committee, Inc. (Metropolitan Milwaukee) have collaborated for more than three years. The agencies are located in the same building, hence communication and collaboration have been conveniently accomplished. Library, duplicating equipment, conference room, and other resources have been shared. Both agencies have provided overlapping committee membership and have collaborated on specific projects, such as the organization of the Southeastern Wisconsin Comprehensive Health Planning Agency.

The Wisconsin Regional Medical Program has also collaborated with the Health Planning Council, Inc. (Madison Area), and hopes to collaborate with six other areawide comprehensive health planning agencies which are now organizing in Wisconsin. The Regional Advisory Committee of WRMP adopted the following policy regarding collaboration with areawide health-planning agencies:

> "To develop Wisconsin Regional Medical Program projects in a subregional or areawide context with an appropriate awareness of the goals, priorities, and guidelines of the existing Areawide Health Planning Agencies.
>
> "To involve consumer participation in Wisconsin Regional Medical Program project development by using subregional or Areawide Health Planning Agencies, where possible.
>
> "When possible, to share expertise, resources, and skills to solve problems of common concern to both agencies.
>
> "To provide professional, scientific, and technological consultation to Areawide Health Planning Agencies.
>
> "To interrelate committee and staff appointment with the State Areawide Health Planning Agencies when desirable."

Regional Medical Programs will undoubtedly be concerned principally with the problems of personal health care and in projects which relate to the delivery of health service. Comprehensive health planning agencies, on the other hand, will be concerned more with resources, finance, long-term planning of facilities, manpower needs, public health, and environmental problems. They will be dealing with consumers and with local government in carrying out their activities. Regional Medical Programs, on the other hand, will be concerned more with education, adaptation of new technology, and improving the actual professional services to patients.

2. Voluntary Health Agencies.

The emphasis in Regional Medical Programs on heart disease, cancer and stroke has stimulated cooperation with voluntary health agencies such as the American Cancer Society, American Heart Association, National Tuberculosis and Respiratory Disease Association, Kidney Foundation, and others. The state and local units of these agencies have become involved in varying degrees with Regional Medical Programs. In Wisconsin a number of examples of collaboration are noteworthy. WRMP has used the Stroke Committee of the Wisconsin Heart Association as its Stroke Study Group. This was done to avoid the duplication of effort in planning stroke programs for Wisconsin. Collaboration in planning coronary care units by assembling a team of consultants to visit hospitals has been worked out in collaboration with the Wisconsin Heart Association. WRMP has planned a Comprehensive Renal Disease Program for Wisconsin in collaboration with the Wisconsin Kidney Foundation which will serve as the administrative agency for the project. WRMP has given program assistance to the Wisconsin Chapter of the Arthritis and Rheumatism Foundation. A conference of physicians interested in arthritis and rheumatic disease was held in Northcentral Wisconsin at Wausau to discuss how diagnostic and treatment centers for arthritis might be established on a regional basis. WRMP will be of continuing service to the Arthritis and Rheumatism Foundation in assisting them to work with areawide health planning agencies to carry out their objectives. The Wisconsin Tuberculosis and Respiratory Disease Association has been an important organizing force in the development of the Southeastern Wisconsin Coalition for Clean Air. WRMP has participated in public conferences, and its staff has served as discussion leaders. WRMP was instrumental in developing liaison with the Medical Society of Milwaukee County and the Marquette School of Medicine for the Coalition.

WRMP has recognized that voluntary health agencies are usually able to provide lay education better than any of the other agencies in the health field. Education is an important instrument for preventive medicine, and voluntary health agencies should be encouraged and supported in carrying out this mission for which they are so well suited. A unique project sponsored by the Wisconsin Department of Public Instruction and

WRMP is the development of a manual for primary and secondary school teachers entitled "The Unfiltered Facts." This manual is now in its final state of preparation and will be available to teachers to assist them in conducting programs designed to reduce the incidence of cigarette smoking among young people. The project will be jointly supported by the Wisconsin Tuberculosis and Respiratory Disease Association, the Wisconsin Heart Association, the American Cancer Society, Wisconsin Division, and WRMP. Direct service to the Wisconsin Heart Association was provided by WRMP through the role which its Coordinator played for two successive years as State Fund Raising Chairman. In carrying out this task the Wisconsin Regional Medical Program was given considerable visibility throughout the state through public appearance, television, and radio interviews. The principal message was one of preventive medicine regarding hypertension and coronary artery disease.

3. Liaison with Group Medical Practices and Medical Centers.

Wisconsin has a high incidence of group medical practice. Two of these, the Marshfield Clinic and the Gundersen Clinic, have become direct affiliates of the Wisconsin Regional Medical Program. The Milwaukee Blood Center, a research and service agency which provides banked blood for Southeastern Wisconsin, is a WRMP affiliate agency which is carrying out what is known as the WRMP Tissue Typing Project.

WRMP has indirectly assisted in the development of the Southeastern Wisconsin Medical Center, an organization encompassing the Marquette School of Medicine, Milwaukee County Institutions, and a group of collaborating hospitals and agencies. WRMP has been instrumental in the development of the Cream City Community Health Center. This agency is now in early development under the sponsorship of the Cream City Medical Society, the Social Development Commission of Milwaukee County, and the Neighborhood Resources Committee of the Milwaukee County Medical Society. The staff of WRMP has assisted in planning this community health center and has supported the Social Development Commission by providing funds for a community organizer.

Finally, we should mention the role which WRMP has played in the implementation of the recommendations of a project conducted by the United Community Services of Greater Milwaukee under a grant from the Division of Chronic Disease Control. This project was completed in July 1969. Among its recommendations was the establishment of an information and referral service for persons with chronic disease. These recommendations stimulated a number of professional groups and community agencies to explore the possibility of carrying out these recommendations. Several conferences were sponsored by WRMP to define which agency might best be suited to carry out the recommendations. The group has recommended that the United Community Services itself carry on this function in the future, and WRMP will assist in the development of the service.

A PROGRAM COORDINATOR'S VIEW OF ALLIED HEALTH

Donald W. Petit, M.D.
Coordinator, Area V
California Regional Medical Programs
University of Southern California School of Medicine

I have been asked to speak this morning on our involvement with allied health. It seems to me that the easiest way to do this is to give a rather simple narrative description of our structure, relate some of the activities that have taken place because of our involvement with allied health, some personal points of view attained through observation of activities that go on when professional groups come together, and share with you some thoughts regarding activities for the future.

Area V of California Regional Medical Programs, which serves a population of close to 5 million people, is one of eight recognized areas within the California region. The area contains dense clusters of urban population, as well as rather large suburban and rural areas in the central, eastern and northern portions of Los Angeles County.

Area V Regional Medical Programs began with a coming together of a hospital administrator and a physician. From this there developed almost instantaneous involvement with allied health. At the present time, our core staff consists of individuals representing the following health-related groups: physician, hospital administrator, public administration, public health, nursing, education, social work, medical librarians. Our Area Advisory Group is comprised of eleven physicians, two dentists, two nurses, a doctor of veterinary medicine, a Ph.D in nutrition, representatives of social workers, hospital administration, pharmacists, as well as members-at-large. Many of the individuals represent not only their profession but various voluntary groups.

Our categorical planning committees, such as heart, stroke, cancer, library services, systems and computers, etc., all contain members of allied health groups, primarily depending upon the committee served--nurses, social workers, physiatrists, Ph.D.'s in Education, etc. In addition to category disease-related committees, there are advisory committees drawn from such professions as nursing, social work, data

processing, systems, etc. This wide diversity of input with varied points of view has resulted in many projects which might not otherwise have taken place.

One of the most interesting of these has been the development of a study of the health needs of East Los Angeles, a large Mexican American community in the Los Angeles area. This was done in conjunction with the Welfare Planning Council and the East Los Angeles Health Task Force. Much of the effort was due to the work of Mr. Frank Aguilera, who came to us from the School of Public Administration at USC and who did an extraordinarily successful job of coordinating and rallying community effort. The needs as seen by the members of the community and identified by this survey have had great political impact and are resulting in definite improvement in the delivery of health care in East Los Angeles.

The interest of the Area V staff in allied health and the delivery of health care, particularly Miss Dorothy E. Anderson and Mrs. Toni Moors, led to the establishment of an American Indian Free Clinic. This is being developed and will be run by American Indians. Los Angeles County has somewhere between 30,000 and 50,000 American Indian residents, one of the largest of such groups in the country.

The presence of members of allied health professions has also facilitated our participation in working with the committees of Comprehensive Health Planning Association of Los Angeles County, in the Los Angeles Area.

Another activity that has risen because of the involvement of different groups in our program was the establishment of the first conference to be held in California addressed to Hospital Administrators, Hospital Medical Staff leadership and administration. This program was entirely self-supporting and highly successful. It arose from planning and enthusiasm within the office and brought together for discussion of mutual problems the members of hospital Boards of Trustees, Administrators, Chiefs of Staff, and some Directors of Nursing.

These are but a few of the activities which have come directly from having a broad base of involvement in our activities. Having lived the team approach for over three years now, I would like to comment briefly on my personal reactions. It is my hope that individuals representing a health profession who come on the staff will maintain many aspects of their professional education. While our points of view become altered gradually--and hopefully for the good-by day-to-day contact, nonetheless the learning and education in depth that comes from the maintenance of professional association is of extraordinary value. I have encouraged all members of the staff to maintain their particular professional growth.

Another observation I am sure others have made is that when a group of strong-minded professionals who have had different sorts of training, come together, there are many rather strong and abrasive contacts. So far, the structure has not blown up and out of these contacts have come creative, innovative thinking, and hopefully, forward progress. It seems obvious to me that the joining together of allied groups in a peer relationship for planning and activities involves a great deal of give and take and is not something that can be accomplished easily.

Finally, I would like to comment on the tasks ahead as I see them. I think there is a role for Regional Medical Programs to play in curriculum coordination of health groups. Thus, our own medical school at USC has been working extraordinarily hard to develop a new curriculum for the medical students. As far as I know, this has been done without any contact with the numerous curricular endeavors going on to train other members of the health care team. There is great need for coordination here and a role for Regional Medical Programs. Perhaps the most fruitful role will be in the true development, in a real world situation, of the team approach to medical care planning, using as a focus the category diseases that are the prime concern for Regional Medical Programs. This will allow an adequate definition of the role of the various members of the team in giving comprehensive patient care in differing health care settings.

AN ALLIED HEALTH COORDINATOR'S VIEW

Eleanor E. McGuire
Associate Coordinator, Education Section
Connecticut Regional Medical Program

When discussing problems of the health care delivery system, developing steps to overcome the impediments to good health care, and making recommendations for changing the system -- the entire health team should be involved in the give and take. At this meeting we have many allied health professionals in attendance but unfortunately a dearth of physicians and particularly Regional Medical Program Coordinators. I firmly believe that until there is universal acceptance of the allied health workers as being allied to patient and health care needs and not to any one professional, we cannot hope to solve the myriad problems facing the health care system today.

This must not be verbal commitment but progressive, dynamic action commitment on the part of each practitioner: commitment based on respect for, and belief in the integrity of, every individual who is working for improved health services, regardless of educational background or role interdependence.

Now that personal interests have been identified, there are three specific points I would like to highlight:

First, at every meeting I have attended these past 10 years - no matter what the subject - the major problem identified has been lack of communications. Somehow we can "communicate" our displeasures and complaints but have great difficulty "communicating" our basic beliefs and positive reactions. Why? It is a mystery to me. I submit, however, that if each of us were to take a few minutes a day to say "Thank you" and add a small compliment to a colleague on a job well done, we would see a great improvement in our basic "communication." Let's give it a try.

