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REGIONAL MEDICAL PROGRAMS; ALCOHOLICS AND NARCOTICS ADDICTS FACILITIES; HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HOUSE OF REPRESENTATIVES

NINETIETH CONGRESS

SECOND SESSION

ON

H.R. 15758

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT SO AS TO EXTEND AND IMPROVE THE PROVISIONS RELATING TO REGIONAL MEDICAL PROGRAMS, TO EXTEND THE AUTHORIZATION OF GRANTS FOR HEALTH OF MIGRATORY AGRICULTURAL WORKERS, TO PROVIDE FOR SPECIALIZED FACILITIES FOR ALCOHOLICS AND NARCOTIC ADDICTS, AND FOR OTHER PURPOSES

MARCH 26, 27, AND 28, 1968

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REGIONAL MEDICAL PROGRAMS; ALCOHOLICS AND NARCOTICS ADDICTS FACILITIES; HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

TUESDAY, MARCH 26, 1968

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers presiding (Hon. John Jarman, chairman).

Mr. KYROS (presiding). The subcommittee will please be in order.

The hearings today are on H.R. 15758, introduced by Chairman Staggers at the request of the administration.

This bill would extend and expand the existing authorizations for regional medical programs, would extend the program of health services for domestic agricultural migratory workers, and would provide matching grants for construction and staffing of facilities for prevention of alcoholism addiction and for treatment of alcoholics and narcotic addicts.

REGIONAL MEDICAL PROGRAMS

In 1965, the Congress considered legislation proposing the establishment of regional medical programs designed to improve the health care of the American people in the fields of heart disease, cancer, stroke and related diseases. The Congress made substantial revisions in the proposed program, providing in general for a maximum of decentralization of the decisionmaking process and encouraging the maximum feasible cooperation between public and private groups interested in the health of the American people.

It is impossible to give a simple description of a regional medical program since every program established is different, with each program tailored specifically to the needs of the region served.

Over 90 percent of the population of the United States is or will be covered by regional medical programs established on the local level either on an operational basis today or through programs currently in the planning stage. Eventually, 100 percent of our population will be covered by these programs.

Many fears and reservations were expressed at the time the Congress was considering the initial legislation. It is my understanding, however, that many of the groups which had reservations about the initial proposals have since modified their positions, in large measure

because of the modifications that were made in the program by the Congress and the manner in which the program has been administered to date.

As I understand the bill presented to us, no major changes are proposed. The principal purpose of the legislation is to extend the program beyond its scheduled expiration date of June 30 this year, with minor improvements that experience has shown to be necessary or desirable.

In regard to the section on domestic agricultural migratory workers, the bill also proposes to extend for two additional years the existing program of Federal grants for health services to domestic agricultural migratory workers.

The existing program is also scheduled to expire June 30 this year, so extension is essential at this time if these workers, who are among the neediest today, are to continue to receive the services they need.

ALCOHOLIC AND NARCOTICS ADDICTS

Title II of this bill would establish a program designed to provide assistance in the treatment and rehabilitation of alcoholic and narcotic addicts. The program proposed is an extension of the principles already embodied in the community mental health centers and mental retardation facilities acts approved by this committee in 1963. The bill provides matching grants for construction and operation of facilities which are part of a complex providing essential elements of comprehensive mental health services in order to provide services for the prevention and treatment of alcoholism.

Grants are also authorized for construction and operation of special residential and other facilities for treatment of homeless alcoholics; grants for construction and operation of facilities for prevention and treatment of narcotic addiction; and grants for training and evaluation relating to the prevention and treatment of narcotic addiction.

There are a substantial number of witnesses who have requested the opportunity to be heard on this legislation, which is indicative of the broad public response to the needs which will be served by the enactment of this bill.

We hope to be able to expedite these hearings in order that the legislation may reach the President's desk at the earliest possible date in view of the relatively brief time remaining before two of the programs contained in the bill are scheduled to expire.

The bill under consideration, and agency reports on the bill, will be included in the record at this point.

(The bill, H.R. 15758, and departmental reports thereon, follow:)

[H.R. 15758, 90th Cong., second sess.]

A BILL To amend the Public Health Service Act so as to extend and improve the provisions relating to regional medical programs, to extend the authorization of grants for health of migratory agricultural workers, to provide for specialized facilities for alcoholics and narcotic addicts, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I—REGIONAL MEDICAL PROGRAMS

EXTENSION OF REGIONAL MEDICAL PROGRAMS

SEC. 101. Section 901(a) of the Public Health Service Act (42 U.S.C. 299a) is amended by striking out "and" before "$200,000,000" and by inserting after

"June 30, 1968," the following: "$65,000,000 for the fiscal year ending June 30, 1969, and such sums as may be necessary for the next four fiscal years,".

EVALUATION OF REGIONAL MEDICAL PROGRAMS

SEC. 102. Section 901(a) of the Public Health Service Act is further amended by inserting at the end thereof the following new sentence: "For any fiscal year ending after June 30, 1969, such portion of the appropriations pursuant to this section as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the program authorized by this title."

INCLUSION OF TERRITORIES

SEC. 103. Section 902(a)(1) of the Public Health Service Act (42 U.S.C. 299b) is amended by inserting after "States" the following: "(which for purposes of this title includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands)".

COMBINATIONS OF REGIONAL MEDICAL PROGRAM AGENCIES

SEC. 104. Section 903(a) and section 904(a) of the Public Health Service Act (42 U.S.C. 299c, 299d) are each amended by inserting after "other public or nonprofit private agencies and institutions" the following: ", and combinations thereof,".

ADVISORY COUNCIL MEMBERS

SEC. 105. (a) Section 905(a) of the Public Health Service Act (42 U.S.C. 299e) is amended by striking out "twelve" and inserting in lieu thereof "sixteen".

(b) Section 905(b) of such Act is amended by striking out "and four at the end of the third year" and inserting in lieu thereof "four at the end of the third year, and four at the end of the fourth year".

MULTIPROGRAM SERVICES

SEC. 106. Title IX of the Public Health Service Act is further amended by adding at the end thereof the following new section:

"PROJECT GRANTS FOR MULTIPROGRAM SERVICES

"SEC. 910. Funds appropriated under this title shall also be available for grants to any public or nonprofit private agency or institution for services needed by or which will be of substantial use to, any two or more regional medical programs."

CLARIFYING OR TECHNICAL AMENDMENTS

SEC. 107. (a) Section 901(c) of the Public Health Service Act is amended by inserting before the period at the end thereof "or, where appropriate, a practicing dentist".

(b) Section 901 of such Act is further amended by adding at the end thereof the following new subsection:

"(d) Grants under this title to any agency or institution for a regional medical program may be used by it to assist in meeting the cost of participation in such program by any Federal hospital."

TITLE II—MIGRATORY WORKERS

EXTENSION OF SPECIAL GRANTS FOR HEALTH OF MIGRATORY WORKERS

SEC. 201. Section 310 of the Public Health Service Act (42 U.S.C. 242h) is amended by striking out "and, $9,000,000 for the fiscal year ending June 30, 1968" and inserting in lieu thereof "$9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, and such sums as may be necessary for the fiscal year ending June 30, 1970".

TITLE III—ALCOHOLIC AND NARCOTIC ADDICT REHABILITATION

SEC. 300. This title may be cited as the "Alcholic and Narcotic Addict Rehabilitation Amendments of 1968".

PART A—ALCOHOLIC REHABILITATION

SEC. 301. The Community Mental Health Centers Act (42 U.S.C. 2681, et seq.) is amended by adding after part B the following new part:

"PART C—ALCOHOLISM

"CONSTRUCTION GRANTS

"SEC. 241. (a) Grants from appropriations under section 261 for construction of any facilities may be made only to a public or nonprofit private agency or organization and only upon an application (1) which meets the requirements for approval under clauses (1) through (5) and clause (A) of section 205(a), (2) which is for construction of a facility for the prevention and treatment of alcoholism, and (3) which contains—

"(A) a showing of the need, in the area to be served by the applicant, for special facilities for the inpatient or outpatient treatment, or both, of alcoholism;

"(B) satisfactory assurance that the services for prevention and control of alcoholism to be provided through the facility to be constructed, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated or having an arrangement with the applicant, will include, or be part of a program providing, principally for persons residing in or near the particular community or communities in which such facility is situated, at least those essential elements of comprehensive mental health services and services for the prevention and treatment of alcoholism, including postinstitutional aftercare and rehabilitation, that are prescribed by the Secretary;

"(C) satisfactory assurance that the application has been approved and recommended by the single State agency designated by the State as being the agency primarily responsible for care and treatment of alcoholics in the State, and, in case this agency is different from the agency designated pursuant to section 204(a)(1), a showing that the application has also been approved and recommended by the agency designated pursuant to section 204(a)(1);

"(D) a showing that the project is entitled to priority over other projects for treatment of alcoholism, if any, within the State in accordance with regulations of the Secretary as to general manner of determining priority, and is in accordance with such criteria, including the willingness and ability to provide satisfactory alternatives to custodial care, as the Secretary may determine to be appropriate for purposes of this section; and

"(E) a showing that adequate provision has been made for furnishing needed services for persons unable to pay therefor in accordance with regulations of the Secretary under section 203(4) and for compliance with State standards for operation and maintenance.

"(b) The amount of any such grant with respect to any project shall be such percentage of the cost thereof, but not in excess of 66⅔ per centum, as the Secretary may determine.

"STAFFING, OPERATION, AND MAINTENANCE GRANTS

"SEC. 242. (a) Grants from appropriations under section 261 may be made to any public or nonprofit private agencies and organizations to assist them in projects for the operation, staffing, and maintenance of new facilities for prevention and treatment of alcoholism or of new services in facilities for prevention and treatment thereof.

"(b) Grants under this section may be made only upon an application which meets the requirements for approval under part B. In making such grants, the Secretary shall take into account the relative needs of the several States for alcoholism programs and the relative financial need of the applicants and the relative population of area to be served by the applicants. In the case of any project the application for which is approved under this section, the maximum

percentage of the cost of the project with respect to which a grant is made hereunder shall be 90 per centum thereof for the first year following the first day of the first month for which a grant is made, 80 per centum thereof for the second year thereafter; 70 per centum for the third year thereafter; 60 per centum for the fourth year thereafter; and 50 per centum for each of the next six years thereafter.

"SPECIALIZED FACILITIES

"SEC. 243. (a) Grants from appropriations under section 261 may also be made for projects for construction, operation, staffing, and maintenance of specialized residential and other facilities, such as halfway houses, day-care centers, and hostels, for treatment of homeless alcoholics requiring care in such facilities.

"(b) Such grants may be made only with respect to facilities which (1) are affiliated with a community mental health center providing at least those essential elements of comprehensive community mental health services which are prescribed by the Secretary, or (2) are not so affiliated but with respect to which satisfactory provision (as determined by the Secretary) has been made for appropriate utilization of existing community resources needed for an adequate program of prevention and treatment of alcoholism.

"PROJECTS ELIGIBLE UNDER REGULAR PROGRAM

"SEC. 244. Nothing in this part shall be construed to preclude approval under parts A and B of a grant for a project for a facility or initial staffing thereof for the treatment of alcoholics but in determining the amount of any such grant under such part there shall be excluded from the cost of the project an amount equal to the sum of (1) the amount of any other Federal grant which the applicant has obtained, or is assured of obtaining, with respect to the project which is to be financed in part by a grant or grants under this part, and (2) the amount of any non-Federal funds required to be expended as a condition of such other Federal grant.

"PAYMENTS

"SEC. 245. Payments of grants under this part may be made in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

"SHORT TITLE

"SEC. 246. This part may be cited as the 'Alcohol Rehabilitation Act of 1968'."

PART B—NARCOTIC ADDICTION

SEC. 302. The Community Mental Health Centers Act (42 U.S.C. 2681, et seq.) is further amended by inserting after part C (added by section 101 of this Act) the following new part:

"PART D—NARCOTIC ADDICT REHABILITATION

"PROGRAM OF TREATMENT

"SEC. 251 (a) Sums appropriated pursuant to section 261 shall be available for grants to any public or nonprofit private agencies and organizations to assist them in projects for constructing, operating, staffing, and maintaining treatment centers and facilities (including posthospitalization treatment centers and facilities) for narcoatic addicts within the States.

"(b) The grant program authorized by subsection (a) shall, insofar as it deals with the kind of activities authorized by parts A and B of this title, be carried out consistently with the grant programs under such parts A and B except to the extent, in the judgment of the Secretary, special consideration make differences appropriate.

"TRAINING AND EVALUATION

"SEC. 252. The Secretary is authorized, during the period beginning July 1, 1968, and ending with the close of June 30, 1970, to make grants to any public or nonprofit private agencies and organizations to cover part or all of the cost of (A) developing specialized training programs or materials relating to the provision of public health services for the prevention and treatment of narcotic addiction, or developing in-service training or short-term or refresher courses

with respect to the provision of such services; (B) training personnel to operate, supervise, and administer such services; and (C) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of narcotic addiction within the several States with a view to determining ways and means of improving, extending, and expanding such programs.

"PROJECTS ELIGIBLE UNDER REGULAR PROGRAM

"SEC. 253. Nothing in this part shall be construed to preclude approval under parts A and B of a grant for a project for a facility or initial staffing thereof for the treatment of narcotic addicts, but in determining the amount of any such grant under such part there shall be excluded from the cost of the project an amount equal to the sum of (1) the amount of any other Federal grant which the applicant has obtained, or is assured of obtaining, with respect to the project which is to be financed in part by a grant or grants under this part, and (2) the amount of any non-Federal funds required to be expended as a condition of such other Federal grant.

PAYMENTS

"SEC. 254. Payments under this part may be made in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine."

PART C—GENERAL

AUTHORIZATION OF APPROPRIATIONS FOR REHABILITATION OF ALCOHOLICS AND NARCOTIC ADDICTS

SEC. 303. The Community Mental Health Centers Act (42 U.S.C. 2681, et seq.) is further amended by inserting after part D (added by section 201 of this Act) the following new part:

"PART E—GENERAL PROVISIONS

"AUTHORIZATION OF APPROPRIATIONS FOR REHABILITATION OF ALCOHOLICS AND NARCOTIC ADDICTS

"SEC. 261. (a) There are authorized to be appropriated for the fiscal year ending June 30, 1969, and the next fiscal year such sums as may be necessary for project grants for construction, operation, staffing, and maintenance of facilities for the prevention and treatment of alcoholism (including specialized residential adn other facilities) under part C or the prevention and treatment of narcotic addiction under part D. Sums so appropriated for any fiscal year shall remain available for obligation until the close of the next fiscal year.

"(b) There are also authorized to be appropriated for the fiscal year ending June 30, 1971, and each of the next seven fiscal years such sums as may be necessary to continue to make grants with respect to any project under part C or D for operation, staffing, or maintenance of any facilities if such a grant was made thereunder with respect to such project from appropriations under this section for the fiscal year ending June 30, 1970, or any prior year, except that grants under such part may not be made with respect to any project after such grants have been made with respect to it from such appropriations for eight fiscal years.

"PROGRAM EVALUATION

"SEC. 262. Such portion of any appropriation under this title for any fiscal year ending after June 30, 1968, as the Secretary may determine, but not exceeding 1 per centum thereof, shall be available to the Secretary for evaluation (directly or by grants or contracts) of the programs authorized by this title."

