Hospital Involvement in Regional Medical Programs

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The purpose of Regional Medical Programs is to improve the care of patients with heart disease, cancer, stroke or related diseases. Rather than subsidizing the cost of patient care, the program encourages the medical profession and medical institutions to establish voluntary, cooperative arrangements that will result in making the latest advances in these diseases available to patients. Programs are planned and implemented at local (Regional) levels through broad-based decision-making processes. This paper reviews five Regional Medical Programs with emphasis on various approaches hospitals are using to implement the program, and lists six criteria applicable to developing operational activities.

The Heart Disease, Cancer and Stroke Amendments of 1965 authorized the establishment of Regional Medical Programs (RMP). The intent of RMP is to encourage and assist in the creation of regional cooperative arrangements among medical schools, research institutions, hospitals and other medical institutions and agencies. The purpose of the arrangements is to give the medical profession and medical institutions the opportunity of making available to their patients the latest advances in the prevention, diagnosis and treatment of heart disease, cancer, stroke and related diseases. The impetus for the legislation was the report of the President's Commission on Heart Disease, Cancer and Stroke issued in December, 1964. A basic premise of the Commission report is that 70% of deaths in the United States are due to heart disease, cancer or stroke, and that a significant number of these people die or are disabled because the benefits of present knowledge in the medical sciences are not uniformly available throughout the country. Among the problems stated in the report are:

a. there is not enough trained manpower to meet the health needs of the American people within the present system for the delivery of health services.

b. there is increasing public demand for health services at a time when increasing costs are posing obstacles for many who require these preventive, diagnostic, therapeutic and rehabilitative services, and

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there is need for a creative partnership among the Nation's medical scientists, practicing physicians and all of the Nation's other health resources so that new knowledge can be translated more rapidly into better patient care.

The widely circulated report suggested that a partial solution would be to create a network of “regional centers” to combat these diseases.

During the congressional hearings that followed the report, representatives of major groups and institutions with an interest in the American health system were heard, particularly spokesmen for practicing physicians and community hospitals. The RMP legislation that emerged turned away from the idea of a detailed Federal blueprint for action. Specifically, the network of “regional centers” was replaced by a concept of “regional cooperative arrangements” among existing health resources. The law establishes a system of grants to enable representatives of health resources to exercise initiative to identify and meet local needs. Recognition of geographical and societal diversities within the United States was the main reason for this approach. Spokesmen for the Nation's health resources, who testified during the hearings, strengthened the case for local initiative. Thus, the degree to which the various regions meet the objectives of the law will measure how well local health resources can take the initiative and work together to improve care at the local level for patients with these diseases.

In general, grant funds will support research activities that contribute to the process of regionalization and the goal of improved patient care, demonstration of patient care when related to the program objectives, and continuing education and training when it is part of a comprehensive approach of enhancing regional capability for the diagnosis and treatment of heart disease, cancer, stroke and related diseases.

Program guidelines have been kept simple to permit the greatest flexibility and adaptation to local need. Fifty-four Regional Medical Programs have been awarded planning grants. Each region is planning its own approach to program implementation and a number of regions have become operational. A review of five regions, with special emphasis on hospital involvement, will illustrate the variety of approaches that are possible.

Review of Programs

The Intermountain RMP

The IRMP began when the University of Utah, the State Medical Association, County Medical Societies, medical staffs of major hospitals and other medical leaders participated in a series of planning sessions. Among the specific goals agreed upon were the development of teaching facilities in community hospitals, creation of better working relationships among hospitals and local educational institutions, provision of new diagnostic facilities, and continuing education of health professionals. To implement these ideas they have developed a number of pilot projects:
1) A network for continuing education. The network connects the major community hospitals by means of two-way radio communication, and a distribution system for a variety of teaching aids, including taped TV programs, broadcast TV, and closed-circuit systems within institutions. An important element of this project is the establishment of a teaching faculty in the major community hospitals.

2) Educational and training programs in heart disease. The curriculum includes acute cardiac care training for physicians and nurses and cardiopulmonary resuscitation courses for health professionals and selected lay personnel.

3) Education and training programs in cancer. This project emphasizes collecting data for identifying educational needs of individual practitioners and facility requirements within each community.

4) Education and training programs in stroke. This project offers library and telephone consultation services and sponsors visits by consultants to small communities.

5) Respiratory therapy training for physicians, nurses and technicians. This training provides instruction in the proper selection of patients for special respiratory therapy and the use of modern equipment in community hospitals.

C. Hillman Castle, program coordinator of IRMP, said that the university medical centers provide the stimuli for education and research in health care and they provide models for study. But the bulk of health services will be delivered in communities by the community hospitals and their staff. Therefore, the functional elements of the RMP should be concentrated in the community hospitals.