Second, for thirty or more years we have had discussions, debates and dissertations on the health manpower shortage. Less commiserating among ourselves about our problems and more planning and positive action to better utilize the over-educated technicians to a full professional

level, such utilization resulting from the development of a coordinated plan based on patient and health care needs with the functioning of all personnel at their maximum work performance level, would do much to help solve that one sticky question.

No other industry would tolerate the waste of manpower that the health industry has fostered for so many years.

This approach to one identified problem would be a major step toward overcoming some of the barriers to meaningful changes in our delivery system.

Finally, I see the Regional Medical Programs as having a tremendous opportunity to serve as change agents. The potential of 55 programs, accepting Dr. Margulies's challenging and visionary philosophy, could have great impact on the improvement of patient care and health services.

Each of us needs to spend a few hours a day identifying those activities we can undertake in our own "regions" to generate the "irritant" which can produce the pearls of wisdom in tackling our knotty problems. Please note: I said irritant - not irritation. And how much can we accomplish without expenditure of great sums of money? This, to me, is the true challenge--providing seed money, dynamic leadership, and fostering true allied health considerations of our mutual problems. Let's talk about patient care needs involving the consumers, and let's minimize our vested interests, personal prejudices and pet ideas or peeves.

We are all involved in our jobs because we are dedicated to serving others. Let's expend our energies recognizing that the other "guy," given a fighting chance, will work with us if he sees we respect him as an individual, recognize his needs, and are willing to listen.

The road is tortuous, and we are all lost if one of us falters. For the time is now. And if we don't put our own house in order, others will, or close it down--permanently.

A DEAN'S VIEW

Robert K. Bing, Ed.D., Dean
School of Allied Health Sciences
The University of Texas Medical Branch at Galveston

Introduction

If I may, I would like to think of my remarks this morning as a progress report to my own alumni association: Regional Medical Programs. My affiliation with RMP began back in September 1966 as the Planning Coordinator of a feasibility study for a proposed School of Allied Health Sciences at The University of Texas Medical Branch at Galveston. This was, and continues to be, a rapidly changing, dynamic, yet venerable medical and teaching hospital complex on Galveston Island. We began our planning for such a school in the year The University of Texas Medical Branch celebrated its 75th anniversary. Through a two-year planning grant we were able to identify an impressive number of issues, potential educational and training programs, and teaching methods which should be related and housed within a School of Allied Health. So far as we know we are unique in that our school, which was officially opened in July 1968, is the only one of its kind which was planned and implemented through a planning grant in Regional Medical Programs. The outcome of our thorough planning and the early stages of implementation have come to be known as the Galveston Plan. But more of this later.

At the outset I need to make reasonably clear three items. In the first place, my thoughts which I share with you today are my own. I have taken no opportunity to check these out or gain feedback from other Allied Health Science deans or directors at this conference; nor have I asked Regional Medical Programs personnel at the national or state levels to review these comments. Secondly, I must talk from a personal point of view, as we see it in Texas. This, then, is a slice of how life is lived in "Longhorn Country." Directly related to this is my own self-concept which says I do not see myself in a leadership role among the deans and directors of schools of allied health. They already have their selected or self-assigned leaders who would be far more vocal and comfortable than I in this present situation.

In a third sense, I believe I do represent somewhat of a minority among the deans and directors in that I evolved into my present set of duties and responsibilities from one of the professional disciplines represented in many of the schools of allied health: occupational therapy. I remain active with my primary professional group as I believe I can best maintain relevance through this kind of affiliation. I also believe I am able to better understand the issues, problems and potential solutions to commonly held concerns if I remain active within a professional group.

Whatever expertise I may possess in terms of allied health sciences comes from the learnings I have acquired not only from my own discipline but from those "significant others" with whom I work. There are such valued individuals as Medical Record Administrators, Medical Technologists, Physical Therapists, Radiologic Technologists, Physicians, Nurses, and other health related specialists. They contribute immeasureably to my thinking and feeling processes. Therefore, I must give recognition to them.

Interdependent Innovation

In organizing this presentation, I sorted through countless numbers of my prejudices, biases, even hobby horses, to finally arrive at some kind of organized core. Even then I found it difficult to lay aside many subsidiary, yet vital points. What I share with you is a synthesis of some of my thoughts on the relationship of Regional Medical Programs and the Allied Health Sciences. In this day of phrase coining I would risk another one: "interdependent innovation." This among many possibilities seems to be of topmost importance if Regional Medical Programs and the Allied Health Sciences are to serve one another. There is no question in my mind that we belong together. Interdependence is important to the growth and development of the idea and ideals of allied health. Further, the schools of allied health are a rightful repository for the ideas and ideals of Regional Medical Programs.

There seems to be some anxiety related to the possibility that Regional Medical Programs may not have permanence in the scheme of emerging health systems. I do not detect the same anxiety among Allied Health Educators, as they seem to believe they are here to stay. I would rather hope I do not come across in a smug way as this is not intended; yet I cannot help but feel that if Regional Medical Programs were to pass from the scene (and I do not wish to indicate that this is my belief), what better tribute could there be than to have it said: "through Regional Medical Programs the collective allied health sciences received some sense of direction, purpose and stability."

To me, interdependent innovation operates very strongly within the various stages of development of the new schools of allied health.

Perhaps I can illustrate this by identifying the first three stages which our school has accomplished. From what we have experienced, as well as what we have learned from other schools, it appears that the first stage can be thought of as "administrative convenience." Colleges and universities are attracted by the idea of a distinct organization for allied health sciences in that it provides greater ease of administration of several somewhat related, yet not coordinated, training and educational programs. There seemingly is some convenience for faculty and staff to better communicate with one another. Legislators or the money manipulators also seem to be interested in organizing a school or college, since they believe there is a potential for the conservation of monies. This initial stage, creating a school, college or perhaps a division of allied health, is not totally unlike the creation of a hospital or health-related institution (in the old days) which was for the convenience of the physician and the nurse rather than the patient or clients.

The second stage is an intensive investigation with possible "restructuring" to begin meeting two sets of educationally related needs: (1) those of the young health professional student, trainee or graduate and (2) those of the consumer of the health care delivery systems. An interdependent relationship between allied health and Regional Medical Programs can be vital to achieving the developmental tasks of this second stage. You who are of the community represent many kinds of thinking at the community level. In addition, you are the activists in transferring information from the isolation of the academic and clinical settings to the overall community setting. You are the facilitators, in many respects, of our movement into the community as a major base of operation. I am convinced that the allied health sciences are very rapidly moving away from a primary base of operation within hospitals and more toward health-related institutions and agencies within the community. On the other hand, we in the allied health sciences need Regional Medical Programs as a primary source of information to the shifts and "mid-course corrections" which are going on in the community, particularly as these relate to health care systems. We in the schools are so busy with the crises of the learner that we do not have the time, or at least we do not take the time, to detect and investigate these shifts. At best, we generally are able to lift a finger to check the windage from time to time. These kinds of unsophisticated data are not sufficient for us to make educated guesses or significant curriculum changes to reflect innovation and change within the community. Our great concern within the schools is to remain relevant, and this most obviously requires complex data of change. Regional Medical Programs can and are providing this kind of information. We must continue to study and alter our curricula in order for the graduate to enter his profession with the cognitive, psychomotor, and affective components of his learnings tuned up and ready to go. Our role in this process is greatly enhanced by the input we receive from Regional Medical Programs.

Perhaps an example would be helpful. Shortly after we opened our doors in July 1968, we realized there was a tiger's tail in our hands. We were not quite sure where he came from but we knew he was there. We created an associated health occupations program in cooperation with the Galveston Community College while we were putting the finishing touches on the professional school. We envisioned a series of paraprofessional, technical education programs at the two-year level which would move the student toward an associate degree and a certificate of proficiency. We built in many innovative features such as laddering and latticing through the identification of core bodies of knowledge and skills which all associated health personnel need to know and use. These core bodies became the freshman year course of study. The student, rather than the subject matter, became the center of the core. On the other hand, while we were developing this innovative program we were looking very closely at what we had accomplished in our planning for the professional school of allied health sciences which was designed for education at the baccalaureate level. We attempted to define a different kind of core body of knowledge. Yet, our first efforts resulted in failure due primarily to the professional biases of the various faculty in the disciplines. In time, we also realized we did not really know much about the core concept. After our brief experience, we restructured to provide a flexible core in the basic and clinical sciences such as anatomy, physiology, human development, clinical medicine, clinical psychiatry and medical terminology. This flexible core was examined in terms of students' needs, as well as the needs of the profession into which the student was moving. By changing course content from simple to complex we were able to transfer students in Medical Record Administration, Occupational Therapy and Physical Therapy in and out of these core courses with relative ease. For instance, in the course of medical terminology, we utilized a basic programmed text for all students. Additionally, some lectures were given to the entire group. Upon completion of the core material, students were split along disciplinary lines and proceeded to study terminology which was directly related to their disciplines.

Once we had accomplished these two kinds of core, we discovered another set of related problems: finding more effective ways to teach core materials to increasing numbers of students. We went to the Regional Medical Program of Texas and located a newly blossomed Ph.D., Dr. Robert Plunkett, who is the director of manpower training. We looked into his areas of expertise of modular learning, unit design, programmed materials and computor-assisted instruction. He helped us considerably in defining the parameters of our problem and located an individual who could help us collect the needed data for designing and implementing a series of learning modules. Dr. Michael Clark, a member of the Research and Development Center at The University of Texas in Austin, was brought in as a second consultant. Dr. Plunkett, Dr. Clark and members of our faculty now are in dialogue, and we believe we are well on our way toward

finding a solution to a very complex problem. Through this kind of input by Regional Medical Programs, we believe we can improve our ways of utilizing the core concept in allied health, as well as do a better job of cross-fertilization between and among the various allied health science students we have in our school. I share this set of circumstances to illustrate what we truly mean by interdependent innovation.

The third stage in the growth and development of a school of allied health seems to be an outreach on the part of the school. We perceive a commitment to facilitate the life-time of learning of all allied health workers regardless of level through continuing education. We would like to think there is something for everybody. If we have instilled a yearning for learning while the student is with us, we then should be able to have some services available to him upon graduation. We ought to be able to contribute to his future where he will spend the rest of his life. For the older worker, we hope we have some ways of assisting him in repairing his mistakes or retracing his steps along pathways which have become indistinct because of a growing of weeds along the right of way.

Regional Medical Programs and the allied health sciences have an interdependence. The school and Regional Medical Programs can attain and maintain continuous dialogue with workers through distinct professional societies at the local, state and national levels. By utilizing the already existing organizational structures of these associations and societies, objectives, learning experiences and evaluation of continuing education can be elicited. Too often the professional organization is neglected. They need to be brought into initial and ongoing phases of planning and implementation, as well as evaluation of continuing education. Regional Medical Programs have the concepts, structure and functions which can facilitate this process of continuing education in the allied health disciplines and, too, they have defined highly effective ways in which these disciplines can work more closely together.

A Question of Relevance

In order to assure that there is no closure to my remarks, may I share two sets of questions which help me in my daily developmental tasks in leading an educational program in allied health. For me, these questions have relevance to the kind of interdependent innovation I propose for Regional Medical Programs in allied health. The first kinds of questions are: "Who are you?"; "Who am I?"; "What is it we <u>are</u> together?"; "What is it we can <u>do</u> together?" These are helpful particularly when I am faced with assisting others in working more effectively within a group setting; our chief mode of operation in problem solving.

The second set of questions is helpful to me when I am faced with making evaluations about changing or instituting programs. "What are

the tasks?" (in other words, what is it we are to be working on?). "What are the assets?" (or what are the things which will help pull us through and will assist us in achieving the tasks?). "What are the liabilities?" (or what are the barriers and constraints which will hold us back from achieving the tasks?). Lastly, "What can I do with whatever skills I possess to facilitate the process of task solution?"