OPERATION AND MAINTENANCE GRANTS UNDER COMMUNITY MENTAL HEALTH CENTERS PROGRAM

SEC. 304. Part B of the Community Mental Health Centers Act is amended by adding after section 224 (42 U.S.C. 2688d) the following new section:

"FACILITIES RELATING TO REHABILITATION OF ALCOHOLICS OR NARCOTIC ADDICTS

"SEC. 225. In the case of any community mental health center which includes (to such extent as may be determined in accordance with regulations) facilities

for the prevention and treatment of alcoholism or narcotic addiction, the purposes for which the portion of the grant under this part which relates to such facilities may be made, the percentage of the cost to be met by such portion of the grant, and the duration of such portion of the grant shall, subject to limitations in such regulations, be determined as though the grant is being made for operation, staffing, and maintenance of facilities under part C, in the case of facilities for prevention and treatment of alcoholism, or part D, in the case of facilities for the prevention and treatment of narcotic addiction."

USE OF ALLOTMENTS FOR COST OF ADMINISTRATION

SEC. 305. Section 403 of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (42 U.S.C. 2693) is amended by adding at the end thereof the following new subsection:

"(c) (1) At the request of any State, a portion of any allotment or allotments of such State under part A of title II shall be available to pay one-half (or such smaller share as the State may request) of the expenditures found necessary by the Secretary for the proper and efficient administration during such year of the State paln approved under such part; except that not more than 2 per centum of the total of the allotmens of such Sate for a year, or $50,000, whichever is less, shall be available for such purpose for such year. Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

"(2) Any amount paid under paragraph (1) to any State for any fiscal year shall be paid on condition that there shall be expended from State sources for such year for administration of the State plan approved under such part A not less than the total amount expended for such purposes from such sources during the fiscal year ending June 30, 1968."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 18, 1968.

HON. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of March 6, 1968, for a report on H.R. 15758, a bill "To amend the Public Health Service Act so as to extend and improve the provisions relating to regional medical programs, to extend the authorization of grants for health of migratory agricultural workers, to provide for specialized facilities for alcoholics and narcotic addicts, and for other purposes."

This bill embodies the legislative proposal contained in a draft bill submitted by this Department to the Congress on March 4, 1968, to implement the recommendations on extension and improvement of regional medical programs contained in the President's March 4, 1968 Message on Health. The bill also includes the legislative proposal contained in that draft bill relating to temporary extension of the program of grants for health services for migratory agricultural workers. In addition, H.R. 15758 embodies the legislative proposal contained in the draft bill submitted by this Department to the Congress on February 8, 1968, to implement the recommendations on prevention and treatment of alcoholism and narcotic addiction contained in the President's February 7, 1968 Message on insuring the public safety and meeting the challenge of crime in our society. (This last mentioned proposal was also included in H.R. 15281, on which we reported to your Committee on February 26, 1968.)

We urge early enactment of this proposed legislation.

The Bureau of the Budget advises that enactment of this proposed legislation would be in accord with the program of the President.

Sincerely,

WILBUR J. COHEN,
Acting Secretary.

DEPARTMENT OF AGRICULTURE,
Washington, D.C., March 25, 1968.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in reply to your letter of March 6, requesting our views on H.R. 15758, a bill "To amend the Public Health Service Act."

This Department favors enactment of that portion of the bill which would provide grants for the health of migratory agricultural workers. We are not commenting on remaining sections of the bill which are more appropriately the interest of other departments.

The bill would extend authorization to continue programs of the Public Health Service Act relating to the health of migratory agricultural workers for an additional two years, through June 30, 1970. The Act provides grants for medical diagnosis and treatment, immunization, and family health, nursing, and sanitation services.

We believe that these programs are in the public interest, and we are particularly concerned that steps already taken to improve the much needed health services for migratory agricultural workers and their families should be included.

The Bureau of the Budget advises that the enactment of this proposed legislation would be in accord with the President's program.

Sincerely yours,

ORVILLE L. FREEMAN, *Secretary.*

THE GENERAL COUNSEL OF THE TREASURY,
Washington, D.C., March 26, 1968.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Reference is made to your request for the views of this Department on H.R. 15758, "To amend the Public Health Service Act so as to extend and improve the provisions relating to regional medical programs, to extend the authorization of grants for health of migratory agricultural workers, to provide for specialized facilities for alcoholics and narcotic addicts, and for other purposes."

Only Title III of the bill is of concern to the Treasury Department. Title III would amend the Community Mental Health Centers Act to authorize grants to public or nonprofit private agencies or organizations for: (1) the construction, operation, staffing and maintenance of facilities for the prevention and treatment of alcoholism and of specialized residential and other facilities for the treatment of homeless alcoholics requiring care in such facilities; and (2) the construction, operation, staffing and maintenance of treatment centers and facilities for narcotic addicts within the States, and for the development of specialized training programs or materials relating to the provision of public health services for the prevention and treatment of narcotic addiction, and for the evaluation of such programs.

The President, in his message on the Challenge of Crime to our Society, urged enactment of legislation which would provide federal leadership and assistance to States and localities in developing non-jail atlernatives for the handling of alcoholics and asked the Secretary of Health, Education, and Welfare to increase the activities of his Department in the area of rehabilitation of drug addicts, and in alerting young people to the threat addiction poses to their lives. Title III of H.R. 15758 would carry out these recommendations of the President.

The Department recommends enactment of Ttitle III of H.R. 15758.

The Department has been advised by the Bureau of the Budget that there is no objection to the submission of this report to your Committee and that enactment of the proposed legislation would be in accord with the program of the President.

Sincerely yours,

FRED B. SMITH, *General Counsel.*

Mr. KYROS. I understand our first witness this morning will be Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs in the Department of Health, Education, and Welfare. Dr. Lee.

STATEMENT OF DR. PHILIP R. LEE, ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY RALPH K. HUITT, ASSISTANT SECRETARY FOR LEGISLATION; DR. RALPH Q. MARSTON, DIRECTOR, DIVISION OF REGIONAL MEDICAL PROGRAMS; DR. STANLEY F. YOLLES, DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH; AND HELEN JOHNSTON, CHIEF, MIGRANT HEALTH BRANCH, BUREAU OF HEALTH SERVICES

Dr. LEE. Thank you, Mr. Chairman.

Mr. ROGERS (presiding). I might say that the committee is pleased to have you with us, and particularly since your new duties have been stated by the Secretary to be coordinator for health, and "Mr. Health" for the Government.

We are delighted to have you with us in this capacity today, and we are pleased to have your associates. We will be glad to hear your statement.

Dr. LEE. Thank you, sir.

Accompanying me are Miss Johnston, Dr. Marston, and Dr. Yolles. Mr. Ralph Huitt is with us this morning also.

Mr. ROGERS. We are glad to see Mr. Huitt here.

Dr. LEE. Mr. Chairman and members of the Subcommittee on Health and Welfare, it gives me great pleasure to appear before you today in support of the Health Services Act of 1968, which contains an extension and improvements to the Heart, Cancer, and Stroke Amendments of 1965, an extension of the Migrant Health Act of 1962, as amended in 1965, the transfer of authorities now in section 402 of the Narcotic Addict Rehabilitation Act of 1966 to the Community Mental Health Centers Act, and the establishment of a program to assist communities to improve treatment services to alcoholics, the latter two programs to be known as the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968.

These programs are all designed to carry forward our commitment to make the best health services available to all Americans. In his special message to Congress on health in 1965, President Johnson stated:

> Our first concern must be to assure that the advance of medical knowledge leaves none behind. We can—and must—strive now to assure the availability and accessibility of the best health care for all Americans, regardless of age or geography or economic status.

Although much has been accomplished in the last 3 years, much remains to be done. We must remove the barriers of discrimination that have so long barred the alcoholic and the narcotic addict from receiving truly comprehensive care—a discrimination based on diagnosis, which is just as intolerable as discrimination based on race.

The migrant worker suffers from not only the disadvantages of language, poverty, and geography, but often the even more difficult

problems of ignorance and inexperience in the use of modern medical services.

The removal of a different kind of barrier—the time lag between discovery and effective application of new knowledge—is a goal of the regional medical program. In his health message this year, President Johnson stated:

> Its purpose is to translate research into action, so that all of the people of our nation can benefit as rapidly as possible from the achievement of modern medicine.

Title I of H.R. 15758 extends the regional medical program through fiscal year 1973 and clarifies and improves certain aspects of the program.

You will recall from your consideration of this legislation in the summer of 1965 that it was introduced as a result of the findings of the President's Commission on Heart Disease, Cancer, and Stroke. The Commission found that medical science has created the potential to reduce the heavy tolls of these diseases but that this potential was not being realized for many of our citizens.

The Interstate and Foreign Commerce Committee played a major role in clarifying both the nature of the program and the direction in which it was to go.

The basic objective of this program is to assure that the people of this Nation, wherever they may be, will benefit from the advances of medical science against the threats of heart disease, cancer, stroke, and related diseases.

As an additional dividend, this program will have an impact extending far beyond the control of specific diseases. The physicians and other health workers involved in the regional medical programs will be applying their new knowledge and new techniques to patients being treated under the medicaid, medicare, and other health programs. The lessons learned in the regional medical programs cannot help but enhance the quality and efficiency of these other activities.

The progress already made has justified our expectation that this program would significantly improve the effectiveness and quality of medical care for those who suffer from the major killer diseases.

The program is already bringing together diverse groups in the health field in an unprecedented fashion and in a manner that results in a consideration of the unfilled health needs of the region, rather than those of the individual institutions. Despite the present shortage of manpower, the program has been successful in recruiting throughout the Nation talented persons willing to make firm career commitments to achieving the goals of the program.

The programs have earned the support of the major health resources, professional and voluntary, at the national and regional levels. They have helped overcome hostilities and divisions which have existed in some cases for generations.

Indeed, there has been a positive response to this committee's mandate in the original legislation that this program would be community based—that the responsibility for planning and organizing the operation of the program would belong to the region, not to the Federal Government.

As evidence of this response almost 1,000 medical institutions are participating in the regional medical programs, including every med-

ical school and hundreds of hospitals. This involvement of medical schools and other teaching and research institutions helps develop close and continuous contact between medical advances and their application in the community.

Almost 800 health organizations are participating, including every State medical society, State health department, State heart association, and State cancer society.

Over 7,000 non-Federal-connected individuals are now actively engaged in the programs, including 1,800 employed either full- or part-time by the regional programs, over 1,900 members of the regional advisory groups required by the law who must advise on the development of the programs and approve all operational activities before they can be funded, and members of various subcommittees, task forces, and local action groups, who are contributing their time.

This represents an involvement not only of the experts in the region but also the health personnel at the grassroots level, and this is illustrated in table I (p. 33) which is submitted with the testimony.

These people, institutions, and organizations are the forces which, with your support, will carry to fulfillment the high expectations for this program.

The scope of the program is enabling the regional groups to assess thoroughly the needs and opportunities within their region and to implement the steps that can be realistically undertaken to improve the diagnosis and treatment of the major diseases. By coping with these problems on a regional scale, the groups are able to plan for the most efficient use of specialized resources for service or training from the largest medical center to the isolated rural physician.

The regions have found that many different types of activities can contribute to objectives such as demonstrations of advanced diagnostic and patient-care techniques, training and continuing education of health personnel, development of communication and patient data networks, application of computer and other modern technology to health care, and research into better means for organizing and delivering improvements in health care.

The first planning grant was awarded less than 2 years ago. Today there are 53 regions which have received planning grants and include the entire population, except Puerto Rico, and an application from that Commonwealth is now being reviewed.

Eleven regions have received grants to support initial operational activities, and 13 other regions have submitted applications to begin the operational phase of their programs. To finance these activities there has been a rapid increase in the obligation of funds, and this is illustrated on table II, which is attached.

The involvement in the regional medical programs by local institutions and individuals has been enthusiastic. Within the next year all of the programs expect to enter the operational phase of their program. They are eager to continue the work they have begun.

In addition to extending the basic authorities of the regional medical program, the bill before you contains amendments to those authorities that would help the regions accomplish their goals more effectively. It contains a provision that would assure proper evaluation of the accomplishments of the program by providing that up to

1 percent of the appropriation for any fiscal year beginning with 1970 may be used by the Secretary for the evaluation.

The bill makes clear that regional medical grants can be awarded to a combination of regional medical program agencies for carrying on a regional medical program.

Also, a new authority is added which would permit the awarding of grants to any public or private nonprofit agency or institution for services which will be of substantial value and use to any two or more regional medical programs. Such services might include producing education materials, developing evaluation techniques, creating uniform data-gathering systems, and other types of activities which cannot always be developed most efficiently on the basis of the needs of a single region.

The act is also amended to authorize the use of regional medical program grant funds to permit the full participation of Federal hospitals in regional medical programs as the important community resources which they in fact are.

Another amendment clarifies that a practicing dentist as well as a physician may refer a patient to a facility carrying out research, training, or demonstration activities which are supported by regional medical program funds. Dentists can play an important role in such areas as the early identification of oral cancer, and the amendment corrects an unforeseen limitation in the original act which does not permit such referrals.

An increase in the Advisory Council membership, from 12 members to 16, is provided in the bill, an expansion made necessary by the increasing workload of the Council in reviewing applications and the desirability of having members who reflect a broad diversity of interests.

The bill also extends the provisions of the programs to Guam, American Samoa, and the Trust Territory of the Pacific Islands. The Hawaii regional medical program has indicated that it would be interested in including these areas in its program.

These provisions will strengthen regional medical programs and will provide the flexibility that will aid in making the most efficient use of all the health elements of the community in the program.

The committee has received copies of the Surgeon General's report on regional medical programs, which describes in detail the initial progress. I would like to submit for the record material which adds to that report and which will bring you up to date on the accomplishments of the regional medical programs.

May I submit that for the record, Mr. Chairman?

Mr. ROGERS. Without objection, it will be received.

(The document referred to follows:)

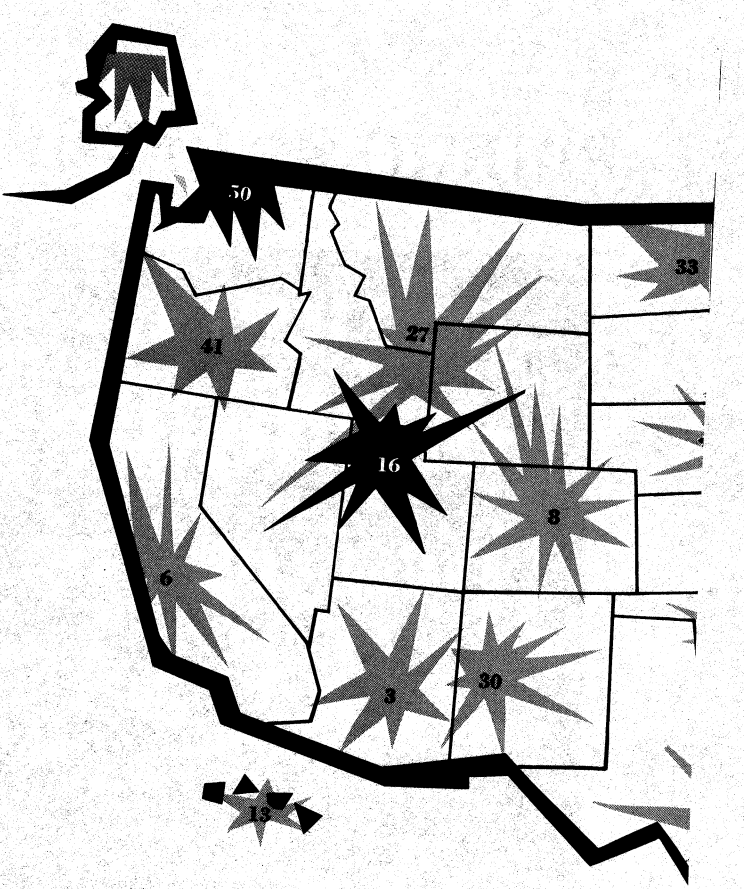
PROGRESS REPORT

regional medical programs

For
Heart Disease, Cancer, Stroke,
And Related Diseases

Division of Regional Medical Programs
National Institutes of Health
Bethesda, Maryland 20014

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

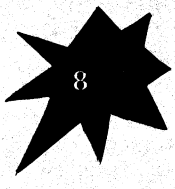


53 Regional Medical Programs have been awarded planning grants*. . .

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

1 Regional Medical Program is currently under development *





Regional Medical Programs have received operational grants*. . .