The Albany RMP

A basic concept of the Albany RMP is that the most pressing needs are to establish adequate communication, identify educational and training needs, and supply opportunities to meet those needs. The first pilot project undertaken, therefore, was to expand the two-way radio network into 35 of the 87 hospitals in the region. In the past, the two-way radio facilities had been used almost entirely for continuing education of practicing physicians. Programs for allied medical personnel, administrators, members of the boards of trustees, voluntary health agencies, civic groups and adult education are now being developed. A second project involving hospitals is the development of community hospital learning centers. The design and configuration of the learning centers is experimental and is being done in conjunction with the National Library of Medicine. The centers will explore various kinds of equipment and methods of presentation, and will be developed in community hospitals of various sizes and locations.
The Missouri RMP

The Missouri RMP is concerned with projects that develop techniques and aides to assist the physician in delivering the highest possible quality medical care, in the patient's own community if possible. Accordingly, a pilot project has been developed that centers on the Smithville Community Hospital. The project is designed to test the proposition that a community hospital can be the base of operations from which physicians can deliver comprehensive health care to the surrounding population. Comprehensive care includes prevention, treatment and rehabilitation, as well as consideration of the social and emotional aspects of illness. An important part of the concept is a program of community education aimed at informing the population of available and possible treatment for heart disease, cancer, and stroke at the community hospital, as well as efforts at public indoctrination in measures for the prevention or early detection of these diseases.

The Ohio Valley RMP

The Ohio Valley RMP is described as a multi-interest effort encouraging the establishment of formal, voluntary, continuing relationships among the health institutions and personnel of the region.

The Ohio Valley Regional Advisory Group developed a set of criteria, each reflecting a goal of the program, which, taken together, form a standard against which any proposed program element can be compared with program priorities. To begin model activities and provide a stimulus for continued planning, a SKELETON Program was formulated. The SKELETON program will consist initially of a combination of inter-related education, demonstration and research activities within and among a defined network of selected cooperating hospitals. It is envisioned that the hospitals selected for participation will be bound together by a variety of affiliations, arrangements and activities that will make them an effective organization for cooperative activities. Each involved hospital must commit itself to the creation of a critical mass of inter-related education and training, patient care demonstration, and medical care research activities. To the extent that this critical mass represents a new effort for a given hospital, it will become a nucleus of RMP-supported effort in that community. The hospitals will thus be agreeing not only to intensify their own education, training and service functions, but also to do this in concert with other hospitals in the region. Similarly, the RMP will not be sponsoring a series of similar, independent projects; rather, it will be supporting the development of inter-institutional cooperative efforts on the part of hospitals with similar needs and goals. A description of the SKELETON program was mailed to the administrator and chief of staff of each hospital in the region. Approximately 25% expressed interest and attended a workshop to discuss the program in detail. Subsequently, eight hospitals were selected to be included in the operational grant application. Hospitals were selected on the basis of their depth of commitment, geographic location, size and staffing pattern.

The Wisconsin RMP

The Wisconsin RMP has elected to use systems engineering as a major component of its planning process. Conceptual planning and program evaluation are being accom-
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plished by a 15-member planning committee that has representation from physicians, nurses, engineers, lawyers, economists, social workers and hospital administrators. Additional input is provided by categorical subcommittees. During the planning phase, a model based on the system pyramid technique was developed. Through a successive expansion of prevention, diagnosis, treatment and post-treatment health care, the left hand side of the model gives various programs in which the WRMP could engage. The right hand side lists the resources that could be used to implement each possible program component. The model describes a comprehensive set of 50,000 potential programs and points out alternatives. Once the planning committee selects a specific program for development, those individuals considered to be potential collaborators and/or experts in the area are convened. When implementive detail has been developed, the proposal is reviewed for its scientific merit, study design, and relationship to the comprehensive program. Operational activities now include a thromboembolism project at the Marshfield Clinic and a cervical cancer dosimetry project relating the medical center to a community hospital.

Discussion

In addition to illustrating the variety of approaches that are possible under the legislation, these five Regional Medical Programs also illustrate a number of features that are common to many Regions. They stress the importance of organized involvement, free communication among people and institutions, regional and sub-regional planning, thorough knowledge of program concept and design, and the prominent role of hospitals. Two years ago, the Division of Regional Medical Programs began to face the monumental task of awarding operational grants. Dr. Robert Marston, past director of the Division and present director of the National Institutes of Health, has suggested six criteria to be considered by regions facing the responsibility of developing operational projects. The criteria assume that the region has a representative decision-making process that includes the ability to set priorities and evaluate results, and that the project itself is concerned with heart disease, cancer, stroke or related diseases. They may be summarized as follows:

1) Manpower — are personnel available to implement the project and is this the best use of them?

2) Science to Service — is the project designed to help bridge the “gap between science and service”?

3) Cooperative Arrangements — does the project encourage cooperative arrangements among people and institutions?

4) Regional Resources — does the project recognize and make best use of the talent and resources in the region?

5) Regional Coordination — how does the project relate to the overall regional program?

6) Educational Opportunities — to what degree does the project contribute to continuing education and training of physicians and other health personnel?
Conclusion

Flexibility and local autonomy are strong features of the RMP and constantly have been emphasized by the National Advisory Council for Regional Medical Programs. There is little question that a great deal of confusion exists about implementing a program of this nature. Administratively, it would have been simpler had the 89th Congress legislated a cut-and-dry program in which implementive details were outlined. There would have been less confusion, but think of the effect it would have had on local autonomy and freedom to set priorities at the local level! The legislation and program guidelines have put the challenge of program implementation in the hands of the medical profession. Indeed, the RMP will be only as effective as the medical profession is innovative and responsive to the challenge.

REFERENCES