To give a sharp point to my remarks, I wish to share with you a brief yet highly significant quote from John W. Gardner, that articulate critic of American society today. In his book, No Easy Victories, Mr. Gardner says:

> "Everything about modern life seems to conspire against a sense of community, and as a result we have lost something that most of us need very much.
>
> "We need the stability that comes from a coherent community. We need the assurance of identity that comes from knowing and being known. We need the experience of a visible social context in which we fit. We need a sense of obligation to others. Perhaps more than anything else, we need a sense of participation."

Conclusion

Together, Regional Medical Programs and the allied health sciences are building a cathedral which is dedicated to the health and well-being of our citizens, as well as ourselves. This is in terms of our need to be of service to others. Most assuredly, together we are on the architectural staff. I suspect that most of the pieces for this cathedral are lying around waiting to be assembled.

Niches are being provided for those who are high priests among us, as well as those who see themselves as missionaries. We are even providing for the preachers who think of themselves as educators. There seems to be not much time for the construction of the cathedral. Change may well out-mode the structure and the function of the edifice. Yet this need not occur if our planning and construction is conjointly accomplished with due speed and far-sightedness.

On the other hand if the planning and building of this cathedral is not a joint endeavor and it fails to be realized, then there seem to be two alternatives open to us. We can rededicate the unfinished structure as a museum; sell tickets to those vigorous people who succeed us; and show them our quaint ways. Or we can convert the cathedral into an euphemistic outhouse where we can deposit unwanted things. At best, this might serve as fertilizer for whatever is yet to become.

THE REGIONAL MEDICAL PROGRAMS SERVICE VIEW

Veronica L. Conley, Ph.D.
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This Conference now in its closing days illustrates one of the strengths of Regional Medical Programs; namely, their capacity to bring together many different professions in such a way that they can collectively focus on ways and means to improve the health care system. This strength is an integral component of a Regional Medical Program which is successfully accomplishing its mandate of establishing cooperative arrangements among the Region's total health resources.

One of the major challenges to the 55 Regional Medical Programs may lie in the extent to which they can meet the priorities of the Department of Health, Education, and Welfare, relative to allied health manpower. Under their current legislative mandate, the priority to which they can address themselves most effectively is that of "improving the quality of existing health manpower."

The majority of Regional Medical Programs are already responding through their support of continuing education activities in promoting the continued competence of health practitioners. The Regional Medical Programs can not be expected to respond to the other major priorities of "increasing numbers of health personnel." This remains the mission of other Agencies: such as, the Bureau of Health Professions Education and Manpower Training, the Office of Education and the Department of Labor. While Regional Medical Programs have supported basic educational activities to some degree, the National Advisory Council has more recently judged such support, except in the case of innovative curricula and programs, as essentially inconsistent with the goals and purposes of Regional Medical Programs.

In considering the quality of existing personnel and approaches for their improvement, the phenomenon of obsolescence of knowledge is an all-persuasive one which greatly impedes improvement in patient care. Regional Medical Programs are in a particularly fortuitous

position to help correct this deficiency through continuing education. The legislation authorizing Regional Medical Programs is such that these programs, unlike most other Federal programs, can expend funds for long-range planning for continuing education activities. Such planning periods have allowed for thoughtful consideration of issues such as a broader concept of continuing education so that the goal reflects not only a translation of science into service, but represents a dynamic process involving itself at the same time in measurable improvements in patient care. A planning period allows for consideration of the newer educational concepts under experimentation in basic educational programs which may have similar applicability in continuing education activities.

After almost five years of experience, Regional Medical Programs' staffs have made several observations on the nature and quality of continuing education. They have noted that funds for planning and for relatively prolonged support have made it possible for continuing education activities to be truly continuing rather than "episodic." The staffs have discovered the general lack of prepared teachers in the field of continuing education and have encouraged critical review of the relevance of continuing education programs to the practitioner's everyday patient care needs. They have encouraged multiprofessional activities wherever possible and are attempting to provide educational opportunities for all levels of health workers -- supportive personnel as well as professionals.

In addition to their impact upon the obsolescence of knowledge and skills among health professionals, Regional Medical Programs can influence the current process of overfragmentation which is another impediment to improvements in the delivery of patient care. For example, the introduction of new health workers without careful planning can lead to a disorganized fragmentation of services. A Regional Medical Program which is structured so that good cooperative arrangements exist between the professional organizations, educational institutions and patient care facilities within its boundaries is in a position to serve as a coordinating body for manpower activities. Regional Medical Programs with true representation and involvement from among the health professions has the potential for promoting a "coalition of health professions." Under such circumstances, a climate is generated wherein the health professions can begin to look at their individual and collective functions and to study interrelationships. With facts in hand and with the understandings which such a process should create, a more systematic and sound approach can be adopted in the development of new health workers; in the definition of their functions; in their relationships with existing personnel; and in public acceptance of their practice.

The need for a coordinating focus for manpower, which will help reduce overfragmentation of health services, has been underscored recently by several major health organizations. The American Hospital Association recently authorized the formation of a Manpower Utilization Clearinghouse which will function largely through state hospital associations. The American Medical Association has authorized a government study of Manpower Utilization which will be conducted in conjunction with Federal agencies and with state and local medical societies. The American Association of Junior Colleges has called attention to fragmentation of the education of the providers of health services citing the example of at least one profession in which five different type institutions are involved in training without much contact or coordination between any of the five.

A coalition of health professions would also help modify professionalism which seems increasingly to be viewed as a process detrimental to constructive changes in the delivery system. In the past, professionalism was regarded as essentially a positive process in that it was an influence in the development and enforcement of high educational standards; in the support of licensure laws and in other measures to promote safe patient care practices. Yet, today the term has increasingly negative overtones. The process of professionalism is often cited as a factor in creating seemingly insurmountable barriers between the health professions and for rigidity even within the individual health professions themselves. The growing sensitivity to the influence of professionalism as an impediment to change was reflected in the fact that Dr. Roger O. Egeberg, in his first official speech as Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, digressed from his original text to chastize professional societies for their growing resemblance to medieval guilds. According to the New York Times report, when asked by a reporter whether he meant just medical societies, he replied that he meant medical societies, nursing societies and all others whose major interest is in protecting their prerogatives.

A major challenge to professionalism can be expected in the growing controversy over the licensure of health personnel. The introduction of new health workers and the need for some measure of assurance to the public of their safe practice is raising issues of licensure, certification and registration. Furthermore, the archaic and confusing nature of some existing professional practice Acts is precipitating action for change. For example, at a recent American Medical Association sponsored Symposium on Physician Support Personnel, one speaker in his plea for changes in licensure pointed out that the licensure of physicians in more than twenty states is governed by medical practice Acts which were enacted in years prior to the discovery of the telephone and have remained unchanged over

this long period of time. He also pointed out that in one state there are ten separate licensing laws for health personnel in addition to the Medical Practice Act. There is general agreement that only clear and collective thinking by all health professions will make it possible to bring about needed changes in licensure requirements.

In summary, a Regional Medical Program which is successful in creating a climate of cooperation and change among the health professions is in a position to meet the many challenges in the improved utilization of allied health personnel in the nation's health services delivery system. Such Regional Medical Programs will be in a position to make a major impact on three processes which are deterrents to improvements in the system -- the processes of obsolescence, professionalism, and overfragmentation of services.

TASK FORCES

Task Force # 1	Leader:	Edith V. Olson
	Recorder:	Irma J. Wilhelm
Task Force # 2	Leader:	Betty J. Dietrich
	Recorder:	Signe Eleanor Froberg
Task Force # 3	Leader:	Marie T. Del Guercio
	Recorder:	Claire G. Farrisey
Task Force # 4	Leader:	Loanna E. Biers
	Recorder:	Gilbert E. Smith, Ph.D.
Task Force # 5	Leader:	Edna Langholz
	Recorder:	Evangeline Hebbeler
Task Force # 6	Leader:	James R. Shaw, M.D.
	Recorder:	Rose Pinneo, R.N.
Task Force # 7	Leader:	Lydia Holley
	Recorder:	Harold E. Henninger
Task Force # 8	Leader:	Laura G. Larson
	Recorder:	Robert C. Ringe, Ph.D.
Task Force # 9	Leader:	Ruth H. Bryce
	Recorder:	Myrl Nygren
Task Force #10	Leader:	E.V. Simison, M.D.
	Recorders:	Louise Shores
		Margaret Sovie

TASK FORCE # 1

Basic Solution:

Interdependence is the ultimate requirement for optimal delivery of health services.

Regional Medical Programs, at the national, interregional and regional levels will promote the climate for quality human communication between consumers and providers, among professional individuals, and among organizations and institutions.

Thus, we achieve the human empathy so fundamental to successful programming.

Related Recommendations or Strategies:

1. Regional Medical Programs should encourage health care delivery projects and programs which will precipitate this communication process and thereby achieve local cooperation.

2. Regional Medical Programs should promote the interdisciplinary (including the consumers) approach in all appropriate activities -- i.e., continuing education, planning, evaluation.

3. Regional Medical Programs should support the development of a coalition of all health professions to communicate for the improvement of the health care delivery system.

4. Regional Medical Programs should have appropriate allied health representatives on review bodies, site survey teams, and advisory councils.

Problems Identified:

1. Gap between knowledge (of professionals and consumers) and its application to the delivery of health care.

2. Unequal distribution of health manpower and services.

3. Guaranteed provisions for continuity of care.

4. Poor communications between consumers and providers, individual professionals and organizations and institutions.

Barriers Identified:

1. Professional and public orientation to crisis care rather than to health maintenance and illness prevention.

2. "Hyperprofessionalism" -- professional vested interests and rigidities (individual, organizational and educational).

3. High costs of programs to provide problem solutions.

4. Legal barriers to health manpower mobility.

5. Varying levels of consumer expectations and priorities related to health care.

6. Inconsistencies in health care financing.

7. Proliferation of government and private health care programs and health occupations.

TASK FORCE # 2

Recommendations:

1. We recommend that Regional Medical Programs support and/or develop methods of broadening the scope and practice of existing health personnel and to support and assist in developing new health careers since they help to enhance the provision of health care to all peoples.

2. We recommend that Regional Medical Programs facilitate and encourage the development of incentives and/or methods to deploy the educated and/or trained health personnel into the areas of greatest need.

3. We recommend that all Regional Medical Programs develop a mechanism to implement Asilomar's recommendation No. 1, namely, "The Development of National and Regional Allied Health Advisory Councils."

4. We recommend that copies of the recommendations from this conference be transmitted to each Regional Medical Program Coordinator/Director within one month, if possible. We further suggest that he make a copy available to each of the Region's Advisory Committee members.

5. Recognizing that the attitudes and resources of family members often play a crucial part in the acceptance of health care planning and its utilization, we recommend that Regional Medical Programs promote projects and programs which improve the family unit's ability to participate in health care.

6. We recommend that this type of conference be held at least once each year.

In an attempt to decide on an approach to bring about some conclusions and recommendations, the group discussed problems, barriers and priorities of health care delivery.

SUMMARY OF PROBLEMS -- BARRIERS -- POSSIBLE SOLUTIONS

Problem 1: FUNDING SHORTAGES

Barriers

a. The variety of application forms for grants and other funds

b. Lack of knowledge regarding all available funds

c. Lack of knowledge as to who can apply for which funds

d. Too many funding groups.

Possible Solutions

a. Develop one or at least not as many different application forms

b. Develop a manual or some mechanism so that all Regional Medical Programs can be informed about the variety of funds and funding agencies available

c. More coordination of all funding groups.

Problem 2: REGIONAL BOUNDARIES DIFFER FOR VARIOUS ORGANIZATIONS/ AGENTS

Barriers

a. Legislative problems in administering or cooperating mechanisms

b. Some Regional Medical Programs' boundaries too large for the small staff.