- to improve patient care through research, continuing education, training, and demonstration projects
- to develop better methods for the exchange of information among medical schools, medical centers, community hospitals, practicing physicians, and other health institutions, organizations, and personnel
- to continue to develop new and expanded plans for further improvement of patient care

*As of February 29, 1968

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HISTORY AND PURPOSES OF REGIONAL MEDICAL PROGRAMS

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

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

other factors which occurred in 1964 and 1965.

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

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

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

- A program is needed to focus the Nation's health resources for research, teaching and patient care on heart disease, cancer, stroke and related diseases, because together they cause 70 percent of the deaths in the United States.
- A significant number of Americans with these diseases die or are disabled because the benefits of present knowledge in the medical sciences are not uniformly available throughout the country.
- There is not enough trained manpower to meet the health needs of the American people within the present system for the delivery of health services.
- Pressures threatening the Nation's health resources are building because demands for health services are rapidly increasing at a time when increasing costs are posing obstacles for many who require these preventive, diagnostic, therapeutic and rehabilitative services.
- A creative partnership must be forged among the Nation's medical scientists, practicing physicians, and all of the Nation's other health resources so that new knowledge can be translated more rapidly into better patient care. This partnership should make it possible for every community's practicing physicians to share in the diagnostic, therapeutic and consultative resources of major medical institutions. They should similarly be provided the opportunity to participate in the academic environment of research, teaching and patient care which stimulates and supports medical practice of the highest quality.
- Institutions with high quality research programs in heart disease, cancer, stroke, and related diseases are too few, given the magnitude of the problems, and are not uniformly distributed throughout the country.
- There is a need to educate the public regarding health affairs. Education in many cases will permit people to extend their own lives by changing personal habits to prevent heart disease, cancer, stroke and related diseases. Such education will enable individuals to recognize the need for diagnostic, therapeutic or rehabilitative services, and to know where to find these services, and it will motivate them to seek such services when needed.

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

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

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

Regions first may receive planning grants from the Division of Regional Medical Programs, and then may be awarded operational grants to fund activities planned with initial and subsequent planning

grants. These operational programs are the direct means for Regional Medical Programs to accomplish their objectives. Planning moves a Region toward operational activity and is a continuing means for assuring the relevancy and appropriateness of operational activity. It is the effects of the operational activities, however, which will produce results by which Regional Medical Programs will be judged.

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

THE NATURE AND POTENTIAL OF REGIONAL MEDICAL PROGRAMS

GOAL—IMPROVED PATIENT CARE

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

MEANS—THE PROCESS OF REGIONALIZATION

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

A regional cooperative arrangement among the full array of available health resources is a necessary step in bringing the benefits of scientific advances in medicine to people wherever they live in a Region they themselves have defined. It enables patients to benefit from the inevitable specialization and division of labor which accompany the expansion of medical knowledge because it provides a system of working relationships among health personnel and the institutions and organizations in which they work. This requires

a commitment of individual and institutional spirit and resources which must be worked out by each Regional Medical Program. It is facilitated by voluntary agreements to serve, systematically, the needs of the public as regards the categorical diseases on a regional rather than some more narrow basis.

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

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

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

Involvement—The involvement and commitment of individuals, organizations and institutions which will engage in the activity of a Regional Medical Program, as well as those which will be affected by this activity, underlie a Regional Program. By involving in the steps of study and decision all those in a region who are essential to implementation and ultimate success, better solutions may be found, the opportunity for wider acceptance of decisions is improved, and implementation of decisions is achieved more rapidly. Other

attempts to organize health resources on a regional basis have experienced difficulty or have been diverted from their objectives because there was not this voluntary involvement and commitment by the necessary individuals, institutions and organizations. The Act is quite specific to assure this necessary involvement in Regional Medical Programs: it defines, for example, the minimum composition of Regional Advisory Groups.

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

The Regional Advisory Group does not have direct administrative responsibility for the Regional Program, but the clear intent of the Congress was that the Advisory Group would ensure that the Regional Medical Program is planned and developed with the continuing advice and assistance of a group which is broadly representative of the health interests of the Region. The Advisory Group must approve all proposals for operational activities within the Regional Program, and it prepares an annual statement giving its evaluation of the effectiveness of the regional cooperative arrangements established under the Regional Medical Program.

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

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

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

In examining the problem of coronary care units throughout its Region, for example, a Regional Program may recognize that the more effective approach would be to consider the total problem of the treatment of myocardial infarction patients within the Region. This broadened approach on a regional basis enables the Regional

Program to consider the total array of resources within its Region in relationship to a comprehensive program for the care of the myocardial infarction patient. Thus, what was a concern of individual hospitals about how to introduce coronary care units has been transformed into a project or group of related projects with much greater potential for effective and efficient utilization of the Region's resources to improve patient care.

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

Definition of Objectives—A Regional Program is continuously involved in the process of setting operational objectives to meet identified needs and opportunities. Objectives are interim steps toward the Goal defined at the beginning of this section, and achievement of these objectives should have an effect in the Region felt far beyond the focal points of the individual activities. This can be one of the greatest contributions of Regional Medical Programs. The completion of a new project to train nurses to care for cancer patients undergoing new combinations of drug and radiation therapy, for example, should benefit cancer patients and should provide additional trained manpower for many hospitals in the Region. But the project also should have challenged the Region's nursing and hospital communities to improve generally the continuing and in-service education opportunities for nurses within the Region.

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

Implementation—The purpose of the preceding steps is to provide a base and imperative for action. In the creation of an initial operational program, no Region can attempt to determine all of the program objectives possible, design appropriate projects to meet all the objectives and then assign priorities before seeking a grant to

implement an operational program which encompasses all or even most of the projects. Implementation can occur with an initial operational program encompassing even a small number of well-designed projects which will move the Region toward the attainment of valid program objectives. Because regionalization is a continuous process, a Region is expected to continue to submit supplemental and additional operational proposals as they are developed.

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

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

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

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

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CHRONOLOGY

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

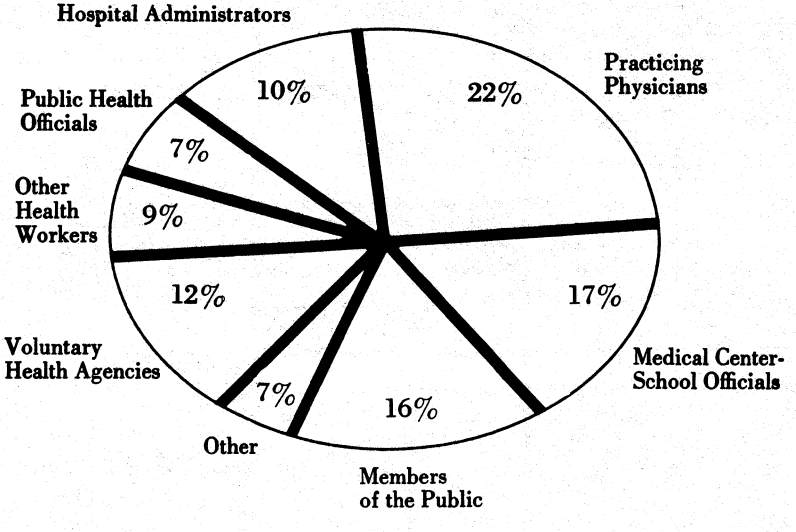
PUBLIC LAW 89-239

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

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

REGIONAL ADVISORY COUNCILS

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



Dr. LEE. The leadership you and members of the subcommittee and full committee have provided in the field of migrant health has brought medical care to great numbers of Americans who might not otherwise have known any of the benefits of modern medicine.

Until passage of the Migrant Health Act in 1962, health care for migrants was virtually nonexistent. Today, thanks to extension of the act in 1965 and your continued support, major gains have been made in bringing health services to this group, who, in spite of their vital role in the agricultural industry, remain the last to receive health benefits most Americans take for granted.

The core provision of the act is the family health service clinic. At present, family health service clinics are operating seasonally or year round at more than 200 locations. The typical project places major emphasis on general medical care offered by private medical practitioners in family health service clinics, in out-patient departments of hospitals, or in their own offices.

Some projects provide dental services. All provide nurses who welcome incoming migrants, informing them of the services available to them. All provide sanitation workers and health education programs.

Hospitalization was added to the scope of service under the provisions of the 1965 extension of the Migrant Health Act. Funds became available for the first time for this purpose during 1967.

In the latest 12-month period for which summarized project data are available, migrants made 215,000 visits to physicians and 24,000 visits to dentists. In addition, nurses made 125,000 visits to migrant households and sanitarians made almost the same number of visits to living or work sites. Many communities and individuals have invested their own time, facilities, equipment, funds, and other items essential to the provision of project services.

The improvements which have been made in migrant health care since the passage of the act are quite dramatic, but there is still much to be done. Grant-assisted projects are reaching only about one-third of the Nation's migrants, and these for only part of the year.

Nearly 40 percent of the counties with seasonal migratory workers still have no grant-assisted project services. Medical visits and dental visits made by migrants are only about one-fifth and one twenty-fifth of the national per capita average. Deaths from influenza and pneumonia, tuberculosis and other infectious diseases, diseases of early infancy, and accidents are from 150 to 300 percent of the rates for the Nation as a whole.

Without continued and expanded financial and technical assistance, much of the current effort would be lost. The President's National Advisory Commission on Rural Poverty has recommended extension of the Migrant Health Act with sufficient funds to expand the program in terms of geographic coverage and services offered.

The advantages of a separate health program to migrant families have been great. But the time will come—and very shortly—when migrant families will be far better served by a recognition on the part of the States and communities that for all their unique problems and needs, migrant families are much like the rest of the population. They must have access to medical services at a price they can afford to pay.

We recommend extension of the act for 2 years. By the end of fiscal year 1970, we expect the States to be dealing with migrant health problems as part of a larger program of continuing operations authorized and supported by the partnership for health.

In short, we believe that this separate program of assistance to migrant families is helping to overcome the inequalities in health care between them and the rest of the population, but that in the long run, true equality in health care will be realized only when their needs are not treated separately by the States.

THE ALCOHOLIC AND NARCOTIC ADDICT REHABILITATION AMENDMENTS OF 1968

As introduced by the distinguished chairman of this committee, this bill will encourage the development of prevention and treatment programs for alcoholics and narcotic addicts in communities across the Nation.

This committee is well aware that the Community Mental Health Centers Act has already been beneficial to many of those suffering from mental illness and to their families, bringing treatment out of the remote custodial institutions into the community and making effective care available close to home. To date more than 260 mental health center grants have been awarded throughout the country. Eighty-five centers are now open.

We propose an amendment to this vital legislation in order to bring these same benefits of readily accessible care to those suffering from alcoholism and narcotic addiction, by providing special incentive grants for that purpose.

Mr. Chairman, it is estimated that some 5 to 6 million Americans can be classified as alcoholics—about 4.5 percent of the population aged 20 and over. Alcoholism, an enormous economic liability to the Nation, costs perhaps $2 billion a year in job absenteeism, lowered productivity, medical insurance expenses, and other losses. The damage in human terms is beyond measure—affecting not only the alcoholic but all those whose lives are touched by his illness.

Further, it appears likely that virtually all American communities shortly will be facing a major crisis in attempting to develop adequate medical, social, and psychiatric services for those alcoholics who formerly were handled almost exclusively by jails, prisons, and other penal institutions.

Two recent Federal circuit court decisions have stated that if a man's drunkenness is part of his illness—and this is a nonvoluntary act—he should be treated as a sick person and not as a criminal. The U.S. Supreme Court will render its decision on a similar case later this spring.

Generally, neither the alcoholic, his family, nor the friend or counselor who wishes to help has any single place in the community to turn for the full range of services he needs. There are few integrated networks to provide the treatment and other services needed to restore him to a productive and satisfying life.

Therefore, Mr. Chairman, government at all levels has an obligation to accelerate the process that will make care and treatment accessible for these people. It is time that we provide the States and communities

with the incentives to enable them to meet this critical public health challenge.

This bill, building on the highly successful Community Health Centers Act, will amend that act to authorize special funds for the construction, staffing, and operation of facilities providing treatment for alcoholics.

The community mental health center approach is well suited for extension into this area of critical need, since it mobilizes the resources of the community in a program meeting the total mental health needs of its people. It helps to provide inpatient care, outpatient care, partial hospitalization, emergency service and communitywide services of consultation and education. It serves the full range of mental health needs—from the seriously ill patient to the person who can lead a normal, successful life with the aid of certain supporting services.

Clearly this is a highly appropriate model in which to integrate treatment and rehabilitation services for alcoholics. The centers are tuned to the community—the setting in which the alcoholic lives. They are involved in essential relationships with general hospitals, with public health departments, with social welfare agencies, with the courts, the schools, the vocational rehabilitation agencies, and also with other community sources of help such as doctors, lawyers, and clergymen.

It is now generally recognized that alcoholics and addicts are in urgent need of social, psychological, and medical assistance. Such assistance in treatment and rehabilitation should take its place in the mainstream of community mental health effort.

The proposed legislation authorizes grants for the construction of facilities for the prevention and treatment of alcoholism, and for their staffing, operation, and maintenance. These facilities are to be coordinated or associated with facilities providing comprehensive community mental health services.

For several reasons, we feel that a specific category of incentive grants for alcoholism should be authorized within the Community Mental Health Centers Act. First, alcoholism is a tragically long-neglected major public health problem. It has received only limited attention for State and community helping agencies in the past, and the problem must now be highlighted.

Second, although community mental health centers have expressed interest in providing services for alcoholics, most of them have not yet taken substantial steps in this direction. They have had difficulty in developing services for these patients because community support for alcoholism programs has been lacking, because services for these patients are expensive, and because the patients frequently lack the means to pay for their own care.

Third, professional interest in providing treatment for alcoholics has been limited thus far. These persons are difficult to treat, and special incentives are urgently needed for an interim period until alcoholics are accorded medical, psychiatric, and other types of treatment on an equal basis with other patients in need of help.

Two types of grant programs would be authorized by this legislation: Grants for construction, staffing, operating, and maintenance of general alcoholism treatment programs, and similar grants for specialized residential facilities for homeless alcoholics.

While those arrested for public drunkenness account for only a small proportion of any community's alcoholics, they do present a very substantial and highly visible problem. The proposed grants for residential and other special facilities for homeless alcoholics will go a long way toward providing help and hope for these persons who have in the past been handled primarily by the courts and police.

NARCOTIC ADDICTION

The problem of narcotic addicts likewise calls for special attention. The number of such addicts is relatively small in comparison with the 5 million or more alcoholics. The Bureau of Narcotics records some 62,000 who are addicted to narcotics, and there are unquestionably countless thousands who exist anonymously.

As in the case of alcoholics, there is today a grievous lack of adequate community services to provide care and treatment. The local community presently offers only minimal help. There is a pressing need for special funds for the construction, staffing, and operation providing treatment facilities, as well as for training of personnel, field trials, and demonstration projects related to improved treatment techniques. As in the case of alcoholism, there is a need for integrated treatment and rehabilitation services. Here, too, we believe the needs can be best met by building on the Community Mental Health Centers Act.