Possible Solution

a. There needs to be special consideration to Comprehensive Health Planning and Regional Medical Programs boundaries, since they are working or should be working closely together.

Problem 3: INEQUITABLE DISTRIBUTION OF HEALTH PROVIDERS

Barriers

a. Lack of knowledge of available positions

b. The inability of a particular community to financially support a health provider or providers

c. Lack of knowledge of community needs as opposed to wants

d. Distances between consumer and provider.

Possible Solutions

a. More effective public relations

b. Financial support

c. Change methods now being used

d. Set up the community as a satellite to a larger one along with communications and transportation

e. Identify incentives needed and develop them.

Problem 4: IMPROPER UTILIZATION OF MANPOWER

Barriers

a. "Status quo" attitude

b. Lack of knowledge as to capabilities of a particular health provider

c. The present administrative structure in health agencies

d. Lack of willingness to share resources (mind power and personnel)

e. Lack of knowledge as to how to obtain provider's assistance.

Possible Solutions

a. Help appropriate people to become effective change agents

b. Provide funds for action research

c. Bring groups together to help them share ideas, problems, etc.

d. Provide expertise of staff

e. Improve public relations.

Problem 5: LACK OF ORDER AND LACK OF COHESIVENESS OF ALL PROVIDERS OF HEALTH CARE, ESPECIALLY AGENCIES

Barriers

a. Vested interests

b. Lack of knowledge of resources each agency possesses and can share.

Possible Solutions

a. Develop some authority at the state level, such as franchising or legislation of some kind

b. Bring groups together.

Problem 6: LACK OF KNOWLEDGE AS TO NEEDS OF CONSUMER

Barriers

a. Communicating with the consumer -- language, culture -- public relations are inadequate

b. Inadequate tools for determining needs or helping consumers determine needs as against wants.

Possible Solutions

a. Develop health councils

b. Obtain consumer participation and give them control

c. Allow consumer group or agency to determine who is to represent them.

TASK FORCE # 3

Problems in Delivery of Health Care:

1. The consumers (patients) are not aware of the function and purpose of Regional Medical Programs.

2. The consumers (patients) have difficulty in sorting out the myriad programs for health and planning. Many professionals have the same difficulty.

3. Many programs for the public are co-sponsored by Regional Medical Programs in conjunction with agencies. In this way, Regional Medical Programs loses its visability. Does it matter?

4. Consumers (patients) question the ability of providers (professionals) to deliver services which meet their wants.

   a. Consumers and providers are seeing things differently. Consumers speak to their "wants" and providers talk about their "needs" to deliver the kind of care they perceive the consumer requires. These perceptions may not coincide.

   b. Consumers (patients) are apt to say to Regional Medical Programs staff that Regional Medical Programs is not interested in "health"--they are interested in "disease."

   c. Consumers (patients) feel they have a social right to state what they want and they would like the financial backing to set the system of care delivery as they perceive it should be done.

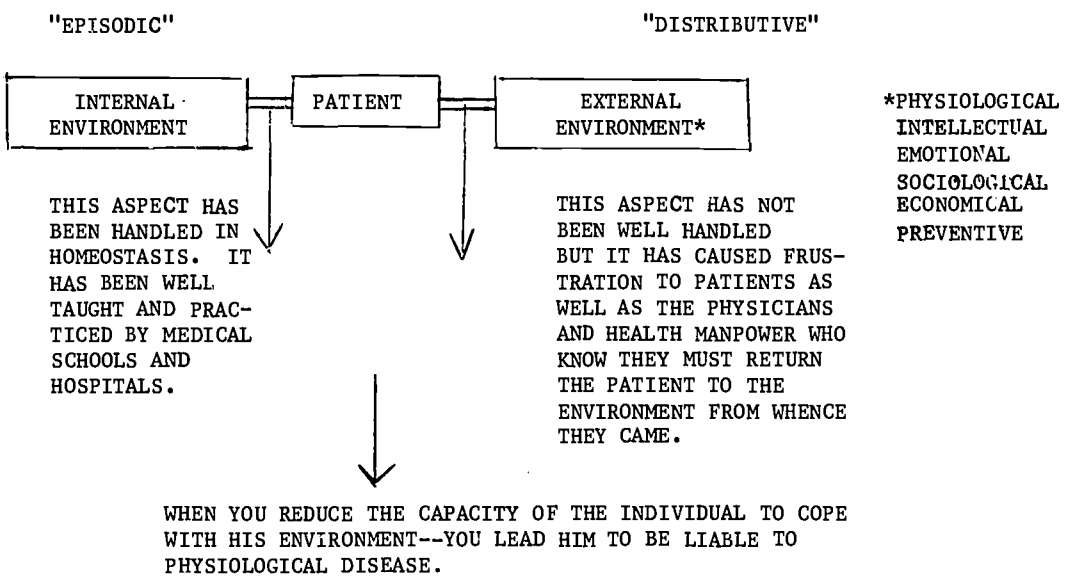
5. What is the expectation of the consumer and what is the expectation of the provider?

   a. For years the providers have been caring for the patient and his internal environment. Providers

have not been so successful in dealing with the patient's external environment.

b. Regional Medical Programs are dealing with disease entities (heart, cancer, stroke, etc.) whose causative factors are not well understood and whose care has not been achieved (to a large degree).

c. Diagram:



d. Who are the providers: who are the so-called professionals:

policeman	doctor
fireman	nurse
minister	Grandma Jones
midwife	social workers

e. What has happened to the consumer (patient) who <u>can</u> afford a private physician but who finds the doctors are so "busy" that they do not take the time to afford emotional support of their patients?

If this is so--how does the "clinic" patient feel? How do the "group medical practice" patients feel about the lack of emotional support?

6. Is Regional Medical Programs to concern itself with the "delivery of care" or is it to concern itself with the preparation of people who will deliver the care?

   a. Because Regional Medical Programs <u>is not sure</u> of its role--doesn't this cause a problem in development of philosophy and purpose for the regions?

   b. If we provide allied health manpower with continuing education to improve their skills, are we not perpetuating a basic system of the delivery of care which many of us consider to be imperfect?

   c. How clear are all the Regional Medical Programs regarding "quality" crisis vs. "quantity" crisis in health manpower?

      <u>Do we really concentrate on continuing education and new types of health manpower</u> or do we need to concentrate on the comprehensive approach to education, i.e., the following:

      (1) recruitment
      (2) guidance and redirection
      (3) formal education programs
      (4) refresher programs
      (5) continuing education
      (6) retraining
      (7) self-development
      (8) retaining employees

7. What is the relationship between the medical schools and their "affiliated" hospitals to say nothing of other non-affiliated hospitals? What is the role of Regional Medical Programs in this regard?

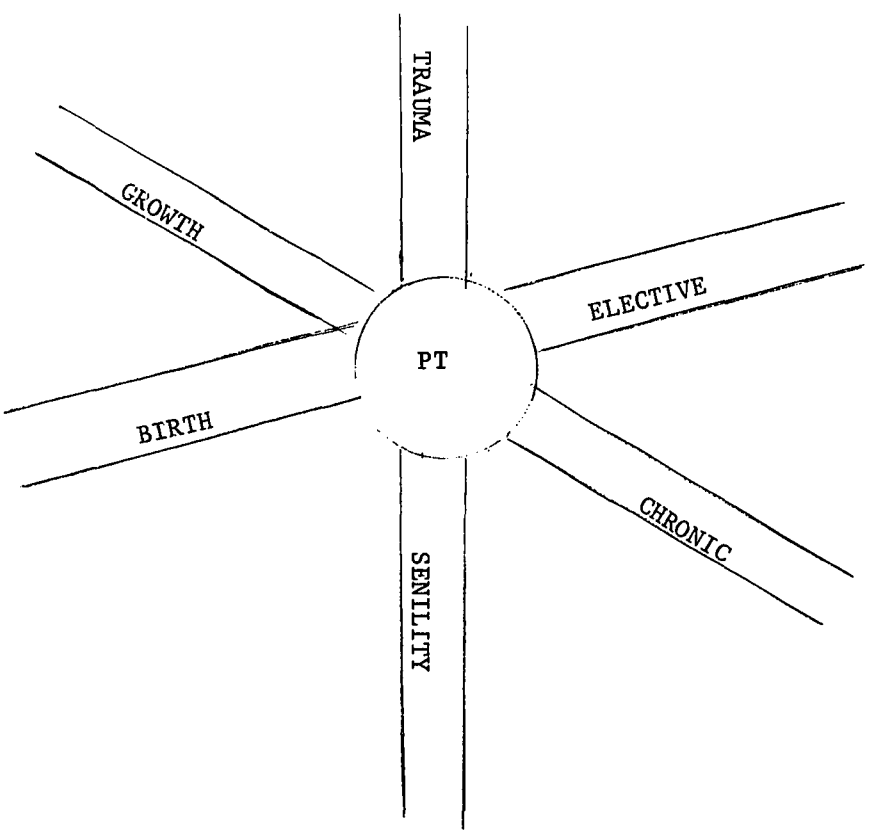
   a. The same problem exists with the relationship between the several schools of allied health manpower and their clinical facilities. Once again, what is the role of Regional Medical Programs?

8. How do you define the organization and make up of manpower for primary health care?

9. How do you describe primary health care?

   a. Some have described it as the care of the patient in a vertical position.

   b. Diagram:



Primary care depends on how you define the roles of physician and allied manpower and effective coordination of the spokes of the wheel.

Barriers to the Solution of Health Care Problems:

1. Separate education for separate health manpower (and occupations).

2. We do not educate our health manpower so that they can understand the fact that new models for the delivery of care must be accepted by them and they must achieve skill in working within them.

3. Parochialism of health manpower to recognize the health system as a sub-system. They must learn how to cope with the total environment in which "health" is only one sub-system.

4. Delivery of care is not only a health problem--nor only an economic problem! It is also a problem in community organization and planning. However, do the providers, facilitators, institutions, trustees, and reimbursers understand this fact?

5. How do we reach the decision makers--the Boards of Trustees, Chiefs of Medical Service, Chiefs of Nursing and Allied Services, and hospital or agency administrators?

   a. Do you gather masses of data and present it to them for problem planning, or

   b. Do you present these several disciplines with a specific problem and urge them to work out a practical solution (which frequently affects many aspects of the delivery of medical care)?

6. How do you get away from the original Regional Medical Programs idea that there was a body of knowledge in our academic and medical centers which should be taught to the staffs of smaller community centers?

   a. How are you sure that the academic and medical centers have a corner on knowledge?

   b. How can you be sure that you have "improved" medical and allied health manpower's performance in practice (in community hospitals)?

c. How do you get beyond the sphere of the doctor whose education has been "episodic" in nature--when you try to act as a change agent in program proposals and development?

7. How do you bring medical school deans and faculties to accept other models of curriculum and training which will not only help them understand the skills of the other health manpower---but make them comfortable in their teamwork with them?

Needed and Available Community Resources:

1. Do we not need to convene representatives from the systems of economics, law, politics, education, and consumer--to help us decide on how to solve the full spectrum of health manpower (recruitment through retraining)?

   a. Which group of representatives do we draw together?

   b. How do we work with them?

   c. What channels do we move through to solve our priority requirements?

2. If we say that the above questions are comprehensive health planning and not the province of Regional Medical Programs--how do we deal with the hospitals of our country where at least 50% of the medical care dollar goes?

   a. Should this approach not take a transdisciplinary approach involving trustees, administration, doctors, allied health manpower, consumer--to sort out how patients are admitted and cared for and how patients are discharged and followed?

3. Utilize all aspects of the communities' health agencies so that professional persons (providers) will learn what is available to help the patient. If the professional can't render the service, himself--he should know how to deliver the know-how of where to find the service.

Formulation of a Priority Listing of Health Care Problems Relevant to the Nature and Mission of Regional Medical Programs:

The group did not discuss priorities. It did discuss problems, barriers, and resources. However, at no time did the group address itself to priority listing.

Regional Medical Programs Strategies for Solution of Problems:

1. Sensitivity training for the providers so that they might be more aware of the wants of the consumer (patient) as well as to become cognizant of what people they should serve and how they should be served.

2. Don't be afraid to set your goals and aspirations beyond your hope for accomplishment.

3. Reach the decision-makers by a transdisciplinary approach to trustees, doctors, administrators, consumers and allied health manpower.

4. Behave as though we understand that until we use our current 60 billion dollars better than we are utilizing them - we may not receive more federal support.

   Why not more group practice? Why not other types of roles for health manpower? Why not reconstruct some of the physician and nurse practice acts as these roles change?

Recommendations:

In making the following recommendations, the members of this task force wish to emphasize the need to assure the durability and continuity of the implementation of the recommended actions:

A. Philosophy: it is recommended-

1. That everything which Regional Medical Programs does should be directed ultimately toward a single standard of health care.

2. That Regional Medical Programs be cognizant of the urgency of the needs of the sick poor.

3. That emphasis be placed on the consumers' need for better access to primary care.

B. Research and Development: it is recommended-

1. That research and development should be fostered in the area of experimentation with new models of the delivery of health services in a number of different settings, geographic locations, and with new types of health manpower.

2. That more imaginative use of allied health manpower be considered in the following areas:

   a. Neighborhood health centers

   b. Group practice

   c. Exploration with changes in delivery of emergency ward services (for example: the use of TRIAGE techniques).

   d. Experimenting with new approaches to pre-discharge planning.

   e. Greater utilization and increased development of co-ordinated home health agencies.

3. That we develop a relevant program for consumer education, utilizing persons who are indigenous to the neighborhoods for:

   a. Health education

   b. Education in health resources

   c. Supplying the providers with understanding of the consumers "wants" and/or needs.

C. Economic Aspects: it is recommended-

1. That the region be given assistance in tapping into other national, state, and local resources to accomplish its objectives and purposes.

2. That the regions should develop and experiment with more effective ways of utilizing existing financial resources in the development of new models for the delivery of health care as well as the education and retaining of the health manpower who will implement these services. (The private sector of financial support).

D. Education: it is recommended-

1. That Regional Medical Programs accelerate newer educational approaches regarding the curricula for all health manpower in both formal and informal programs.

2. That, simultaneously, Regional Medical Programs emphasize the need to conduct research and experiment in better utilization of the health manpower which we have presently in our ranks.

3. That, in addition, Regional Medical Programs should concern itself with the reorientation of present health manpower so that they may deliver the service in the new models and methods for the delivery of health care.

4. Regional Medical Programs should begin to educate the universities as to how to go about educating allied health professions.

5. The organizational system which the universities should adopt to train health manpower should be described.

TASK FORCE # 4

Strategies

Strategies by which Regional Medical Programs may exert positive influence in bringing about the resolution of problems and improved delivery of service were identified by Task Force #4 to be: the use of Core staff to plan and present broad educational programs at all levels, the use of Core staff to study manpower needs and stimulate other agencies to meet these needs, the use of Core staff to get funding from Regional Medical Programs and other sources to carry on recruitment programs and educational programs for all levels of health workers, the use of health workers at all levels in the planning process and in committees within Regional Medical Programs, and to actively seek affiliation and cooperative arrangements with all agencies concerned with health care delivery, particularly comprehensive health planning agencies.

Resolution:

Whereas Regional Medical Programs have achieved wider acceptance, cooperation and support by the health professions, hospitals, voluntary health agencies, medical schools, consumer groups, etc., than any other governmental health program, and,

Whereas Regional Medical Programs have gone far towards applying the knowledge of the medical center at the bedside of the patient with heart disease, cancer or stroke, and,

Whereas so much remains to be accomplished in these categorical titles, now therefore, be it

Resolved that Regional Medical Programs intensify their efforts towards reaching the goals so well delineated in PL 89-239.

Task Force #4 Recommends that Regional Medical Programs:

A. Encourage downward transfer of functions where possible.

B. Encourage development of educational programs enabling upward mobility of all health workers.

C. Stimulate, coordinate and fund programs of training and education for new and existing health workers.

D. Provide programs of continuing education for all levels of health workers.

E. Recognize the value of inputs from all levels of health workers dealing with PATIENTS, and assure their participation in planning for comprehensive health care.

Needed Resources:

1. equivalency exams
2. money to increase salaries
3. physician assistant's training programs
4. manpower
5. curriculum development
6. research in training needs
7. evaluation of training goals
8. mobility
9. flexibility
10. health education faculty members
11. tutorial education

Available Resources:

1. veteran medics
2. public acceptance of less training
3. junior colleges
4. vocational-technical schools
5. neighborhood health centers
6. work-study programs
7. volunteers
8. patients themselves
9. families of patients
10. inactive health personnel
11. handicapped persons
12. minority groups

Barriers:

1. licensing laws
2. practicing laws
3. fear of malpractice suits
4. traditions

Problems:

1. Entry and continuance in the health system.
2. Limited through physicians
3. Don't know how to affiliate with physicians.
4. Can't find physician to affiliate with.
5. Forced use of Emergency Rooms
6. Inadequate and misused emergency system
7. Inadequacy of Medicare and Medicaid
8. Lack of insurance
9. System does not provide what is needed.

Professional Education:

1. Improper evaluation of medical students in admission procedures
2. Over-training of professionals
3. Solo practice leads to professional obsolescence
4. Curriculums and specialization lead to congregation of professionals
5. Community health not emphasized
6. Fail to apply lessons of military training and delivery
7. Fail to use maximum skills of veteran medics
8. Assistants are too dependent
9. Nurse training tries to qualify for too many areas of care
10. Nurses misused

Consumer Education:

1. Public does not admit or respond to symptoms
2. Uneducated to care for own health
3. Educated to depend upon physicians only
4. Difficult to educate the poor
5. Patient decides what he needs
6. No continuing educational programs for consumers

Regional Medical Programs Mission:

1. Mission unclear; priorities undefined
2. Understanding of mission: emphasize quality care
   build with Comprehensive Health Planning
   emphasize cooperative arrangements
   stimulate and effect educational programs in educational institutions
   define manpower needs
   extend continuing education to all levels

Other:

1. Lower level personnel not involved in educational programs and actions
2. Allied health personnel are too dependent
3. Allied health personnel do not know how to supervise and consult with employees
4. Educational materials are not specific and are not written for lower level personnel
5. Regional Medical Programs limits and limitations are not known or well understood

TASK FORCE # 5

Participants of Task Force #5 preferred to look at one aspect of the delivery of health care within our present system, rather than discuss the broad ramifications of the assignment. It further agreed that with our combined expertise and time alloted, the group would zero in on definite recommendations and suggest ways in which the recommendations may be implemented, fully realizing these methods are not all-inclusive.

Recommendation Number 1

Develop better acceptance and utilization of allied health personnel by institutions, physicians, and Regional Medical Programs.

Recommendation Number 2

Provide a method in the system of health care services which will give consumers access to the unique expertise of individual disciplines such as dietitians, physical therapists and so forth.

The group was fully cognizant that there was no one way in which to implement these recommendations. The group saw the use of a combination of methods, while keeping in mind that the ultimate goal of all health professionals alludes to their belief and desire to improve health care and the delivery of the health care system.

Task Force #5 suggests the following methodology for implementation of recommendations:

1. Develop mechanisms which will facilitate communication and understanding among all members of the health care team -- that is, allied health, nurses, physicians, hospital administrators, and so forth.

a. Draw upon the body of knowledge from educators or any other resource about how adults learn and interrelate.

b. Use core curriculum and case study methods for multi-disciplinary continuing education programs. Encourage core curriculum for multidisciplinary approach in basic education.

2. Increase representation of allied health on advisory groups at all levels to insure equitable representation in decision-making processes as related to delivery of health services.

3. Regional Medical Programs' encouragement of family practice teams in the delivery of health care (definition of family practice team includes the multidisciplinary approach to delivering health care service).

4. Develop health care committees at the Regional Medical Program level.

   a. These committees should be multidisciplinary professional advisory bodies.

   b. These committees should relate to a definite population to answer how the delivery system within that population utilizes multidisciplinary manpower within a given community of solution to better delivery health care to that community. (Recommend this committee may want to look at or use patient flow studies, utilize Comprehensive Health Planning B-Agency data when available.)

   c. Relate all data and information to obvious health care needs in the community of solution.

   d. Correlate committees' findings and recommendations with project activities.

5. Involve consumer through education and participation in methodology for resolving problems as they relate to health care needs.

   a. Local health care forums.

   b. Involve all agencies and disciplines in a concerted effort to provide the public with information regarding how health care services are delivered through use of the multidisciplinary approach to patient care, including acute, ambulatory, chronic, and home care services.

6. Develop annotated State Directories of available health manpower resources by counties, and provide mechanisms for distribution of this to health care providers and related agencies.

7. Examine feasibility of using programmed medical records to improve patient care and define the roles of allied health personnel.

8. Develop information-sharing system within Regional Medical Programs from the national to the local level whereby all members of core and project staffs can:

   a. Share resources.

   b. Improve program strategies.

   c. Avoid duplication.

   d. Broaden perception of those in the decision-making positions.

9. Development of a publication (possibly nationally or at least regionally) which would be available to all Regional Medical Program persons and which is designed to improve communications between and among health professionals. For example, "Health Alliance," a publication produced quarterly by the Missouri Health Manpower Project.

10. Increased emphasis on continuing education to upgrade skills and knowledge of all health workers realizing that this term encompasses the entire health care team.

11. Where applicable, involve direct participation members of the various members of the health care team in planning and developing projects.

Therefore, if the expertise of any discipline is needed to carry out a project or the project involves a given discipline in any way, a member of this discipline should be directly involved in the planning process.

It is fully recognized that the suggested mechanisms for carrying out the recommendations of this task force are not listed in any order of priority -- rather, they reflect the group's thinking regarding a multiplicity of methods for implementing the recommendations. Again, we stress, these recommendations are made with full awareness of the present health care system and Regional Medical Programs' role in that system.

TASK FORCE # 6

Problems:

1. Health delivery systems focus on the cure of the ill rather than on comprehensive care.
2. Unequal distribution of health services.
3. Unequal access to the m ical care system.
4. Allied health personnel are in need of expanding continuing education opportunities.
5. Overlapping roles of health professions.
6. Ineffectiveness in the Regional Medical Programs in being an equal agent for change.

Barriers:

1. The term "allied health" implies second best.
2. Lack of continuing educational programs for allied health personnel.
3. Lack of interagency planning and evaluation of needs.
4. Unclear definition of the role of each health professional.
5. Educational barriers to career ladder concept.
6. Lack of orientation of the consumer about health care.
7. Economic restrictions, enforced by Regional Medical Programs, in implementing needed actions.
8. Basic health curriculum often excludes the relation of health personnel to community needs.

Strategies:

1. Establish dialogue among health professions regarding patient needs and how to meet them.

2. Promote continuing educational programs focused on patient care.

3. Increase participation of community agencies in Regional Medical Programs' planning.

4. Encourage dialogue regarding career ladder approach among institutions preparing health professionals.

5. Design methods for routinely informing Congressional representatives about Regional Medical Program activities and impact on the local level.