The proposed legislation would amend the Community Mental Health Centers Act by transferring to it the authorities now contained in section 402 of the Narcotic Addict Rehabilitation Act of 1966.

This section provides for project grants to States, communities, and nonprofit agencies for construction, staffing, and operation, and training of personnel for facilities for the treatment of narcotic addicts as well as related surveys and demonstrations.

The proposed transfer will not affect the relationship between this program and other activities authorized under the Narcotic Addict Rehabilitation Act.

Professionals have long believed that narcotic addiction is, to a great extent, a symptom of underlying mental illness, and therefore that recent advances in treatment and rehabilitation of the mentally ill should be extended to the addict. The Narcotic Addict Rehabilitation Act of 1966 was an important step in advancing this concept.

Let me describe briefly the program envisioned in such a narcotic addiction treatment center.

A model comprehensive treatment program would provide care for approximately 400 narcotic addicts per year. Such a program would include a 10- to 12-bed inpatient unit to be used for withdrawal. Residential treatment or partial hospitalization services, such as day care, would be another element of the program.

Outpatient treatment and followup services, including rehabilitative, vocational, or educational programs, would also be provided. Preventive and diagnostic services should also be provided either directly or through cooperation with other community agencies.

A halfway house or residential treatment center located in the community would house 30 to 40 patients. One or two outpatient facilities connected with each center would serve addicts and their families and would be staffed by two or three mental health professionals, a

vocational rehabilitation counselor, a community organizer, two trained ex-addicts, and five other persons, such as nurses or social workers.

An evaluation and epidemiologic unit to study the extent and characteristics of that community's addiction problem might be another component.

Mr. Chairman, the proposed amendments to the Community Mental Health Centers Act are intended to strike at the roots of an intensely tragic situation. In most American communities, alcoholics and narcotic addicts—and their families who suffer with them—have few places to turn for professional help. Yet many of these people could be restored to productive living if such help were within reach.

Community mental health centers will be operating in cities with a high incidence of alcoholism and narcotic addiction. However, the Community Mental Health Centers Act now offers no special inducement to centers wishing to attack these critical and difficult problems. The proposed grant program is intended to provide the necessary stimulus and the capability to do the job.

In addition, the amendments before this committee today will serve as a model for the States in developing and modifying their own community mental health, alcoholism, and addiction legislation.

This committee, by recognizing the importance of incorporating facilities for the prevention and treatment of alcoholism and narcotic addiction into the community mental health center complex, will make a vital contribution toward achieving prevention and control of these major public health problems.

I would like to insert in the record two tables, showing participation in the regional medical program, and total obligation of funds.

(The documents referred to follow:)

TABLE I.—*Participation in regional medical programs by individuals and organizations*

Individuals	7,200
Staffs of 54 programs	1,800
Members of regional advisory groups	1,900
Subcommittee members	2,500
Local action group members	1,000
Institutions	934
Hospitals	800
Medical schools	[1] 103
Dental schools	18
Schools of public health	13
Organizations	779
State medical societies	[1] 52
County medical societies	90
State health departments	[1] 52
State cancer societies	[1] 51
State heart association	[1] 52
State hospital association	40
Areawide health facility planning agencies	30
State dental association	29
Other professional societies, local voluntary agencies, etc	383

[1] 100 percent participation.

TABLE II.—*Regional medical programs, total obligation of funds*

Fiscal year:	
1966	$2,500,000
1967	28,900,000
1968	[1] 53,800,000
1969	[2] 99,800,000

[1] Projected.
[2] President's budget.

Dr. LEE. Thank you, Mr. Chairman, for this opportunity to explain to this subcommittee our views on H.R. 15758. Mr. Huitt, Dr. Marston, Dr. Yolles, and Miss Johnston will be happy to answer any questions you may have.

Mr. ROGERS. Thank you very much, Dr. Lee, for your statement covering the proposed legislation. I think we will start our questions by Mr. Kyros.

Mr. KYROS. Thank you, Mr. Chairman.

I want to commend you, Dr. Lee, on a very excellent statement and to welcome you here. I would like to start with the last thing you said on page 18 of your statement.

How will community mental health center completions, where you will have facilities for treatment of alcoholism and narcotic addiction, make a vital contribution toward preservation of such problems?

Dr. LEE. I would like to ask Dr. Yolles to comment on that, and then I will comment also.

Dr. YOLLES. The prevention referred to in terms of these programs, which are primarily pointed to treatment of alcoholics and addicts, refers to secondary prevention. The secondary prevention approach is, in effect, early intervention to prevent further pathology from occurring.

We would hope that the preventive aspects—education, consultation with other agencies, would be handled under other legislation, Public Law 89–749, the Partnership for Health Act, which also will deal with these problems.

Mr. KYROS. Will these centers be similar to some of the mental health centers in Massachusetts? Will they treat people as outpatients?

Dr. YOLLES. Depending on the type of case, you may have a variation in types of treatment. If someone came in in an acute state, he would be hospitalized, generally in a general hospital, and then go on to perhaps transitional day care or night care and then outpatient care, and followup thereafter.

Mr. KYROS. Let me ask a question generally about the regional medical program.

As I understand it, it has been in operation nearly 2 years, is that right?

Dr. LEE. That is correct.

Mr. KYROS. Have you been able to make qualitative analysis on whether this program has made knowledge of medical science available to practitioners in rural areas?

Dr. LEE. Yes; I think we can cite examples. I would like to emphasize that the efforts until now, of course, have been primarily bringing the various groups together, building the foundation on which the operational programs will be moving forward rapidly.

Dr. Marston?

Dr. MARSTON. This is not an easy question to answer at this early stage in the program. We do have operational grants awarded which include more than 100 projects that are underway in the regions.

Perhaps the best way I could answer this might be to take the example of one region and how it has moved in the area of heart disease, cancer and stroke.

I would like to use, from time to time, some of the words of the applicant, because this is a program that is occurring in the region.

The North Carolina regional medical program decided in the late summer of 1967, about a year after it received its planning grant, that it had attained readiness for operational status. Conceptual strategy to achieve the goals of the regional medical program had been developed. A unified, representative leadership of the region, the principal health interests in the region, had been organized for the stimulation of productive, cooperative effort for guidance and coordination of program development, and an organization structured for effective decisionmaking based on needs in the region had been developed and adequately tested.

During 1966 and 1967, North Carolina had had a small project in the area of heart disease. This development was described in the region's progress report as follows: Since cooperative arrangements involving such a wide assortment of people and institutions in one project was a novel departure for us, the experience has been invaluable. We quickly learned that the original project contained seriously inadequate provisions for manpower. Thus, in our operational grant application submitted in October 1967, an expansion of the project was proposed, and as time passes, further modification is anticipated. Conferences with staffs of small community hospitals and observations of patients with acute myocardial infarcts being treated therein convinced us that an effort had to be made to determine the feasibility of an appropriately designed coronary care unit for these small hospitals.

The region's report goes on later to describe the availability of coronary care units, and particularly the ability in these units to do something as far as the rhythm or the electrical disturbances in the heart is concerned, which is not possible without the specialized equipment and trained people in these units.

The growing interest and availability of coronary care units in this region also has generated the need to provide a cardiopulmonary and resuscitation training program to expand on an earlier, limited program of the North Carolina Heart Association.

Additional projects in the heart area, which are in various stages of implementation or planning, include the diagnosis and treatment of hypertension, the use of specially equipped ambulances, pediatric cardiological screening, and so forth.

In the cancer area, the North Carolina program worked with existing groups who have worked in the cancer field before, and they state an increasing number of community hospitals and their staffs are attempting to meet the standard of the American College of Surgeons for the approval of their cancer programs. In this region there are only seven hospital programs that currently are approved, and they would hope to increase this through the regional medical programs.

The North Carolina regional medical program now enjoys, according to a report of progress, an unusually active cooperative arrangement with all of the major groups concerned with planning and implementing cancer activities.

The cancer subcommittee of the regional advisory group provides a mechanism whereby efforts can be better coordinated and tasks more rapidly and effectively accomplished. They are about to initiate a central cancer registry and a central cancer information service. Their goal is to establish a well-coordinated, comprehensive cancer program with full participation of State agencies, academic agencies, community hospitals, and professional and voluntary organizations. This group of cooperating groups also includes a special cancer commission established by the Governor some years ago, before the advent of the regional medical program.

The North Carolina program reports that much less has been accomplished in the area of stroke than in the other disease categories, but there is an emphasis in this statement that there is an intent to bring the program into balance.

Knowledge sufficient to launch and maintain a meaningful stroke program in both urban and rural North Carolina communities is available, and they have an application before us for development of a community stroke program.

I would like to just mention one other thing, not in a categorical area, about a particular problem that this region has identified through its associate director for hospitals. In the western part of the State there are seven hospitals in as many communities that are facing manpower problems—that are facing the problem of keeping up.

Dr. Amos Johnson, who is a past president of the American Academy of General Practice, told the 1968 Washington conference workshop on regional medical programs that these seven hospitals will be brought together in a coordinated program by the people in the region. These hospitals are prepared to go so far as to apply as a group for a single accreditation under the Joint Commission on Accreditation of Hospitals.

Thus, North Carolina is in the midst of testing the concept of a unique regional hospital organization where no one hospital is able to provide the full range of necessary capabilities.

Mr. KYROS. Thank you.

Dr. LEE There has been in the last 3 years—and we want to make it clear we do not take credit for this with respect to the regional medical programs—a significant decline in deaths from high blood pressure. It is about a 20-percent decline over the past 3 years. I think there is no question that as the regional health programs develop activity and the knowledge of early detection of hypertension, and early treatment becomes more available, we will see an acceleration of this very significant decline, which, of course, will affect particularly the stroke problem and, to a lesser extent, the deaths from coronary disease.

Mr. KYROS. Dr Lee, pursuing the question of the effectiveness of the program, let's think for a moment about costs.

As I understand it from your table II, "Regional Medical Programs," a total obligation of funds for the fiscal years 1966 through 1968, you show approximately $85 million, either in planning or operational grant obligations.

Now, as measured against that $85 million, have you made any kind of an analysis or evaluation which shows that, for that kind of money, we have achieved some significant advance through the regional medical program?

Dr. LEE. The program to date primarily has been one of planning and developing the mechanisms which then can be evaluated. For example, we were developing the data base which in many areas is seriously lacking.

After we develop such a data base in the regions, we will carry forward the evaluations for which we are asking specific earmarked funds.

I think it is really too early to be able to state with any degree of certainty a cost-to-benefit effect.

I think that we should also recognize what I think is going to be one of the most significant contributions of the program. That is the spin off of benefits, well beyond the program itself, not only in terms of people whose care is paid for through medicare or medicaid. For example, as improvement takes place in community hospitals the way Dr. Marston described it, as physicians are able to participate in these programs in community hospitals, the program is bound to have a significant impact on improving quality.

I think the best buy in medical care is good care, high-quality, and this, to me, is going to be one of the most important long-term contributions of the program. And I think this is one of the reasons that we see the kind of enthusiastic support among practicing physicians in many parts of the country who were at first really very suspicious of the program.

As they have seen it develop, as they have participated, they have become increasingly enthusiastic. We will be developing for this spin-off some techniques for measurement so that we can determine the additional conditions of the program.

Mr. KYROS. Dr. Lee, in this bill as it is proposed, I understand that $65 million is sought for the fiscal year ending June 30, 1969.

Dr. LEE. That is correct.

Mr. KYROS. What carryover of funds will we have for this program?

Dr. LEE. The carryover is $30 million.

Mr. KYROS. So of the approximately $95 million we are talking about, you have $30 million unobligated as yet.

Dr. LEE. Yes. That is held in reserve, actually, by the Bureau of the Budget.

Mr. KYROS. My next question is a general one about your program. Has the American Medical Association now endorsed this program as it is being carried out?

Dr. MARSTON. I think the best answer to that is a paper that Dr. Dwight Wilbur gave at a conference workshop—which has been published in the current issue of JAMA. It is very supportive of the program.

Mr. KYROS. What does this program do for a general practitioner, say, in a rural area like in my own State of Maine?

Dr. LEE. I might add one thing. If the AMA has endorsed it, these are actions that would have to be taken by the house of delegates. They would have to vote on a resolution saying they endorse it, and I am not sure that action has been taken.

Mr. KYROS. But the President has put in a statement that he supports it.

Can you tell us specifically how a general practitioner in a rural area gets involved in a program? Say there is a regional program in the area in which he practices, but he is in a small town that doesn't have a hospital.

Dr. MARSTON. A number of examples come to mind. There was a problem—again in North Carolina, to take up where I left off—of a community that was about to be without a physician, and the people in the community turned to the regional medical program for assistance.

The regional program was able to examine what the problems were in attracting physicians to that community and growing out of that, there has developed a rather major study for that region in the problems of the rural area.

The principal example, I think, is an easy one: The tradition of the Birmingham Associates which, as you will recall from testimony leading to passage of this legislation, was held up as a model of how various health institutions and resources can have a relationship through an organization such as the associates. The activities of the Birmingham Associates are being expanded and carried further by the regional medical programs.

There are a variety of other things being done to assist the physician in rural areas where no hospital exists. There are opportunities for physicians from one part of Washington State to come into and actually spend time in larger hospitals. This includes an exchange so that someone arranges to take over their practice for a period of time. There are the usual continuing education programs, but I think with a different emphasis—with the emphasis on doing those things that meet the needs of the physician rather than offering a course that is preselected for him.

The difference has been that the physician is involved in decisions and in planning in terms of his needs rather than coming in at a later stage.

There are also other facilities or services in a number of the regions that are planned and will be implemented for the physician.

Dr. LEE. I would just add another comment on that, and this relates to a personal experience I had visiting Vinel Haven Island, where there is one physician in general practice. He has been able to attract occasionally third- and fourth-year medical students to come and spend part of the summer with him, and this has been a tremendous stimulus to him. It has provided him the best possible opportunity to keep up.

It has also been a unique educational experience for the students, because people have lived there for many, many generations, and certain disease patterns there are somewhat unique. He has developed relationships with, for example, diabetic experts at Harvard, who have been interested in diabetes in this particular population group.

He has been able to keep up far more effectively than the average practitioner, and one of the things that is being explored in the program is the participation of third- and fourth-year medical students in these community hospital teaching programs.

The development of teaching programs in community hospitals, the extension of teaching programs, will attract young physicians to areas

that would otherwise not have been attractive to them. They have been used to active teaching programs in the university centers, and they have tended not to want to go too far from these.

But I think the opportunity to keep up professionally, to interact with other people and with students on a continuing basis, will be an added benefit.

Maine is a very good example of the needs of the country to attract physicians to areas other than these urban areas where most of them have settled, or the suburban areas.

I think that the regional medical programs are making and can continue to make a significant contribution to this.

Mr. KYROS. I have one last question, Mr. Chairman. That is this: You have seen the program in operation for a couple of years now.

What can you say about the fact that this is Federal money, that there is a possibility, always, when using Federal funds, that the Federal Government gets some kind of control over the medicine and medical practice. You know, we hear this all the time, and we are concerned about it, and I wouldn't want to see Federal control over medicine.

How can you say, sir, as administrator of this program, that Federal control is not an encroachment on medical practice through this program?

Dr. MARSTON. I think this committee took a very important step when it gave essentially veto power to the regional advisory groups. This means that we cannot establish on the national level any regional operational activity that has not had prior approval of the appropriate Regional Advisory Group. And this is perhaps the strongest point.

The other point is that, again, the Surgeon General is limited by the fact that every application must be recommended for approval by the non-Federal, National Advisory Council on regional medical programs. I think basically these are the two sharpest assurances that the control will remain at the regional level.