6. Include community approach in all health educational programs.

Recommendations:

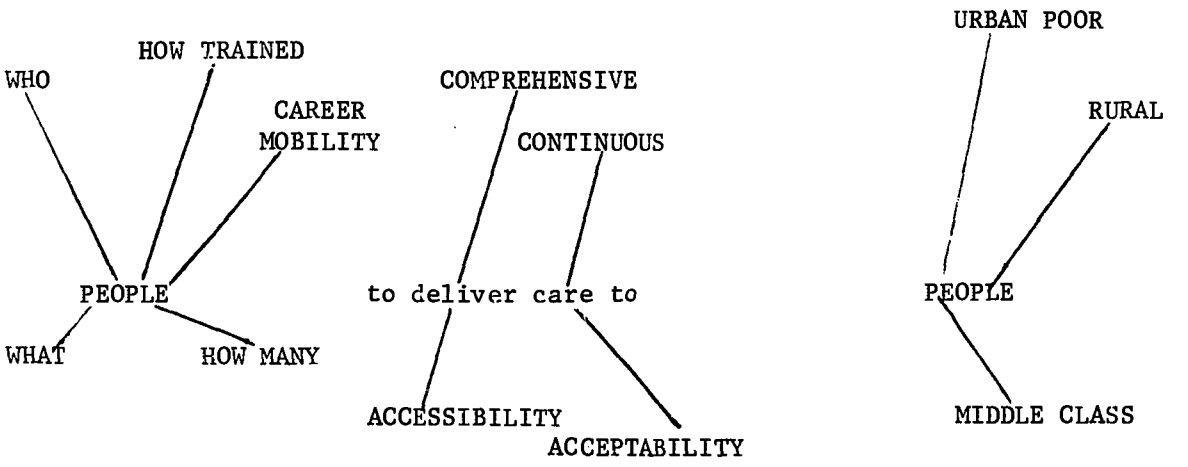
1. More equitable distribution of health professional representation at future conferences.

2. Encourage projects to demonstrate the team approach.

3. Become more involved in basic health educational programs as consultants (as in health care concepts, core curricula, etc.).

TASK FORCE # 7

A MODEL OF HEALTH DELIVERY



Issues in Delivery of Health Care:

1. Accessibility of care for all.
2. Continuity of care.
3. Acceptability of care.
4, Total health care for all.
5. Social mores.
6. Professional conservatism.
7. Detection of health problems.
8. Prevention

9. Facilities

10. Equipment

11. Duplication of services.

12. Organization of Health Care Delivery.

13. Identification of health problems.

Barriers to Solution of Health Care Problems:

1. Limited numbers of health manpower.

2. Improper utilization of manpower.

3. Limited knowledge of need in manpower area.

4. Limited ability to educate and train.

5. Limited opportunity for career advancement.

6. Geography.

7. Transportation.

8. Low income for certain members of health team.

9. Unwillingness to change the system.

10. Medical schools.

11. Other professional schools.

12. Licensure and certification.

13. Fear of liability.

14. Child care facilities for working mothers.

Needed and Available Community Resources:

1. Basic Education

   a. medical schools and other professional schools

   b. colleges and universities

   c. vocational tech

d. high schools

e. hospitals

2. Consultant Services

a. professional groups

b. educational and training institutions

c. practitioners

d. systems analysts

3. Continuing Education

a. hospitals

b. societies

c. educational institutions

d. voluntary agencies

e. commercial groups

4. Manpower

a. veterans

b. unemployed professionals

c. disadvantaged groups

5. Guidance and Counseling Services

Regional Medical Programs Priorities:

1. Development and utilization of manpower.

2. Development and/or improvement of the delivery system.

3. Continue continuing education efforts.

Regional Medical Programs Strategies:

1. Initiate problem-centered discussion between health groups.

2. Consider epidemiological and sociological data in the evolution of the health care system.

3. Develop systems for multidisciplinary continuing education.

4. Discover new types of occupations for health education and delivery of services.

5. Encourage schools to increase health education in grades K - 12.

Recommendations:

1. That Regional Medical Programs promote the development and utilization of new or expanded allied health occupations and to promote the improved utilization of existing personnel.

2. That Regional Medical Programs make funds available to improve and change current patterns of our health care delivery system.

3. That Regional Medical Programs provide information to Federal, state and local legislative bodies about needs for basic education of allied health occupations and thereby stimulate additional funds for the development of new and/or enlargement of existing basic educational programs. This is focusing on role of Regional Medical Programs as a stimulator, catalyst, identifier of needs, rather than the source of funds.

4. That Regional Medical Programs increase the participation of health care recipients at all levels of activity -- planning, review, administration and operational.

5. That the review process at the national and regional levels take greater cognizance of regional differences in needs and activities.

6. That Regional Medical Programs promptly transmit comments on review and approval action to the regions.

7. That Regional Medical Programs make available current information about new and evolving health occupations, i.e., education, qualifications and utilization.

TASK FORCE # 8

The initial reaction to the Task Force Assignment, namely, to answer six general questions, was that the questions were too broad and represent the routine kinds of questions asked in a conference such as this. However, the group did feel that the questions were intended to be suggestive of the kinds of issues with which we should be concerned. It was felt that each question would stimulate a discussion of many of the other questions on the list.

Before considering the general task force questions, the group proposed two questions with which allied health personnel should be concerned. The questions were:

1. What can we, as allied health personnel, do to improve the quality of health care?

2. And, what is the future of allied health in Regional Medical Programs?

With respect to improving the quality of health care, it was pointed out that four major innovations in the delivery of health care give rise to the conclusion that allied health personnel are making contributions. Allied Health professionals are:

1. Increasing the level of sophistication about patient services (e.g. multiphasic screening).

2. Working with increased freedom in satellite hospitals.

3. Participating in the development of community health centers.

4. Providing increased home health care services.

Group 8 next considered the question of improved utilization of health manpower. It was felt that the physician is the key to better utilization and, if this is true, then increased emphasis needs to be given to his continuing education. In other words, if the physician is to improve utilization then he must be aware of efficient and

innovative methods for the administration of the health team. While the physician may sometimes be viewed as a barrier to improved utilization, there are other barriers such as:

1. Legislation

2. Legal issues

3. Certification

4. Differing perceptions of role dimensions.

It was felt that the development of new medical and allied schools would increase health manpower. It was also recognized that increasing the efficiency of all health professionals would produce essentially the same manpower result. While greater utilization of allied health personnel should improve health care delivery, it should not be concluded that improved utilization is the only mechanism available for accomplishing this goal. For example, biomedical engineering has produced technologic advances which have ultimately improved patient care.

As the group wrestled with trying to separate "problems" from "barriers," it was felt that they are one and the same and that separation of the two is impossible. The following constitutes the list of "problems-barriers" identified by Group 8:

1. There is a lack of continuity in the delivery of health care. A disparity exists among disease prevention, disease diagnosis and treatment, rehabilitation, and long-term health care maintenance. Perhaps most critical has been the limited amount of attention paid to disease prevention.

2. Because we have been able to perfect the delivery of health care services faster than we have been able to distribute them, an inequality of health service delivery has resulted.

3. Coupled with the problem of an inability to distribute is the problem of our inability to apply new knowledge. Either new knowledge and/or health data have not been utilized in planning, or there has been a duplication in the production of health knowledge and/or data.

4. Another problem in the delivery of health care is the lack of communication which has existed among health providers and between providers and consumers. For example, one can easily see why communication cannot effectively take place between providers and consumers when it is not even possible for health providers to agree upon common terminology. If confusion abounds over elementary terminology (e.g. "medical

care" versus "health care"), is it any wonder that there is an exponential increase in the amount of confusion over meanings?

5. With respect to the problem of the inequality which exists in the distribution of health manpower, it was felt that often times there is a lack of educational, cultural, and health benefits made available for both the provider and his family. In other words, if rural or inner-city areas are going to be effective in attracting health manpower, attention must be paid to increasing the appeal and attractiveness of these areas.

6. Often the weight of tradition and vested interests prohibit change from taking place. Very simply, one of the problems in the delivery of health care is the desire on the part of many in the health community to preserve the status quo.

7. In the past, more attention has been paid by various government agencies, including Regional Medical Programs, to setting priorities using a research-model approach rather than a planning-model approach. The research-model approach includes:

   a. Waiting for an idea to develop

   b. Formulating the idea into a proposal

   c. Making the proposal available, among others, to a review body

   d. And, then having the proposal ranked ordered in relation to others

   In contrast, the planning-model approach includes:

   a. Looking at the whole spectrum of health problems in a given region and/or area

   b. Establishing priorities among regional and/or area problems

   c. Actively encouraging the development of projects and/or programs which are consistent with already established priorities.

   The research-model approach, which is a reactive process, will continue as long as project funds reward this system. Until a premium is placed on the planning-model, change will not take place.

Needed and Available Community Resources:

1. Colleges and universities have not been tapped to the fullest potential for providing and developing allied health training programs.

2. Similarly, two-year community colleges offer a previously untapped potential.

3. The elementary-secondary educational system has been frequently overlooked as a resource for future manpower development. Earlier contact with school-age children for purposes of health careers recruitment seems warrented.

4. Business and industry offer the potential of providing the health system with effective principles of industrial management to solve health problems. Increased application of these principles suggests that changes might be made in the areas of cost effectiveness, quality control, central purchasing, etc.

Health Care Problems Relevant to Regional Medical Programs:

1. Organizationally, we are faced with the problem of centralization vs. decentralization. Similarly, this is compounded when one considers national Regional Medical Program goals in relation to regional goals.

2. The lack of funds in Regional Medical Programs is a health care problem. With limited funds available for projects, at this critical time, core staffs are faced with the problem of having their credibility challenged. Having once been able to "deliver," and not being able to do so now, disenchantment has affected the morale, and ultimately, the credibility of core staff members.

   Lack of funds has also made it difficult to recruit "core" staff. When prospective staff members are informed about the funds with which they must work, some reconsider Regional Medical Program affiliation.

Regional Medical Program Strategies for Solution of Problems:

1. Increased utilization needs to be made of the planning-model approach to problem-solving.

2. We need to continually remind ourselves of the "neutral" position from which we operate, thus permitting continued efforts to fulfill a catalytic role.

3. Another strategy might be that of trying to influence previously unrecognized "influentials" in the health care decision-making process (e.g. wives of physicians).

4. It might be necessary for us to recognize that certain, previous educational approaches (undergraduate, graduate, and continuing education) may no longer be useful or salvageable. Instead, new methods may have to be formulated.

5. There needs to be increased planning together by those who eventually will work and learn together.

Recommendations:

Three recommendations developed out of the deliberations of Task Force #8. These included one national recommendation and two regional-local recommendations. All of the recommendations address themselves to the need for improved planning as an active process in developing a systems approach to health care:

National

> Local and regional strategies need to be given greater consideration by the National Advisory Council of Regional Medical Programs. For example, innovative approaches to manpower development systems need to be given as much emphasis as innovative manpower occupations.

Regional-Local

> Health professionals who work together, should learn and plan together. In other words, the concept of a working health team appears to have increased validity in today's health care system. In a world of increased specialization, the team approach will ensure better personal relations with patients.
>
> Allied health professionals should include increased consumer input into the planning and design of health services. If we genuinely believe in the notion that the consumer has a valuable stake in his own health care, then he must be included in the planning process.

TASK FORCE # 9

Problems:

1. The capabilities of the Allied Health professions have not been suited to the need.

2. There is a maldistribution of capabilities. There is a need for better distribution and utilization of manpower.

3. We must determine how to increase production of manpower.

4. There is a lack of national strategy for mobilization and distribution of our health manpower resources.

5. There is a need to get everyone in the Allied Health Fields working together to solve the health care problems.

6. There is a need to provide continuity of medical care.

7. There is a need to get people to use health care services. People can't get into the system.

8. Red tape in funding tends to encourage fragmented health care projects, rather than projects based on basic health needs, because it tends to encourage innovative concepts just to qualify for funds.

9. There is a need to resolve what is meant by Allied Health; to redefine roles and delineate responsibility.

Barriers:

1. Ignorance of the consumer of what health care services are available.

2. Apathy of the consumer as to how to use health care services available.

Strategies:

1. There must be an inter-dependence of the health disciplines; a cohesive planning of medical care and medical training.

   a. Professionals must be made aware of other professionals, of what their services and responsibilities are and to define their purpose for being.

   b. We must provide an intense, complete educational system at the basic level to educate professionals toward use of other professionals and towards working with each other.

2. Must involve consumer in deciding what his health care needs are and develop an educational system that will help provide this. Tailor the health care system to meet the needs of the people.

3. Get more production

   a. Get people to produce more.

   b. Get more people to produce.

   c. Use more types of health training.

4. Attack problems at the community level.

   a. Involve people at the community level with training.

   b. Train people and provide with financial support during training.

   c. Provide continuing education.

5. Change the system of health care to get the right people tending the right problem with education of the consumer to make him aware that other professionals in the health care fields can give help beside the physician.

6. Get health care to the patient at a cost he can afford.

7. Provide cost benefit alternative solutions to the consumer through project activity, pilot programs, data gathering and interview to determine his needs.

8. Determine what capabilities we need to increase; increase capabilities through continuing education.

9. Develop professional cooperative arrangements among professional groups.

10. Concentrate on constancy of funding.

11. Improve communications among various government agencies to acquaint each other with what is being done.

12. Build on successful continuing education programs of Regional Medical Programs by developing more effective continuing education programs and making them accessible.

13. Improve quality care by developing and supporting continuing education programs for licensure and thus encourage and support relicensing.

14. The Regional Medical Programs policy group should re-look at how innovative approaches have solved medical care problems, refine those approaches and insist on more precise evaluation of the solutions.

Recommendations of Task Force #9:

1. That Regional Medical Programs act in a coordinating relationship with various government and voluntary agencies in using community needs as a basis for defining the need for and utilization of manpower in health care services.

2. That for maximum effectiveness for its programs for action, Regional Medical Programs should collaborate meaningfully with other agencies involved in health planning and assume the responsibility of taking appropriate action.

3. That Regional Medical Programs direct increasing attention to the preventive aspects of illness through cooperative and collaborative arrangements with other relevant organizations and services.

4. That Regional Medical Programs encourage development of interdisciplinary continuing education to enable health care providers to function more effectively as a team in the delivery of health services.

5. That Regional Medical Programs work toward the organizing and mobilizing of all community resources toward continuity of health care.

TASK FORCE # 10

The task force focused on the development of strategies by which Regional Medical Programs may exert positive influence in bringing about the resolution of problems and improved delivery of services.

1. Alternative Solutions Re: Manpower: Cultural, social, ethnic and racial heritage are essential ingredients to be considered in both provider and consumer populations as one considers manpower needs in today's health delivery and tomorrow's improved system. Junior, community, and technical colleges and schools are capable of providing 85% of provider population. New educational forms and certifications can and must be created to increase the population of providers. Flexible and broader entrance requirements, new advancement patterns, both lateral and horizontal, and career mobility schemes should be devised, implemented, accepted and utilized in the area of manpower.

   The essential end is that quality patient care be delivered to all with the dignity of each individual demonstrated in every interaction and action component of the system.

   Educational patterns should have no mandated end point or termination. The individual entering the educational community should be able to enter, exit and reenter without pejorative results.

   The provider population as represented here in the conference, must look within itself to "clean up its own house" and "remove barriers and solve problems of its own making." Actions speak louder than words and the action model should be "Do what I do, since I do what I say."

   Regional Medical Programs, each according to its own area needs, must help conceptualize models of manpower

preparation and utilization. One recommendation is that each Regional Medical Program have a Council of Health Manpower, which includes, but is not limited to representatives of the following groups:

a. Consumer - one who reflects the point of view of a significant number of persons who will be recipients of programs in the area where policy decision will have the greatest impact.

b. Public and private educational agencies and institutions (policy makers).

c. Producers of manpower (program developers, teachers, etc.).

d. Potential Funding Groups (foundations, philanthropists, industry, Federal programs, etc.).

e. Employers of health manpower (hospitals, clinics, etc.).

f. Health Occupations and Professions.

It is suggested that these Councils of Health Manpower might begin with a consideration of the problems, barriers as identified in the area of manpower by the Second National Health Conference.

We urgently request that these recommendations be communicated to regional coordinators and Regional Advisory Groups and that they be encouraged to consider this Council of Health Manpower and its charges as a high priority area in solving the regional health problems.

We also urge Regional Medical Programs to develop a coordinated national policy statement which interrelates with other appropriate federal manpower agencies, e.g., Health, Education, and Welfare, Department of Labor, so that a concerted directional force will be viable nationally. Specific roles and priorities for Regional Medical Programs in the area of health manpower should be identified.

In addition, Regional Medical Programs should assume the responsibility of promoting and providing interregional feed-back to all regions, as it relates to the implementation of recommendations or problems studied at this conference.

2. Avenues for Entry into Personalized Health Care and

3. A New Community Institution for Health.

The group felt that these two situational areas should be approached as one since the creation of a new Community Institution for Health will intentionally create new or newly recognized avenues for entry into the system.

This Community Institution for Health would have a coordinated focus on all aspects of health care - primary, secondary and tertiary. It includes a community of consumers, physicians, service and education facilities of all types, third party payment agencies, satellite centers, etc.

In large areas there may be multiple consortiums serving geographical areas.

In this system, the needs of the well population as well as the sick population would be in the target area.

This new system will be a new blend of the public and private providers of health services for the entire population in a given geographical area. Health care would be delivered in a different sense than the episodic mode currently practiced.

Community developed systems must be designed and implemented with careful evaluation for use as possible models for adoption.

Regional Medical Programs should cooperate with other federal and local agencies in realizing this concept. It may be advisable to designate this responsibility to a Regional Medical Program staff member whose primary role is one of coordination and facilitation, if this concept is accepted by the individual Regional Medical Program as one of its priorities.

Eventually it may be necessary to designate legal authority to these new community patterns for health delivery.

4. Communications

Effective communications are essential in every area of problem-solving in health delivery. The solution of

each of the preceding problems are thus dependent on recognition and attention to overcoming communication barriers.

It may be helpful to add a communications council and/or staff member responsible for developing new channels of communication or better ways to use existing channels between consumer and provider groups, community organizations, Regional Medical Programs activities, etc.

It was recommended that Regional Medical Programs improve its capability to reach the consumer with information about Regional Medical Programs functions and to increase the dialogue between the health providers and consumers groups.

The Task Force concluded its considerations of communications with the warning "Caution: Poor Communication is hazardous to your health delivery system."

5. Cost

Consideration of the problems and barriers related to cost was tabled for consideration at the Third National Conference on Allied Health.

6. Finally, the task force recommends that the proceedings of this Second National Conference be made available to all interested groups within 30 - 60 days following the conference.

SPECIAL INTEREST GROUPS

Integrating Community Resources for Comprehensive Health Planning II
Chairmen--Dorothy E. Anderson
T. F. Zimmerman, Ph.D.

Physician Support Personnel-Physician Assistant and Nurse Practitioner II
Chairmen--Rose Heifetz
Ralph Kuhli

New Health Occupations
Chairman--Israel Light, Ed.D.

Regional Medical Programs' Program Evaluation Models
Chairman--Phyllis Higley

Developing Multiprofessional Educational Programs II
Chairmen--Marian E. Leach, Ph.D.
William Stucker

INTEGRATING COMMUNITY RESOURCES FOR
COMPREHENSIVE HEALTH PLANNING

This session was devoted mainly to discussions of experiences in planning related either directly or indirectly to Regional Medical Programs.

1. Two years ago in Texas, a school of Allied Health Sciences was established with a model first year core curriculum. The second year included clinical work in seven technical programs. The students were urban dwellers with a background of academic failure who had decided against the career choice of nursing. Graduates have been utilized in the Galveston area in community and branch hospitals of the University of Texas. The program has not yet extended to other Texas Junior Colleges.

2. A Health Survey conducted in East Los Angeles resulted in the development of a Health Center to provide primary medical care. The Regional Medical Program provided seed money for the survey, leadership consultation in establishing the center, and secretarial assistance. An outcome of this activity was the appointment of an advisor from the minority group to the State Department of Health, Education, and Welfare.

3. Several Regional Medical Programs described their involvement or lack of such with Comprehensive Health Planning, e.g., the South Dakota portion of the Nebraska-South Dakota Regional Medical Program is actively involved in area health planning. Susquehanna Valley Regional Medical Program has no active involvement with Comprehensive Health Planning.

4. Mountain States Regional Medical Program reports that in Montana a Medical Education and Research Foundation was established which encourages sharing of inservice education activities between large and small hospitals. There is no medical school in this state.

5. Florida Regional Medical Program reported on the use of Directors of Medical Education for inservice education with the emphasis on a multidisciplinary approach.

6. The Illinois Regional Medical Program reports that a Community Health Council has been developed in Chicago.

In summary, the group concensus was that Regional Medical Programs are mature enough to realize the need for community involvement. The group further concluded that the most direct route to such involvement is through the use of allied health professionals.

PHYSICIAN SUPPORT PERSONNEL-
PHYSICIAN ASSISTANT AND NURSE PRACTITIONER

Mr. Ralph Kuhli opened the discussion with a description of the nature and length of the medical curriculum. He touched upon the various kinds of nursing programs now offered and reviewed the training and experience required of military corpsmen. He described the Physician Assistant Program at Duke University and the Medex Course at the University of Washington. In this discussion, he distinguished between formal and informal education.

He made it clear that the concept of physician's assistants had been enthusiastically accepted by physicians who realized that they would be responsible for the activities performed by this group of health workers. Mr. Kuhli pointed out that as long as the physician's assistant worked under the direction and supervision of a physician, licensure was not required. It was only when a health professional intends to practice independently that a license is essential.

Mrs. Rose Heifetz briefly described a plan in New York City for using these categories of health workers. A conference was sponsored by the New York Metropolitan Regional Medical Program to discuss resources and guidelines for those who were contemplating expanding the role of the nurse.

A lively discussion ensued in which many views were expressed, and numerous aspects of the "new" activities touched upon.

The evening closed with two appropriate presentations. A nurse educator stressed the value of sitting down with those concerned with these issues to solve the problems together through deeper understanding and the promotion of common interests for patient care.

A physician put the issues in historical perspective and called for collaborative efforts in charting the course we will need to follow in providing better medical care for more people.

NEW HEALTH OCCUPATIONS

The group, though only nine in number, was vocal in discussion. Health, Education, and Welfare's planning and program emphases give the highest priority to manpower development, specifically to Family Physicians and Allied Health Professionals and Personnel. Among the strategies to be given high priority are two of particular interest: (1) substitute less skilled for highly skilled personnel wherever possible; and, (2) assure physicians in training an opportunity to learn how to work effectively with allied health personnel. Therefore, "Regional Medical Programs are in the ballpark and in the ballgame."

A list of six questions were provided to serve as a springboard for discussion:*

1. What kinds of new health occupations do we need?

2. What is the relation between new health occupations and the health team concept?

3. How do we go about assuring educational mobility, advanced standing, and occupational mobility for new health occupations specialists?

4. Are we obligated to confine ourselves to the consideration of new health occupations that are direct-patient-care-oriented in terms of heart, cancer, and stroke?