A third assurance is that the programs are working with the control remaining at the regional level. This is recognized, I think, at the Federal level as well as throughout the country.

Mr. KYROS. You have had no feedback of any problems concerning complaints of Federal control like we have had in programs, such as OEO and others?

Dr. LEE. I think there was a great deal of speculation that this would be the case. The fact that it has not been the case, the fact that there has been increasing participation by practicing physicians in the planning of the programs and as the operational programs develop, the extent of participation, the fact that there are 800 hospitals with their staffs participating are indications that this, in the planning and early operation stage, really has grassroots support.

I would add one other thing to what Dr. Marston said. I think the actions of this committee and the periodic oversight of the program by the Congress is another assurance to physicians, with the law as it is written, that there will not be Federal control.

Certainly, the way in which the program has been administered has been just in the opposite direction, to stimulate to the maximum extent possible, local initiative. Those who participate have to solve their local differences, which have been considerable in some of the regions.

Some people have felt that the program was moving too slowly, but it takes time to work out differences which have long existed.

But as we view it, the way we are proceeding gives the best possible foundation for the program, because it is stimulating local initiative all over the country.

Mr. KYROS. I am delighted to hear you say that, Dr. Lee. I know from my experience from talking with doctors in the State of Maine, that they think the program is an outstanding one, that it doesn't encroach on them, and I think this is a credit to your administration.

You are the people who have to do a hard job, and I want to commend you highly on administering a program like this, which is complicated—and particularly because of the important relationship between doctors and patients.

You have done an outstanding job, and I am proud of you.

Mr. ROGERS. Mr. Carter?

Mr. CARTER. I notice that the new bill will include an authorization for funds for treatment of alcoholics, and it will also include funds for treatment of addicts, too.

Dr. LEE. Yes, sir.

Mr. CARTER. How much will that be this year and next year, your additional authorization?

Dr. LEE. The amount that we have requested is, for the alcoholics, $7 million, and for the narcotic addict rehabilitation, $8 million, and in fiscal 1970, $15 million for the alcoholics and $10 million for the addicts.

Most of that money will be for the development of services rather than construction. It is about 30 percent for construction or renovation of facilities.

Mr. CARTER. Will these treatment centers for alcoholics and narcotic addicts be an integral part of the mental health centers, or will they be separate?

Dr. LEE. I would like to ask Dr. Yolles to further elaborate on that.

Dr. YOLLES. These treatment facilities, Dr. Carter, would be built into the community health center and would be an integral part of it.

We would even relate the special facilities for homeless alcoholics to this continuum of services. This is the key point in the legislation to relate these services for treatment of alcoholics and narcotic addicts to the total panoply of services in the community health center.

They may be physically separated, but there would be adequate transfer of patients and records between the services, just as in the basic program.

Mr. CARTER. I think that it is good that it is so. It will be less difficult, as I see it.

I notice that in your regional health development, 11 regions have been funded. Is that right?

Dr. LEE. Yes, 11 operational grants have been funded, and 53 planning grants.

Mr. CARTER. This is in its infancy at the present time?

Dr. LEE. That is correct, sir.

Mr. CARTER. Of course, there has been a decrease in the number of strokes in the past 3 years, but you really wouldn't attribute all that decrease to the establishment of these 11 regions?

Dr. LEE. No, not at all, Dr. Carter.

I think we would not want to imply that either these programs or some of the other programs that have been initiated in the last 3 years that have been making good progress would in any way have done so. They may have contributed, but certainly, as far as the national figure is concerned, it would be a slight contribution to date.

Mr. CARTER. Actually, there are improved methods of treatment, really, different medicines used in treatment of strokes that have been mainly responsible for this.

Dr. LEE. Yes, sir. I think the improved drugs and the earlier diagnosis of the hypertensive association that they get under treatment at an earlier stage of the disease have contributed to this.

Mr. CARTER. I would like to know how the specific organization of a region is. Could you give us a plan, who is head of it, and how it branches down?

Dr. MARSTON. I think what one needs, Dr. Carter, is the organization of more than one region to achieve what you want.

The one thing that has to be established in each region is a broadly representative regional advisory group. It is a requirement of the law that this be established.

In every region, so far as I can remember, there are task forces in the areas of heart disease, cancer, and stroke, which include people with special knowledge in these areas.

In each region there is also a core administrative unit, a staff that varies in size. But on the average in the regions funded for planning only, it is about 20 to 26 people, and in the operational regions, the staff that is actually paid on an average number about 90.

Operation of the program is set up differently in different regions. In Connecticut there are 10 subregions. In Kansas there are 10 subregions. In Georgia, there is really a subregion for each county, with representatives from every hospital in the State, and with representatives from every county medical society. These local-level groups are active in determining their local needs. In some instances these units are called local advisory groups.

Now, to come to a specific region, in Kansas these local action groups may either respond to information that has come from studies carried out by the regional staff or, indeed, other groups in the State. Or the local action groups may propose projects that they themselves identify as being particularly needed in that area. In designing these projects, the local action groups can work with the staff of the regional medical program, calling on experts from outside of the region, if necessary.

Kansas has a substantive review committee, that is, a committee that reviews, on the basis of scientific and professional merit, the proposals.

Finally, with the results of this review available, the application, which may have been stimulated either at the local level or may have been stimulated as the result of data that has been gathered elsewhere, comes before the regional advisory group, which must approve all operational project proposals.

A recent example of this process in Kansas resulted in about half of the proposals that came to the regional advisory group being returned to the originators for one reason or another for additional work before final approval at the regional level. After regional ad-

visory group approval is gained, a grant proposal for funding program activities comes to the Division of Regional Medical Programs. At this point, we have the opportunity to have special site visits as we did in the case of the Washington–Alaska Region's operational application. In this case we actually visited the locations where projects were proposed, and made a report to our review committee and, finally, to our National Advisory Council.

Does this help?

Mr. CARTER. Yes, sir; that is helpful.

What procedures do you have for continuing education to get to the general practitioner and communities your advances in research?

Dr. MARSTON. Again, this has varied. There have been some instances in which a community took the lead. Great Bend, Kans., for example, has established an educational subcenter, if you want, for the area immediately surrounding Great Bend.

The purpose here is to try to focus education and to focus care as close to the patient's home as possible. And in the instance of Kansas, you find this focus has been moved out away from the university to subcenters.

In other areas, preexisting programs and facilities have been utilized—Albany, N.Y., for example, has a two-way radio system which provides in-hospital education throughout much of the New England area. This has been augmented by the Albany regional medical program.

I would say continuing education related to the physician and the patient's needs, as opposed to continuing education that somehow has drifted away from the care of patients, is a very major focus of the program.

Mr. CARTER. Do you have regional seminars on newer concepts in medicine attended by practitioners from the subregions?

Dr. MARSTON. There was a major one in Oregon that a member of my staff attended not long ago.

Mr. CARTER. The purpose of this bill is to diminish deaths from heart disease, cancer, and stroke.

Do you have available to the practitioners in the subregions close liaison with specialists in the regional areas so that they can get information quickly, or advice, or help in treatment?

Dr. MARSTON. There is an example in Wisconsin of a 24-hour-a-day telephone service to physicians in the area. There is a specialty team in Iowa that has been activated to actually go out to the scene and provide consultation to the local physician and his stroke patients.

Mr. CARTER. That is part of your regional system at the present time?

Dr. MARSTON. Yes.

Mr. CARTER. I want to congratulate you on that. I think that is very good. I certainly feel that these ideas, or these questions which I have asked you should be further implemented, if possible.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Skubitz?

Mr. SKUBITZ. Thank you, Mr. Chairman.

Doctor, I am a new member on this committee, and I am from the great State of Kansas that you have been praising so highly.

Doctor, I am interested in a number of things.

First, I want to say I appreciate the fact that you are interested in Kansas. I hope we can get some money to keep this show on the road.

How much money was authorized, Doctor, for these regional medical programs in 1966?

Dr. MARSTON. The authorization was $50 million.

Mr. SKUBITZ. How much was appropriated?

Dr. MARSTON. $25 million, including $24 million for grants—$25 million total.

Mr. SKUBITZ. In 1967, how much was authorized?

Dr. MARSTON. The authorization was $90 million. The appropriation was $43 million for grants and $2 million for direct operations.

Mr. SKUBITZ. You have a total of how much?

Dr. MARSTON. $45 million was appropriated for 1967, $25 million appropriated for 1966, so that would be a total of $70 million.

Mr. SKUBITZ. In 1968, how much was authorized?

Dr. MARSTON. $200 million. We have received $53.9 million in appropriations for grants and $4,900,000 for direct operations, for a total of $58.8 million.

Mr. SKUBITZ. Out of this total amount of appropriations, how much do you have available to you now?

Dr. MARSTON. $53.8 million—including $4.9 million for direct operations. This total is comprised of $27.9 million of our 1968 appropriation—$30.9 million was put in reserve—plus $25.9 million in carryover funds.

Mr. SKUBITZ. The thing that bothers me, Doctor, is that you come here with an excellent program. It looks fine on paper. But, unless this Congress gives you money we accomplish nothing. So far as I am concerned, I want to be as helpful as I can to assist you in this important work.

Thank you, Mr. Chairman.

Dr. LEE. I would like to make an additional comment on that, Mr. Chairman.

As the program has developed, of course, with the evolution of the planning, the authorizations were well above those required, and as we move into the operational phase, we feel that, of course, significantly more funds will be required with the operating programs. Planning is one thing, but operating programs is quite another.

Mr. CARTER. Mr. Chairman, would the gentleman yield?

Just how has this money been spent, Doctor, most of it?

Dr. LEE. The money, primarily, goes, of course, for the hiring of staff and for the activities of the staff, in some cases for the purchase of equipment, the development of coronary care unit, or for long-distance transmission of cardiograms, which is being tested on an experimental basis.

This kind of thing, staff and equipment, which would be related to the educational efforts—

Mr. CARTER. Do you have a central place in each region, to which place cardiograms may be transmitted by phone?

Dr. LEE. Not in each region. I think that the experimental program is going on in Missouri.

Dr. MARSTON. That is a major one, which has been supported by the National Center for Chronic Disease Control over the last 5 years. It is being field tested in Missouri at the present.

Mr. CARTER. In one region you have such—

Dr. MARSTON. Yes.

Mr. CARTER. Do you envision in the future the use of such centralized diagnostic aids?

Dr. LEE. If we find the experiment in Missouri is successful, and it is demonstrated that you can improve patient care, and that it is feasible from a cost standpoint, that other regions will then want to develop similar programs. It may be that a computer would serve perhaps more than one region. These are expensive, depending on the kinds of programs that are developed, such as automated multiphasic screening.

Mr. SKUBITZ. For example, to detect some of the diseases early, cancer and cardiovascular diseases particularly, the development of the automated long-distance cardiograms—as other advances take place, say, in the area of radiology, it may be that those would also be applied on a regional basis.

I think it is wise to test them out first in a single area, as is now being done in Missouri, to find out how feasible it is at the level of the community hospital, and in the communities where the patients are and the physicians are in practice, to see if it is practical.

Mr. CARTER. Many of our community hospitals have lines to these places to interpret their cardiograms in that way.

Dr. MARSTON. Dr. Carter, this goes a bit beyond that. The reason they wanted to try this advanced system is that, in addition to the usual telephone lines for the transmission of EKG, this new system doesn't take the place of interpretation by the physician, but does save time in supplying the attending physician with an analysis of the electrocardiogram done by a centrally situated computer.

What this project is facing is the fact that we are not going to have enough trained manpower over time to do EKG analyses, and we have to develop some system to augment the highly skilled manpower required in this area. So this system is more than a telephone line.

Mr. SKUBITZ. Mr. Chairman, may I ask one more question?

Mr. ROGERS. Yes.

Mr. SKUBITZ. Did you say $200 million was authorized in 1968?

Dr. MARSTON. Yes, sir.

Mr. SKUBITZ. How much did Congress appropriate?

Dr. MARSTON. $53,900,000 for grants, and $4,914,000 for direct operations.

Mr. SKUBITZ. Thank you.

Mr. ROGERS. What do you think of combining the comprehensive health planning program and the regional program? What would you think of combining these two programs?

Dr. LEE. The two programs have a different purpose. As we move down the path and as these programs develop, they will be obviously closely coordinated and integrated. But I don't believe they should be combined into a single program.

Mr. ROGERS. You don't feel that a comprehensive health plan for a State should include what we are doing in this regional program?

Dr. LEE. Yes, I think as we develop our capabilities at the State level for planning and a capability in the areawide planning, it will encompass concerns with migrants, with other kinds of disadvantaged groups, and it will also include considerations of regional medical programs.

Mr. ROGERS. In the comprehensive plan, don't we give money for treatment of heart disease to a city?

Dr. LEE. In the partnership for health, a formula grant goes to the State, and project grants for the development of comprehensive health services, and these may include services for people who have heart disease or other diseases.

The focus of the regional medical programs, and I think this is fundamental to an understanding of the program, is that they have developed a foundation for cooperative arrangements that simply didn't exist before. We did not have this—in some areas, there were programs of continuation of education, such as in Kansas, or we had the Bingham Associates in New England, but we had not seen the kind of grassroots participation focusing on improving patient care.

The comprehensive health plan has to encompass manpower, environmental health problems—the full spectrum—and the project grants can relate to a variety of these things.

Mr. ROGERS. I realize we are getting this program started now, and it is in a beginning stage, but I would think your planners should be giving thought to combining these programs where there will not be an overlap, because I would think that there would be some areas where there would be rather considerable overlap within a State plan, particularly for heart, cancer, and stroke.

Dr. LEE. We are concerned not only about the relationship of the regional programs with the partnership for health, but also the better and more efficient use of all of the programs, such as OEO programs, and we have seen in the Watts area an excellent example of close cooperation between a regional medical program, the development of a community hospital, and the neighborhood health center program funded by OEO.

We are concerned at the national level with stimulating at the State and local level the close integration of these programs so that we can make most efficient use of manpower, which is our scarcest resource, but also the funds available.

Mr. ROGERS. Yes. I hope to see some of these OEO programs under your department. I feel strongly on this. I realize this was an innovative approach, but I think it should be tied in more closely.

Let me ask a few questions that you may want to give answers for the record, that you may not have with you.

How many regions are actually operating as of January 1968?

Dr. MARSTON. There are now 12 with funded operational programs.

Mr. ROGERS. I know funds. I am talking about operating.

Are they really operating now?

Dr. MARSTON. Yes, sir; they are beginning. This will vary from one I signed yesterday, which is obviously not doing much, to ones that have been operating a year.

Mr. ROGERS. Would you just give us for the record a rundown of each of these 12, the personnel, how they are involved, how much money they are getting, and I would like to know where that money is being

spent, how much on television tie-ins, and how many hospitals are tied in, what improvements are made in hospitals.

In other words, when we passed this bill, the idea of the thrust of this program was to make sure the new methods of treatment were going to get to the people.

Now, I realize it is very early and too soon for us to make a critical judgment, probably, but I get the feeling that this may be stopping in the dean's office at the medical colleges.

Well, I just want to find this out.

[Laughter.]

Dr. LEE. It had better not be.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE (PUBLIC HEALTH SERVICE)
REPORT ON 12 OPERATING REGIONAL MEDICAL PROGRAMS

ALBANY REGIONAL MEDICAL PROGRAM

The Albany Regional Medical Program was one of the first regions to receive an operational award on April 1, 1967. Currently funded with $755,605, the region has approximately 43 operational staff members, including approximately 14 physicians, 17 nurses, 5 other allied health personnel, and 6 general support personnel. Over two-thirds of the staff are from the community hospitals, and they are working closely with the local medical center and RMP staff to increase the capabilities for quality care at the local hospitals.

Approximately 60 hospitals from the Albany Region are participating in the program. Approximately 30 of these hospitals are directly participating in the operational projects outlined below. Two hospitals are represented on the Advisory Committee, and the remaining are involved in on-going planning activities.

Operational Projects

1. Two-way radio communication system, direct cost—$144,100

This project will expand an existing two-way radio network to include 57 hospitals and 24 high schools. It will provide continuing education for physicians and allied medical personnel. It will also provide information and education programs for administrators, members of boards of trustees, voluntary health agencies, adult education classes, and selected civic groups.

2. Community information coordinators, direct cost—$73,800

Former pharmaceutical representatives will be used to contact local physicians to tell them about Regional Medical Programs and to evaluate their attitudes towards RMP.

3. Postgraduate Instruction Development Panel, direct cost—$102,600

This program proposes to have experimental and control groups of doctors to determine their educational needs. These doctors will then participate in instructional programs. Afterwards they will be tested to determine the effectiveness of the instruction.

4. Community hospital learning centers, direct cost—$75,800

This project will establish learning centers at community hospitals using "Self Instruction Units" and audio-visual equipment for rapid dissemination of new medical knowledge. Eventually, the directors of this project hope to evaluate physician progress. Initially, 8 hospitals will be involved.

5. Albany Medical Center coronary care training and demonstration programs, direct cost—$125,200

A coronary care unit will be established at Albany Medical College to serve as a model and training unit for training physicians and nurses who will then be able to establish similar units at community hospitals. This project will augment the existing Coronary Intensive Care Unit at the Albany Medical Center.

6A and 6B. Community hospital coronary care training and demonstration program, direct cost—$55,400

This will complement project #5 by establishing coronary care units of three beds each at three community hospitals: Pittsfield General, St. Lukes, and Vassar Brothers. These will serve as demonstration and educational projects for other hospitals in the region. A continuing educational program will serve the permanent Unit Staff and staffs from smaller hospitals.

7. Training and demonstration project, intensive cardiac care unit Herkimer Memorial Hospital, direct cost—$3,500

The initial phase of this project is to train 6 or 8 nurses from small community hospitals in cardiac anatomy and physiology, coronary disease, the principals and staffing of a cardiac intensive care unit, and in handling the complex equipment. These nurses will also be sent to Albany Medical Center for active training with specialized equipment.

INTERMOUNTAIN REGIONAL MEDICAL PROGRAM

The Intermountain Regional Medical Program received its first operational grant award on April 1, 1967 and its current operational award totals $1,832,800. Approximately 80 staff members are serving in the operational projects, about one-third of whom are from community hospitals working together with the Regional Medical Program staff from the medical center, they are bringing to local health practitioners and hospitals throughout the region modern techniques for treating patients with the categorical diseases.

Approximately thirty hospitals are currently participating in the Program. Three hospitals are represented on the Regional Advisory Group, and almost every major hospital in the region has established a local planning group to study local needs and to serve as liaison with the Central IRMP staff. Seventeen hospitals are participating in the operational projects outlined below, and as the program continues to grow, it is anticipated that additional hospitals will become involved.

Operational Projects

1. Regional faculty and core-staff seminar, direct cost—$12,600

The University of Utah Medical School will hold a series of quarterly seminars on comprehensive health care, continuing education, contemporary learning theory, behavioral science principles, and measurement technology. The faculty, experts from across the country, will address an audience of health professionals involved in IRMP.

2. Network for continuing education in heart disease, cancer, stroke, and related diseases, direct cost—$243,000

The objectives of this program are to develop a communications network between patient-care and research institutions to encourage liaison between health care personnel in the area. The currently existing 2-way radio system, including 11 hospitals in 7 communities in or near Salt Lake City, will be extended to remote hospitals to serve as one link. Closed circuit TV and use of KVED (University of Utah education TV) is also planned. This may establish the community hospital as the locus of continuing education.

3. Information and communications exchange service, direct cost—$40,000

The CIES is a region-wide clearing house for information about IRMP. Staff will be put in local communities to act as public relations representatives and also to distribute information to medical personnel and the public. The community staff will also gather information on community needs and resources and resources and serve as a station for collecting economic, social, and medical data.

4. Cardiopulmonary resuscitation training program, direct cost—$63,400

The University of Utah will give a 3-day course in resuscitative techniques to selected physicians from small communities. Each physician will then be responsible for teaching the techniques to health personnel in his community. This "resuscitation consultant" will also collect data about the number of times resuscitation is employed and the results.

5. A training program in intensive cardiac care, direct cost—$118,600

A core faculty of experts in using Cardiac Care Units and diagnosing and treating heart disease will teach short courses in their subjects. The students will be interested physicians and nurses from community hospitals building coronary care units.

6. Training for nurses in cardiac care and cardiopulmonary resuscitation, direct cost—$34,000

This is an integral part of both the cardiac care and cardiopulmonary resuscitation programs for physicians (#4, #5). Nurses trained in Salt Lake City will return to their communities to serve as a core faculty for reaching the techniques at the local level. The nurses will work closely with the similarly trained physicians.

7. Clinical trainee program in cardiology, direct cost—$65,700

This program has two emphases—

(1) To provide general practitioners, internists and cardiologists with training programs in heart disease techniques tailor made to their individual situations.

(2) To increase the number of formally trained clinical cardiologists through a training period (3 months to one year) at the existing cardiology school at the university of Utah.

8. Visiting consultants and teacher program for small community hospitals, direct cost—$14,800

Small communities will be given the option of requesting one or two-day clinics. A minimum number of four cardiac patients will be required. These clinics will upgrade the level of care to victims of heart disease living in remote areas. Visiting physicians will assist the local physician in a precise diagnosis in a precise diagnosis of his patients.

9. A regional computer-based system for monitoring physiologic data on-line from remote hospitals in the regional medical program, direct cost—$637,100

This project's purpose is to test the feasibility of using a central computer to process a variety of physiological signals generated by patients in remote hospitals, feeding the results of calculations from these signals back to stations within the hospitals, and using the information for diagnosis.

10. Cancer teaching project, direct cost—$94,300

This project attempts to upgrade the level of care available to local communities. The coordinator will direct a program of physician education to create trained cancer specialists who in turn, will become centers of cancer information in their local communities. The physicians will receive a small stipend for teaching and obtaining information. A region-wide tumor registry will be started, as will a training program in new techniques for pathologists.

11. Stroke and related neurological diseases, direct cost—$98,700

This project will establish clinics to bring expert consultation service in stroke and related neurological diseases to local communities; will provide continuing education to local physicians and Nurses; will collect data about stroke patients seen and the problems they present to the practitioner. A 24-hour telephone consultation service and information library service will be maintained at the Utah Medical Center to provide community physicians with immediate advice. In addition, practicing physicians will be trained at the medical center in the latest diagnostic and treatment techniques. The courses will last from 4 weeks to one year.

12. Educational program in respiratory therapy for physicians and nurses, direct cost—$25,300

To train physicians and nurses to utilize the special techniques and equipment in respiratory therapy. Five day seminars and follow-up 2 day refresher courses will train participants to administer therapy and to teach others.

13. Regional endocrine metabolic laboratory, direct cost—$237,900

To provide service facilities where practicing physicians can obtain laboratory data essential to the diagnosis and treatment; to create awareness among physicians of the possible presence of metabolic and endocrine abnormalities; to

derive statistical information. Three laboratories will be established: an immunoassay laboratory, a chemical laboratory to measure steroid hormones, and a developmental laboratory to refine techniques. Seminars will be held both inside and outside of the laboratories. Abnormal findings will be reported to the referring physician by telephone by a physician who is competent to offer consultation.

KANSAS REGIONAL MEDICAL PROGRAM

The operational activities of the Kansas Regional Medical Program began on June 1, 1967, and are currently funded at the level of $699,852. Approximately 80 individuals with varied backgrounds, comprise the current staff, of which about one-sixth are physicians, one-fifth are nurses, and an additional one-fifth are other types of allied health personnel. The remaining staff includes related health personnel, such as communications specialists and social scientists, and general support personnel. About half the staff are from the medical center and the other half are from community hospitals. Together they are working on programs to improve community capabilities for treating the categorical diseases.

Approximately 20 community hospitals are currently involved in the Kansas Program, and it is anticipated that additional hospitals will become involved as expansion takes place during the next few years. Ten of these hospitals are directly involved in operational projects, two are represented on the Advisory Committee, and eight are involved in on-going planning activities.

Operational Projects

1. Educational programs—Great Bend, Kans.—$261,000 (direct cost)

To develop a model educational program in this small community a full-time faculty, which will be affiliated with the Kansas Medical Center, will be in residence. Included in this comprehensive program are plans for continuing physician and nurse education and clinical traineeships for heath-related personnel. Studies will be made of community needs, resources, etc.

2. Health Sciences Communication and Information Center—$77,900 (direct cost)

This project is engaged in conducting studies to determine the feasibility of establishing communication linkages vital to education, service, and research programs. Specific studies to be undertaken are a physician communication system, TV teaching, electronic linkages, and Medlars search capacity.

3. Study of the quality and availability of medical care—$149,000 (direct cost)

To determine unmet needs of patients, locations, professional education, and working arrangements of physicians and those in the health related disciplines.

4. Hospital information system and data facilities—$67,500 (direct cost)

To conduct studies within the region concerning various aspects of community resources and needs, epidemiologic data and participation of health care personnel in continuing educational programs. A *computer system* will be used.

5. Cardiovascular nurse training—$98,500 (direct cost)

To develop an in-service training program to prepare nurses, who are the mainstay of coronary care units in community hospitals, with basic physiological knowledge of coronary care, ability to use instruments and equipment in coronary care units, experience in home care, and familiarity with social agencies that can aid in the rehabilitation of patients.

6. Cancer detection program—Providence Hospital—$25,000 (direct cost)

To evaluate the strengths and weaknesses of the Cancer Detection Center now operating as an area referral center in Providence Hospital in Kansas City, Kansas. The records of patients will be studied to show effectiveness and yield of test results, type of personnel who have used the clinic and their source of referral, and effectiveness of follow-up.

7. Cardiovascular work evaluation—$21,100 (direct cost)

This project will demonstrate the Cardiac Work Evaluation Unit and show its usefulness for the evaluation and rehabilitation of the patient. It is developing an effective technique for showing physicians and the community at large the ability of patients to return to work after receiving the appropriate rehabilitation.

METROPOLITAN DISTRICT OF COLUMBIA REGIONAL MEDICAL PROGRAM

This region began its operational activities on March 1, 1968, with an award of $418,318. A staff of 47, including about 11 physicians, two nurses, seven other allied health personnel, and 27 other types of supportive personnel such as computer programmers, coding clerks and secretaries will work together to improve local medical capablities and resources. About half of the staff is from the medical center and the other half is from community hospitals and other local health agencies. This combination of medical center-community personnel helps assure a quality, community oriented program.

Seven hospitals are currently participating, and this number will increase as the program expands over the next few years to reach out to the entire region. Three of these hospitals are directly participating in the projects outlined below, two additional hospitals are on the Regional Advisory Group, and two are serving on planning subcommittees. However, several additional hospitals will benefit from these programs as they send their personnel to be trained in the programs outlined below.

Operational Projects

1. *Freedman's Hospital Stroke Station for the Diagnosis, Treatment, and Investigation of Cerebral Vascular Disease, direct cost—$181,889*

This project is a comprehensive approach to stroke, from diagnosis and treatment to home care and rehabilitation in an urban Negro area. Based in the Freedman's Hospital, a community hospital in the region, the stroke station will serve as a teaching component for physicians and medical students. Related epidemiological and socio-economic studies will be undertaken.

2. *The Washington, D.C. Regional Cerebrovascular Disease Followup and Surveillance System, direct cost—$94,200*

Under the sponsorship of Georgetown University, this project is attempting to establish a uniform system for measuring and evaluating medical care given to stroke patients in the area, in order to facilitate nursing and follow-up services. It will provide information helpful in determining community medical facilities requirements, and in carrying out epidemiological or demographic studies. Patients entering the system through the various community hospitals in the region will receive follow-up attention and therefore greater continuity of care.

3. *A training program for cardiovascular technicians, direct cost—$74,707*

Qualified students are being trained at the Washington Hospital Center in Washington, D.C. in specific areas of medical observation and procedures to complement nurses' activities. In addition to training personnel for work in hospitals throughout the region, this project hopes to produce a manual for training these technicians in the other regional hospitals.

MISSOURI REGIONAL MEDICAL PROGRAM

Operational activities began in Missouri on April 1, 1967, and current operational funds amount to $2,619,000. An estimated 160 operational staff people, with diverse backgrounds, are serving on the Program, including approximately 15 physicians, four nurses, 16 allied health personnel, three social scientists, and approximately 60 computer specialists and their supporting personnel. The remaining staff provide overall support, such as research and staff assistants and administrative and clerical personnel.

The developmental approach being employed by this region and outlined in project descriptions below suggests that hospital involvement will increase rapidly over the next two years. Currently, nine hospitals are involved in the program, including two hospitals which are represented on the Regional Advisory Committee.

Operational Projects

1. *Smithville community health service program—direct cost $200,957*

The purpose of this project is to establish a model community health service program including continuing education and training programs and health education for the public; emergency intensive and restorative care facilities; home care programs; public health, preventive medicine, and school health; coordinated with voluntary health agencies. Program centered around Smithville

and to include about 50,000 persons in county (Clay). Activities are centered around Smithville Community Hospital and the group practice clinic as a nucleus.

2. Multiphasic testing of an ambulant population—direct cost $421,471

This project is designed to establish centers for performing series of diagnostic laboratory tests to identify the most useful tests feasible for screening large rural population groups; determine the different patterns for ill and healthy populations as an aid in detection of heart disease, cancer and stroke in preclinical stages. Model test centers will be established at the University Medical Center, Columbia, Missouri, and the State Mental Hospital in Missouri. A third is planned for the Smithville complex.

3. Computer fact bank—direct cost $279,365

This project is designed to develop and apply techniques for delivering latest information on diagnosis and care of patients with stroke and allied diseases to the local physicians. Electronic data information storage and retrieval system will be developed at the University Medical Center (Columbia, Missouri) and later extend to include Smithville and other communities in the region.

4. Mass screening-radiology—direct cost $54,814

This project will help improve the accuracy of radiologic diagnosis of heart disease, cancer and stroke through electronic communications media. Three small rural hospitals will be hooked into the University of Missouri computer and Department of Radiology to evaluate diagnostic efficiency and determine applicability of ultra-sound and thermography in diagnosis and therapy.

5. Comprehensive cardiovascular care units—Springfield, Mo., direct cost $69,347

A comprehensive care unit for grouping patients with heart disease or other circulatory system illness or who have been admitted for other purposes but require close cardiac observation is being developed. The project is to be undertaken at hospitals without a house staff, where it is hoped that grouping of patients will relieve the workload for nurses on general medical and surgical wards. St. John's Hospital medical staff and Greene County Medical Society are coordinating activities with 3 local hospitals in Springfield.

6. Communication research unit—direct cost $61,743

Supporting research unit for program to identify public attitudes and knowledge about heart disease, cancer, and stroke; to understand motivations for seeking health care and to determine and develop effective methods for communicating with public and lead them to seek medical care.

7. Data evaluation, computer simulation and systems design—direct cost $329,712

This program will help to determine data needed from the public and physicians for early detection of heart disease, cancer and stroke through studies on the form of data, mechanisms for classifying, storing and retrieving data most effectively.

8. Bioengineering project—$229,129

The aim of this activity is wider distribution in rural areas of sensor transducers, for early detection of heart disease, cancer and stroke and to generate more information on physiological patterns of these diseases.