5. Do Regional Medical Programs' legislation and Guidelines actually permit the development of new health occupations?

6. What evidence can we produce or how can we measure the value of creating any new health occupation?

*Light, Israel - "Development and Growth of Allied Health Field," JAMA, October 1969

Many concerns were shared -- concerns which have been identified and discussed time and again over the past months -- even years:

1. How do we eliminate some of the barriers to the preparation and proper utilization of health workers?

   a. Traditional, and often, rigid requirements of certification, licensure, etc.

   b. Vested interests of professionals which adversely effect acceptance of allied health personnel.

   c. Inadequately qualified personnel to administer and teach in preparatory and continuing education programs.

   d. Limited financial resources for the development and implementation of programs.

2. How can we affect attitudes and procedures which will allow for career mobility within a health field and across health fields?

   a. Core for modular unit content

   b. Ladder and lattice concepts

   c. Articulation of the several levels of preparation for health workers.

3. What are appropriate curriculum length and content to adequately prepare for a specific role?

   a. Skills and techniques only?

   b. General education -- how much?

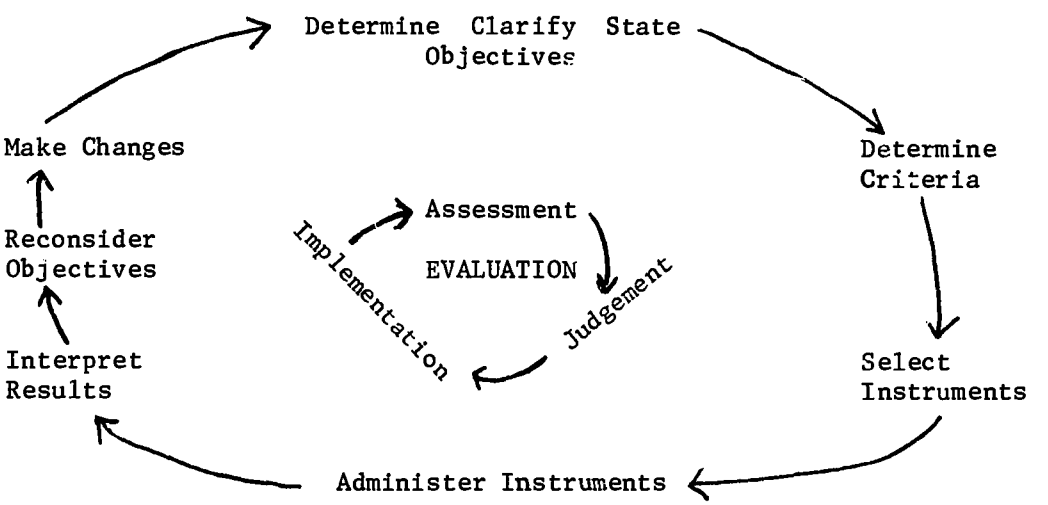
   c. Based on hours in class or as measured by behavioral outcomes?

While recognizing that new health occupations continue to emerge, the group felt there is great merit in first determining whether modification, integration or combination of roles of those already prepared can meet the need or whether; in fact, a need has been identified for a truly new role with its tasks clearly identified.

With expressions of their tiring of platitudes related to oft-identified constraining barriers, some of the participants were vocal about their hope that the Regional Medical Programs through concerted efforts would provide the leadership needed to spearhead attempts to alleviate them.

REGIONAL MEDICAL PROGRAMS' PROGRAM EVALUATION MODELS

The Group Leader introduced the session with a few remarks relative to evaluation. She stressed that evaluation must be an integral part of the planning process, but reminded the participants that evaluation is a difficult concept to sell; that the writing of behavioral objectives requires training and skill; and that the development of valid and reliable test items is difficult. The Group Leader presented the following diagram so that the group would have the same basic terminology and frame of reference:



The following questions were developed by the group as a focus for discussion:

1. Does one evaluate individual projects, the entire Regional Medical Program, or both? In relation to specific projects, the question raised was, "How does a coronary care training program really change the care of coronary patients?"

2. If one has a goal of developing strategic relationships between medical centers and outer communities, then how does one use behavioral objectives for a specific training project?

3. Are there passing or failing criteria for training programs? (Many Regions' representatives said "Yes")

4. Are there criteria for admission to training programs? (Many of the Regions' representatives said "Yes")

5. Is self-evaluation used as a measure? (Most answered "Yes)

6. Can we really use improved patient care as a criterion Can it be measured? Do we know what is good care?

7. How does one measure regionalization? (Very difficult--much political influence)

The discussion concerned itself primarily with examples from the various Regional Medical Programs using coronary care training programs as models. The following two major points were made during the discussions:

1. Evaluation is not well understood either in Regional Medical Programs Service or in the individual Regional Medical Programs.

2. There are various levels of evaluation such as the use of testing; observations of behavior; and changes in patient care.

IMPORTANT RECOMMENDATIONS:

Short term workshops should be sponsored by the Regional Medical Programs Service to assess area of evaluation and to help implement the evaluation of effectiveness of regional projects. These workshops might be held on the East and West Coasts as well as in the Mid-West.

DEVELOPING MULTIPROFESSIONAL EDUCATIONAL PROGRAMS - I

In answer to the question of the development of training opportunities for more than one health occupation, the following examples were presented:

New Jersey Regional Medical Program is working with six hospitals in two counties where it has designed a multidisciplinary program in stroke care for nurses, physicians, physical therapists, nutritionists, etc. The didactic portion of the training is separate for each discipline, but clinical experiences are shared. Acute care facilities in one hospital and rehabilitation facilities in another hospital are shared.

New Jersey Regional Medical Program has also developed a program for physicians and nurses in the care of the cancer patient with the use of $2500 seed money from core. Inservice nursing educators from five hospitals will learn about cancer care and then teach it to nurses at their home hospital. As a result, physicians have requested continuing education in cancer care for themselves. A Philadelphia hospital, which specializes in cancer care and had been training only physicians, has been approached by New Jersey Regional Medical Program and has agreed to include the training of nurses from the southern part of New Jersey.

Metropolitan District of Columbia Regional Medical Program has held a series of workshops to plan for comprehensive stroke care in that region. Workshop participants have included all disciplines involved in stroke care. The workshops resulted from a District of Columbia Regional Medical Program award of $50,000 for planning in the care of the stroke patient.

The Virginia Regional Medical Program has developed a multidisciplinary stroke committee which has elected the case conference approach to continuing education. At the first session, a movie will be shown and a patient will be presented. The various disciplines represented will then discuss their various roles in patient care of the stroke patient.

Work Evaluation Units, sponsored by American Heart Association, involve a multidisciplinary approach. The purpose of these units is

education, not service. Anyone interested in this multidisciplinary approach for cardiac patients can refer to the Directory of Work Evaluation Units.

University of Florida has a core curriculum for medical, dentistry and allied health personnel for the first year. Areas of common experience are background information in the medical care system, learning of community resources, some anatomy and physiology and medical terminology.

Allied Health Professions Project at University of the County of Los Angeles, funded by Office of Education, links junior colleges, health care institutions and medical schools. The objectives are: (1) to examine particular tasks needed to carry out specific functions; (2) to look at health professionals who carry out these tasks; (3) to look for a central resource to carry out the core part of training; (4) to find out what educational levels are required to perform the different functions. They are now looking at functions in nursing.

The Florida Regional Medical Program is exploring stroke problems. Many physicians seem unaware of the abilities of physical therapists, occupational therapists, when to prescribe, when to stop treatment.

In Florida, Easter Seal brings in professional teams, patients and families to learn together in a special summer camp for the handicapped. The problem is that the same people come back.

In Florida, radiologists, x-ray technicians and nuclear medical technologists meet regularly to examine film exposures and learn from each other. This is not associated with Regional Medical Programs but is, nevertheless, a good example of professionals learning together.

The Washington/Alaska Regional Medical Program is planning for renal dialysis training for multidisciplinary groups.

At Mt. Zion Hospital, San Francisco, a Home Care Training Program Staff member assesses home situation and decides which service is needed. Services are then developed by the team.

The West Virginia Regional Medical Program suggested that a demonstration could be made at State and National Society Meetings of how physical therapists, physicians and other professionals can work together. The first task may be to change attitudes.

Suggestions for Regional Medical Programs Service:

1. Communication system of letting others know examples of what is happening in other regions.

2. Conference for Regional Medical Programs' Coordinators on allied health. Encourage Coordinators to attend Allied Health Conferences.

3. Need to start training together at undergraduate level.

4. Value of interprofessional education, Regional Medical Programs should provide money.

DEVELOPING MULTIPROFESSIONAL EDUCATIONAL PROGRAMS - II

Participants of this group session exchanged information concerning operational programs illustrative of multiprofessional education. The discussion dealt primarily with examples of short-term training programs.

North Carolina Regional Medical Program Comprehensive Stroke Program -- continuing education for physicians, nurses and physical therapists in hospitals, nursing homes, and community agencies was described. In approximately one year and a half of project operation, over 14 teams have been trained in as many counties. Following the courses, the trainees prepare a second hospital team from the community. The multiprofessional members are trained together whenever possible. In some hospitals sending trainees a physical therapist may not be employed. In such cases, the state health department physical therapist whose geographic scope of work covers that hospital has usually attended the course as a member of the team. Physicians in private practice have participated actively as team members.

Training consists of a 2-day period followed by a similar period 2 weeks later. Training includes aspects of acute and rehabilitative care of stroke patients from the time of admission through discharge from the hospital and follow-up care.

It is planned that all teams which have been trained will be brought together for evaluation purposes.

New Mexico Regional Medical Program -- Stroke demonstration unit-staff are facilitating training of professional personnel in hospitals and community agencies in the care of stroke patients. Physicians and nurses provide the team nucleus, with involvement of physical therapists, occupational therapists, rehabilitation nurses and/or rehabilitation counselors from the community, wherever they may be available. An important aspect of the program is that the hospital discharge planning for the stroke patients now includes planned rehabilitation follow-up for patients returning to the community.

Married and retired professional staff have become interested and are working on a voluntary basis in their communities with the stroke

patients. Project staff are hopeful that some of the volunteers will become reactivated as members of the professional work force.

A California Regional Medical Program representative stated that because of stroke programs, physicians and nurses have reportedly become much more aware of stroke patient care than in the past. Educational programs are being conducted for physicians, nurses and physical therapists in hospital and community settings.

In the Oklahoma Regional Medical Program, multiprofessional education programs were sponsored when it was reported back that educational television programs for hospital nurses were attracting many other professional disciplines as well.

The Veterans Administration Hospital in Lebanon, Pennsylvania, uses ETV for physicians and allied health staff as well as for family educational programs.

In the Memphis Regional Medical Program, a stroke team provides demonstrations of rehabilitation techniques applicable to stroke patient care, upon request by hospital medical staffs at "breakfast meetings." This is followed by consultation being provided when the stroke team goes on hospital rounds with the medical staff.

In Ohio, a "stroke club" of former patients and their families provides many benefits to participants. A wide variety of professional people have participated individually as speakers to the club. An occupational therapist serves as consultant to the group, and provides orientation to each of the speakers prior to their participation in the programs.

The New Jersey Regional Medical Program arranges for multiprofessional conferences held in sub-regional areas. At the monthly programs, case presentations are given in order that the various disciplines learn from each other concerning all aspects of patient care from preventive through the treatment, control and rehabilitation phases.

In St. Luke's Hospital in New Bedford, Massachusetts, a team composed of a physician, nurse, physical therapist, medical social worker and dietitian function in the Intensive Care Unit for stroke patients. A community agency nurse provides a liaison function in working as a team member and with agency nursing staff. Team conferences are regularly held in which all attendees participate as appropriate.

This program provides training for other teams at its home base in the hospital and has also gone to other states as a team to give demonstrations.

At the conclusion of the Session, the Chairman summarized the multiprofessional education activities as being provided through such media as courses, clubs, TV, traveling teams, and sub-regional conferences.

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