9. Program evaluation center—direct cost $103,899

Through a multidisciplinary research approach accumulate data in two separate communities about health care, needs and attitudes as a base for developing instruments for measuring quality of care and levels of health in terms of an individual's function in his community.

10. Automated patient history—direct cost $77,561

This project is testing the feasibility of an automated system for obtaining patient history and analyze complaints prior to examination by physicians, as an aid in early disease detection.

11. Automated electrocardiography in a rural area—direct cost $369,000

To provide hospitals and physicians in rural areas with automated facilities for transmitting electrocardiograms and an automated system for analyses of ECG's; to demonstrate the feasibility of such systems where this service is limited or non-existent, and to develop, test and implement the use of bioengineering signals as aid in diagnosis.

12. Operations research and systems design—direct cost $39,055

This activity will help develop systems concerned with testing "early detection" hypothesis-develop operational methods of early detection tests for a large rural population.

13. Population study group survey—direct cost $65,200

Using National Health Survey questionnaire study factors contributing to use of health services in small towns, with emphasis on the influence of availability of care.

14. Automated hospital record system—direct cost $52,100

This activity is testing the automation of hospital record data through use of computer systems to organize a ready reference service and easy access to hospital data as a base for measuring effectiveness of changes.

15. Computer Assembled On-Going Manual of Medical and Paramedical Services—direct cost $26,842

16. Central core administration, planning and coordination—direct cost $238,805

(University of Missouri Medical Center, Columbia, Missouri) Missouri Regional Medical Program.

MOUNTAIN-STATES REGIONAL MEDICAL PROGRAM

This four-state region (Idaho, Montana, Wyoming and Nevada) began its operational activities on March 1, 1968 with an operational award of $206,913 to include one activity in coronary care. An operational staff of approximately eleven will serve in the project, and includes five physicians and six nurses. The hospitals involved will include the community hospital in which the activity is taking place as well as those hospitals who will send their staff to the unit for training. The Regional Advisory Group also includes two hospital representatives.

Operational Projects

1. Intensive coronary care in small hospitals in the region—direct cost $206,913

Hospitals in the Region will send Registered Nurses into St. Patrick's Hospital, Missoula, Montana for coronary care training. This 3 week course will be offered three times a year for 21 nurses, and there will be follow-ups at the home hospitals four times a year. In addition, a 4-day training program especially designed for small town physicians will be held at the University of Montana four times a year.

NORTH CAROLINA REGIONAL MEDICAL PROGRAM

On March 1, 1968, the North Carolina Regional Medical Program received a combined planning and operational award totalling $1,485,341. The operational component of this award totalled $753,759 in direct costs only. The operational staff includes approximately forty individuals, including twenty-eight physicians, one nurse, six other allied health personnel, and five general support personnel.

North Carolina has already involved twenty-seven of its hospitals in the Program. The Advisory Group includes four hospital representatives and planning subcommittees include an additional ten hospitals. Approximately twenty-one hospitals are participating in the operational projects outlined below:

Operational Projects

1. Education and research in community medical care, direct cost—$209,200

To develop resources for training more medical and allied medical students; to provide new types of educational experiences which will make family practice more attractive; to have a post-graduate education program at the medical school; to strengthen ties between the medical school faculty and practicing physicians; and to have the medical school become involved in community planning for improving the quality and availability of medical care. Affected by this project are the following groups: the University Community; the Caswell County Rural Health Services Project; the Regional Health Council of Eastern Appalachia, Inc.; the State of Franklin Health Council, Inc.; the Charlotte Memorial Hospital; the Moses Cone Memorial Hospital, Greensboro; and the Dorothea Dix Neuromedical Service.

2. Coronary care training and development, direct cost—$56,938

To use the project as a medium for developing cooperative arrangements among the various elements in the health care community. Initial and continuing education will be provided to nurses and physicians in community hospitals, consultation will be available to hospitals in establishing CCU's, and a computer-based system of medical record keeping will be developed. This project has led to new working arrangements: (1) between the university medical centers; (2) between medical and nurse educators; (3) between doctors and nurses in community hospitals; (4) between university medical centers and community hospitals.

3. Diabetic consultation and educational services, direct cost—$132,081

To establish three medical teams to deliver services throughout the state; to assist in expansion of diabetic consultations and teaching clinics; to provide seminars for physicians and teaching sessions for nurses and patients to assist in organization of a State Diabetes Association and local chapters; to test techniques of data collection. Many people of different disciplines in many communities are involved in this project.

4. Development of a central cancer registry, direct cost—$66,615

To devise a uniform region-wide cancer reporting system, integrated with the PAS, the computer-stored data from which can be retrieved to serve a broad range of educational, research, statistical, and other purposes. The following hospitals are participating in the first year of the project: Duke University Medical Center, North Carolina Memorial Hospital, North Carolina Baptist Hospital, Charlotte Memorial Hospital, Veterans Administration Hospital, Watts Hospital, Hanover Memorial Hospital, Southeastern General Hospital, Craven County Hospital. In subsequent years the registry will be expanded to include all hospitals and physicians in the region.

5. Medical library extension service, direct cost—$25,839

To bring medical library facilities of the three medical schools into the daily work of those engaged in medical practice. Local hospital personnel will be trained to assist medical staff; libraries will be organized into a functional unit for responding to requests for services. Bibliographic request service will be established.

6. Cancer Information Center, direct cost—$41,716

To provide practicing physicians with immediate consultation by telephone and follow-up literature. Each of the three medical schools will be responsible for providing service in its geographic locale. The aims of this project are two-fold: (1) to assist physicians in providing optimum care of patients with cancer; and (2) to continue the education of the physicians by giving new information in a patient-centered experience.

7. Continuing education in internal medicine, direct cost—$33,313

To bring practicing internists from all over the state to the Medical Center for a month of up-to-date training in their subspecialities. They will share responsibilities with attending physicians and make ward rounds with students, staff, and together. This experience should enhance the appreciation in the University, both at faculty and student levels, for the expanding role of the medical center for the quality of care in the community.

8. Continuing education in dentistry, direct cost—$67,500

To provide physicians and dentists with the knowledge of mutual concern which will enable them to be more effective members of the health team. Courses will be given at the University of North Carolina and in communities. Studies will be made of facilities needed to provide dental care in hospitals. The purpose of this project is to insure that as many patients as possible who suffer from heart disease, cancer, stroke, or a related disease receive appropriate dental care as a part of their comprehensive treatment.

9. Continuation education for physical therapists, direct cost—$27,838

To develop and establish regional continuing education programs for physical therapists in order to strengthen physical therapy services for patients in all parts of the state. Subregions will be delineated where needs and interests will be identified and committees will be organized to arrange local activities.

10. The establishment of a network of coronary care units in small community hospitals in Appalachia, North Carolina

This is a proposal to develop coronary care units in seven hospitals in this rural, mountainous area. RMP will supply the monitoring equipment (the hospital provides suitable space) when adequately trained physicians and nurses are available. An intensive training course for physicians will be conducted in the geographic region, and continuing education programs will be conducted when necessary.

ROCHESTER REGIONAL MEDICAL PROGRAM

On March 1, 1968 the Rochester Program began its operational activities with a modest operational grant award of $255,487. Approximately 15 people are currently serving on the staff which will expand with additional recruitment. The current staff includes 13 physicians, and two allied health personnel. A majority of the staff are from community hospitals, and are working closely with medical center and RMP staff to improve the quality of local patient care.

Approximately eleven hospitals from the region are now participating in the program, and this will expand as the program moves forward over the next few years. Four hospitals are initially participating in the operational projects. Three of these four are represented on the Regional Advisory Committee. Seven additional hospitals are serving on the Advisory Committee and planning subcommittees.

Operational Projects

1. Renovation and equipping of facilities for a learning center for projected training programs related to heart disease, cancer, and stroke, direct cost—$26,400

The awarded funds are for the purpose of altering and renovating space in Helen Wood Hall, which houses the Departments of Nursing at the University of Rochester. It is planned to convert five rooms into two rooms for self-instructional learning. These facilities initially will be used for four 4-week coronary care training courses for nurses and physicians in the region. New techniques that are disseminated by means of these courses will then be caried to the various community hospitals and rural areas in the region by the training course participants.

2. Postgraduate training program for the physicians in the Rochester 10-county region, direct cost—$83,900

The objectives of this project are centered around the further development of a postgraduate program in cardiology. Learning opportunities will be made available for general practitioners and internists, as well as cardiologists practicing in the region. Several different programs are planned and vary in length from one-half day to two weeks. It is anticipated that a number of the participating physicians will represent community hospitals in rural areas.

3. Registry of patients with acute myocardial infarction in the Rochester regional hospitals, direct cost—$21,200

One objective of this registry is to provide a uniform data collection system from which both periodic information as well as longitudinal analyses may be extracted. Appropriate information as to prognosis and treatment will be disseminated to participating hospitals and cooperating physicians in the region. Strong Memorial Hospital in Elmira, New York is already participating in this project, and it is anticipated that several other community hospitals, especially those in rural areas, will soon also be participating.

4. Proposal for establishment and support of a regional laboratory for the education and training in the care of patients with thrombotic and hemorrhagic disorders, direct cost—$69,400

At the present time no single, central facility concerned with the diagnosis and therapy of patients with thrombotic or hemorrhagic disease exists in the Rochester region. Laboratory technicians from the regional hospitals will be invited to spend three or four days in the new facility. In addition, the physicians directing this project will visit the participating communities so that a continuing educational program for practicing physicians in the care of patients with thrombotic diseases will be maintained.

TENNESSEE MID-SOUTH REGIONAL MEDICAL PROGRAM

On February 1, 1968, the Tennessee Mid-South Regional Medical Program began its operational activities with a diverse array of programs designed to

provide local health practitioners and hospitals with advanced techniques and facilities necessary for quality health care. Over fifty people are currently serving on the staff of the operational program, including approximately thirty-five physicians, five nurses, five other allied health personnel, and nine general support personnel. About one-fourth of the staff are from community hospitals and the remaining are medical center staff who are working on the community oriented projects discussed below.

Seventeen hospitals are currently participating in the operational projects, representing broad geographic spread throughout the region. Ten of these hospitals are also represented on the Regional Advisory Group.

Operational Projects

1. Continuing medical education—Meharry, direct cost—$44,800

Meharry Medical College is informing Negro physicians in the region about more effective techniques for treating heart disease, cancer, and stroke. Teams of physicians will teach two-week courses in the three areas at the Medical Center, using various audio-visual aids and, where feasible, programmed instruction. One of this plan's interesting provisions is sending a senior resident from Meharry to care for the physician's practice while he is attending the course.

2. Continuing education—Vanderbilt, direct cost—$141,600

Vanderbilt proposes to establish continuing education centers at community hospitals linked to a proposed Department of Continuing Education at Vanderbilt. Libraries and information centers at the local hospitals will bring Vanderbilt's information resources to the local physician. The program, though planned and coordinated by Vanderbilt, will function through the local centers and emphasize bringing information to the physician at the times he needs it.

3. and 4. Hopkinsville Education Center and Chattanooga Education Center, direct cost—$73,700

These are the first of the local continuing education centers specified in the Vanderbilt plan. At each hospital, a full-time Director with an appointment at Vanderbilt and an assistant director will supervise resident and physician education in their area. Their services will be available to physicians at smaller community hospitals in each area, as will the enlarged hospital library facilities. The Chattanooga and Hopkinsville locations provide the basis for looking at problems in continuing education in urban and rural settings.

5. Special training for practicing radiologists—Vanderbilt, direct cost—$50,400

This plan focuses on developing practicing radiologists' skills in vascular radiology, but might later be broadened to include all aspects of diagnosis and therapeutic radiology. Two post-graduate educational methods will be used. One to three month courses for technologists will be offered. In addition, eminent radiologists will preside at two-hour monthly seminars to which all radiologists in the region will be invited.

6. Cardiac nurse training program—Mid-State Baptist Hospital-Nashville, direct cost—$49,600

The key factor in reducing mortality from cardiac arrest is the immediate availability of a knowledgeable person to initiate resuscitation. Mid-South Baptist proposes to instruct cardiac nurses in new resuscitation techniques by holding three four-week courses. These nurses will then be available to hospitals throughout the region.

7. School of X-ray and technology—Meharry, direct cost—$19,500

Meharry plans to establish a two-year program for training at least ten X-ray technologists per year. The faculty will be Meharry's Radiology staff. Feasibility studies for establishing nuclear medicine and radiotherapy programs will be conducted.

8. Radiology technologist training program—Vanderbilt, direct costs—$30,300

Vanderbilt proposes to increase the number of X-ray technologists, improve the quality of their training, and increase their opportunities for continuing education. Three small hospital training programs in the area will be discontinued as separate entities and subsumed by a new school of X-ray technology at Vanderbilt. Practical clinical experience will be both at Vanderbilt and the smaller hospitals.

9. Nuclear medicine training program—Vanderbilt, direct cost—$25,300

A new series of courses taught by paramedical and medical personnel will be made available to physicians and technologists to increase their skill in nuclear medical techniques. When possible the physician and his technologist will spend some training time together to work out procedures suited to their situation. Trainees will be accepted from smaller community hospitals planning to establish or improve nuclear medicine services.

10. Expansion of School of Medical Technology—Baroness Erlanger Hospital—Chattanooga, direct cost—$35,400

To augment medical technology capabilities in the area, this plan makes two proposals: (1) Expand the Baroness Erlanger program for medical technologists; and (2) establish a school for certified lab assistants who could free technologists from more routine work for more complex procedures.

11. Vanderbilt Coronary Care Unit, direct cost—$51,600

This project's purpose is to establish a network of coronary care units with adequate equipment, staffed by well trained personnel. Vanderbilt will be the training and information center for the region; a demonstration unit there will provide a focal point for continuing education. In addition, communication systems will be set up to facilitate the flow of information from Vanderbilt to the community hospitals. Studies are being made to see if the small hospitals connected with Vanderbilt can become, in turn, centers for local networks of coronary care facilities in still smaller hospitals.

12. Franklin Coronary Care Unit—Williamson County Hospital—Franklin, direct cost—$31,400

This is one of the subsidiary units mentioned in the Vanderbilt proposal. This is primarily a pilot project to study the feasibility and usefulness of establishing a center in a small community hospital.

13. Hopkinsville Coronary Care Unit—Jennie Stuart Memorial Hospital—Hopkinsville, Ky., direct cost—$49,500

This plan is similar to the Franklin plan, except that it mentions establishing links to smaller community hospitals by helping set up smaller care units in them, thus providing for the grouping of rural community hospitals for more efficient use of existing resources.

14. Clarksville Coronary Care Unit—Clarksville Memorial Hospital, direct cost—$19,000

As the Franklin program, this project is a subsidiary of the Vanderbilt proposal. Since this hospital has been operating a unit, the plan calls for its expansion, continuing education and a phone hook-up to Vanderbilt.

15. Nashville General Coronary Care Unit—Nashville Metropolitan General Hospital, direct cost—$42,100

Again, this is like the Franklin plan. Nurses here will be included in the in-service training programs initiated throughout the participating hospitals.

16. Meharry Medical College Coronary Care Unit, direct cost—$35,800

Meharry intends to establish a demonstration unit of coronary care facilities which will serve as a continuing education center for smaller hospitals in its region.

17. Murray Coronary Care Unit—Murray—Calloway (Ky.) County Hospital, direct cost—$38,800

Murray-Calloway County Hospital, the training center for Murray State University School of Nursing, will serve as a demonstration center for the subregion. Direct phone communication will be established with Vanderbilt, which will send consultants from its school of continuing education. This project has the dual objective of relating the Murray State Nursing program to an established medical center and providing regional training resource to a remote area.

18. Chattanooga Coronary Care Unit—Baroness Erlanger Hospital, direct cost—$14,400

Baroness Erlanger plans to establish a coronary care unit in a program of cooperation with Vanderbilt. Both telephone communications and electronic maintenance systems connected with Vanderbilt will be installed. This unit will serve as a center for the smaller hospitals in Chattanooga.

19. Baptist Hospital Coronary Care Unit—Mid-State Baptist Hospital, Nashville, direct cost—$51,000

This plan is similar to the others included in the Vanderbilt plan. Baptist Hospital will expand its present facilities and aid establishment of smaller centers at Tullahoma and Crossville, Tennessee. Direct telephone lines will be established for consultations. The unit director will have a clinical faculty appointment at Vanderbilt. He will devote approximately 25% of his time to the unit.

20. Crossville Coronary Care Unit—Uplands Cumberland Medical Center, Crossville, direct cost—$28,300

This project has two purposes: (1) to establish a two-bed coronary care unit in the hospital; and (2) to determine the feasibility of operating acute coronary care units in rural areas. The hospital will cooperate with Mid-State Baptist Hospital and Vanderbilt.

21. Tullahoma Coronary Care Unit—Harton Memorial Hospital, Tullahoma, Tenn., direct cost—$28,800

See Baptist Hospital Program.

22. Meharry supervoltage therapy program, direct cost—$58,300

This project is aimed specifically at improving cancer therapy for a large indigent population. Meharry will use its funds to obtain a cobalt 60 High Energy Source for therapy and a computer hook-up with Vanderbilt. These facilities will also be used to improve undergraduate and graduate radiology training programs at Meharry.

23. Project to improve patient care in a remote mountain community by recruiting and training health aides for a new extended care facility—Scott County Hospital—Oneida, Tenn., direct cost—$10,300

Manpower shortage in this isolated mountain hospital is critical. Personnel to man an extended care facility now under construction will be obtained by two methods: (1) In-service training for hospital personnel; (2) an educational director (an RN) to serve as a liaison to the high schools to encourage young people to enter the medical field and come back home to practice. In addition a training program leading to the LPN would be initiated. Clinical training will be supervised by the Educational Director while local high schools provide basic training.

24. Health evaluation studies on a defined population group—multiphasic screening—Meharry Medical College, direct cost—$436,000

Meharry will determine the effectiveness of a comprehensive health program and multiphasic screening examinations in early diagnosis of heart disease, cancer, stroke and their precursors. To run this experiment, a neighborhood medical center supported by OEO will serve a selected population of 18,000. The test population and a control population will be evaluated with reference to morbidity, changes in health attitudes and utilization patterns, effectiveness of the screening procedure and the cost per patient diagnosed or treated.

25. Experiment to test and implement a model of patient care—Vanderbilt University Hospital, direct cost—$110,400

This is an attempt to define a new structure for patient care. New personnel called stewardesses will be trained to take over the nurses' non-clinical duties. Nurses would then be free to spend more time with the patient and to keep up their specialized skills. After the model is refined at Vanderbilt, it will be tested in community hospitals—specifically Baptist and St. Thomas.

26. A medical surgical nurse specialist graduate program to improve nursing care of patients with heart disease, cancer, and stroke—Vanderbilt University School of Medicine, direct cost—$23,600

Vanderbilt is developing a program to train medical surgical nurse specialists to improve nursing care of heart, cancer, and stroke patients. It will be a master's degree program staffed by physicians and clinical nurses (1 calendar year) plus one year of clinical experience half at Vanderbilt and half at the *community hospital.* Stipends will be provided during the first year only.

WASHINGTON-ALASKA REGIONAL MEDICAL PROGRAM

With an operational grant award of $1,032,003 on February 1, 1968, this two-state region began its efforts to bring quality care to the dispersed populations

of this area. About forty operational staff members are currently serving on the program, including about seventeen physicians, three nurses, six other allied health personnel, and fourteen related health and general support personnel. About one-third of the staff is from the medical center, another third is from community hospitals and the last third is from other health and medical organizations. The entire staff is working in concert to bring up-to-date medical techniques to communities throughout the region.

Strong hospital involvement in the Washington-Alaska program is evident in the project descriptions below. Approximately 36 hospitals are currently participating in the program, almost 20 of which are directly involved in operational activities. Six of these hospitals are represented on the Regional Advisory Groups, and an additional four of these are on planning subcommittees. The remaining participating hospitals are involved in current planning activities. It is likely that these, and the many other hospitals in the region, will become increasingly involved in operational activities.

Operational Projects

1. Central Washington—Communication system for continuing education for physicians—$18,181 (direct cost)

This project is designed to bring the medical resources of the University of Washington to physicians and community hospitals in Yakima, who in turn will act as consultants to surrounding smaller communities through seminars and conferences, educational TV, other audio-visual instruction; and exchange of teachers and practitioners. It will also connect internists in Central Washington to Yakima cardiologists via EKG telephone hot-line, to permit quick analysis (starting with 5 community hospitals). Three general hospitals in Yakima involved are: St. Elizabeth's, Yakima Valley Memorial, and New Valley Osteopathic. Nine other community hospitals to be reached initially are located in Ellensburgh, Moses Lake, Othello, Toppenish, Prosser and Cynnyside.

2. Southeastern Alaska—Postgraduate education—$27,062 (direct cost)

This program will help improve communication between Seattle Medical Community and University to alleviate problems of the isolated physicians in southeast Alaska cities and communities: Juneau, Sitka, Ketchikan (3 largest). As in Central Washington several methods will be used such as telelectures, consultant services, seminars and the EKG hot line to hospitals in Juneau, Sitka, and PHS Native Hospital at Mt. Edgecumbe and Ketchikan community hospital.

3. Postgraduate preceptorship for physicians—Coronary care—$17,610 (direct cost)

A pilot project to provide opportunity for practitioners from isolated communities to spend a week or more under a preceptor at major medical centers to study advances in care of coronary heart disease. The 4 major medical centers in Seattle are Providence Hospital, Swedish Hospital, Virginia Mason Hospitals and Medical Center, and University Hospital and Medical Center; two in Spokane are Deaconess Hospital and Sacred Heart Hospital.

4. Coronary care unit coordination—$70,255 (direct cost)

This activity will serve as coordinating unit for CCU related projects—their development, improvement of operations, and training activities. A mock-up coronary care unit will be used in the educational programs for nurses and physicians; audio-visual self-instruction materials will be produced and evaluated.

5. Cardiac pulmonary technician training—$41,554 (direct cost)

This program will help develop a formal program for training cardio-pulmonary technicians to perform non-critical functions in coronary care units and free physicians for other duties. Four larger general hospitals in Spokane will participate with Spokane Community College. The 4 hospitals are Deaconess, Holy Family, Sacred Heart and St. Luke's Hospital.

6. Information and education resource support unit—$522,304 (direct cost)

This program will help provide medical communities with the skilled assistance which will help identify their educational needs and serve as a support unit in developing programs to meet them; to establish a central production unit, to coordinate audio-visual projects and the distribution of materials, to penetrate the entire region.

7. Two-way radio conference and slide presentation—$8,445 (direct cost)

Six pilot programs on heart, cancer and stroke topics to be transmitted via two-way radio-telephone slide conferences, to physicians and hospital staffs on topics selected by a panel of physicians, starting with 20 hospitals in Washington are underway. It will explore potential for continuing network series with local and remote regions.

8. Continuing education and on-the-job training of laboratory personnel—$53,446 (direct cost)

Primary purpose of this activity is to train technical personnel in newer clinical laboratory procedures, and shorten gap between availability of advance in techniques and actual use. First phase is to be directed at 5 local designated training centers in Washington (cities of Seattle, Tacoma, Spokane, Yakima and Vancouver) and Anchorage, Alaska. University of Washington will select from a list of available lab procedures, arrange training courses for technicians in specific ones at designated facilities and establish quality control criteria; they will follow through with education of physicians in newer and practical tests for better diagnosis and treatment.

9. Alaska medical library facilities—$21,754 (direct cost)

This activity will help develop a community medical library located at the PHS Alaska Native Medical Center, Anchorage, for Alaska physicians and health related staffs and agencies. It will have close ties with community colleges, Arctic Health Research, University at Fairbanks and to supplement continuing education projects for Southeast Alaska and the Anchorage cancer project.

10. Anchorage cancer program—$51,450 (direct cost)

This project will aid in providing a supervoltage therapy unit for cancer patients to be located in an addition to Providence Hospital in Anchorage. It involves training of radiologist and technical staffs, consultant clinical conferences and accumulation and analysis of dianogstic data. Presbyterian Community Hospital in Anchorage will be participating.

11. Care of children with cancer (study)—$28,030 (direct cost)

This is an epidemiological study to determine the impact of different methods of care for children with cancer, focusing on differences among children treated in local communities and at major centers; to be conducted by the staff of Children's Orthopedic Hospital and Medical Center, Seattle.

12. Radiation physicist consultation program for radiologists in Washington and Alaska—$56,393 (direct cost)

This project will provide consultation services of a radiologist-physicist for smaller hospitals, in dosimetry and other problems of radiotherapy. To enhance postgraduate education for radiology residents and paramedical trainees outside of the University system.

13. Computer-aided instruction in heart disease, cancer, and stroke and related diseases—$53,390 (direct cost)

To develop and evaluate the effectiveness of computer-aided instruction for teaching medical techniques. Participants will be instructed in the use of computer terminals.

WESTERN NEW YORK REGIONAL MEDICAL PROGRAM

With an award of $357,761, the Western New York Regional Medical Program began its operational program on March 1, 1968. The current operational staff of seven physicians, one nurse, and two secretaries will be expanded to over 20 during the next several months. Over forty hospitals are currently involved in this program, almost all of which are slated to be part of the developing regional two-way TV network for continuing education. Eleven hospitals are represented on the Regional Advisory Group, and an additional two hospitals are serving on planning subcommittees.

Operational Projects

1. Two-way communications network, direct cost—$170,519

A two-way communication network will link hospitals of Western New York and Erie County, Pennsylvania to the Continuing Education Departments

of the State University of New York at Buffalo and the Roswell Park Memorial Institute. The network will serve several purposes, such as continuing education for physicians and the health-related professions, public education, administrative communication, consultation with experts, and contacts among blood banks. It will assist both the physician and community hospital in either the rural or urban environment in having at their fingertips the latest advances in the diagnosis and treatment of heart disease, stroke, and cancer. Particular emphasis will be placed upon involving rural hospitals in this program thereby improving both their didactic and restorative function.

2. Coronary care information coordinators, direct cost—$127,544

This project will test a training technique for providing qualified nurses who will be required to staff developing coronary care units in the Region. Approximately 80 nurses will be selected from all parts of the Region for a combined academic and clinical course. It is planned that the nurses receiving this training will return to both rural and urban hospitals for the purpose of providing a diagnostic and didactic function. While the program will be housed at the medical center, the community hospitals of this region will be the beneficiary factors of the project. Since there are few nurses trained to work in coronary care units, particularly in the rural environment, special attention will be paid to attracting nurses who will return to the community hospital.

WISCONSIN REGIONAL MEDICAL PROGRAM

The Wisconsin Program began its operational activities on September 1, 1967 when it became the first Regional Medical Program to be awarded a combined planning and operational grant. Currently funded with $630,147, about one third of which is for operational activities, the operational staff numbers 20. About one-third of the staff are physicians, another third are allied health personnel, and the last one third are supportive and other type of personnel.

Approximately 20 hospitals are involved in the current phase of the Program. Eleven of these hospitals are directly involved in the operational projects. Five are represented in the Regional Advisory Group and the remaining are represented in planning subcommittees. As the program develops additional activities during the next few years, it is anticipated that many additional hospitals will be involved.

1. Study program for uterine cancer therapy and evaluation, direct cost—$40,100

This pilot project is designed to review and evaluate current radiotherapy for patients with uterine cancer. In its first phase it will involve information exchange and dosimetry standardization. Hospitals at Marquette and the University of Wisconsin will be connected to a central, computerized data bank in Milwaukee which will compute radiation classes. When the necessary computer techniques are developed, it is projected that the central facility will be linked to other hospitals outside the Milwaukee and Madison areas with similar treatment programs, and the long-term result will be to improve local medical capabilities for the treatment of all uterine cancer patients in the Region.

2. A pilot demonstration program for pulmonary thromboembolism, direct cost—$84,600

In this project a center is being established at Marshfield Hospital in Marshfield, Wisconsin, for demonstrating diagnostic techniques and the available therapy for pulmonary thromboembolism. The project has a continuing education component which will reach physicians from many hospitals in the Region. This will involve a 24-hour consultation service, the preparation of a movie on the topic, and special training sessions for groups of physicians.

The project will demonstrate a comprehensive program which will encompass diagnostic, preventive, therapeutic, and rehabilitation procedures for patients, postgraduate education, a rapid transportation system for patients from Northern sections of the state, and cooperation between the clinic and other hospitals and medical schools in the State.

3. Telephone dial access tape recording library in the areas of heart disease, cancer, stroke, and related diseases, direct cost—$18,950

This feasibility study will be carried out by the University of Wisconsin which will record and store short, 4–6 minute, tapes on various aspects of treating patients with the three diseases. Any physician anywhere in the

Region can dial the library at any time and request a tape relevant to a problem in which he is interested.

4. Nursing telephone dial access tape recording library in the areas of heart disease, cancer, stroke, and related diseases, direct cost—$18,800

This feasibility study, similar to the one above, will establish a central tape library with information recorded on nursing care in emergencies, new procedures and equipment, and recent developments in nursing. Nurses from any hospital in the region will be able to call at any time to have a tape played to them.

5. Development of medical and health related single concept film program in community hospitals, direct cost—$33,250

This education feasibility project involves ten community hospitals in its first phase. Fifteen films on procedures and techniques used in treating heart, cancer, and stroke, will be developed. Projectors and the films will be installed in the hospitals for use by physicians and other health personnel at their convenience as a continuing education device. After four to six months the materials will be relocated in ten additional hospitals.

TELEVISION, RADIO AND TELEPHONE NETWORKS FOR CONTINUING EDUCATION

OPERATIONAL PROJECTS

I. Albany Regional Medical Program

Two-way radio communication system—Direct cost, $144,100

This project will expand an existing two-way radio network to include 57 hospitals and 24 high schools. It will provide continuing education for physicians and allied medical personnel. It will also provide information and education programs for administrators, members of boards of trustees, voluntary health agencies, adult education classes, and selected civic groups.

II. Intermountain Regional Medical Program

Network for continuing education in heart disease, cancer, stroke, and related diseases—Direct cost, $243,000

The objectives of this program are to develop a communications network between patient-care and research institutions to encourage liaison between health care personnel in the area. The currently existing two-way radio system, including 11 hospitals in 7 communities in or near Salt Lake City has been expanded to 10 additional remote hospitals to serve as one link. This system will be expanded to additional hospitals in response to physician requests. Closed circuit TV and use of KVED (University of Utah education TV) is also planned. This may establish the community hospital as the focus of continuing education.

III. Kansas Regional Medical Program

Health sciences communication and information center—Direct cost, $77,900

This project is engaged in conducting studies to determine the feasibility of establishing communication linkages vital to education, service and research programs. Specific studies to be undertaken are a physician communication system, TV teaching, electronic linkages, and Medlars search capacity. Linkages will be established at hospitals in Great Bend, Pittsburg and Kansas City.

IV. Washington-Alaska Regional Medical Program

Central Washington—Communication system for continuing education for physicians—Direct cost, $18,181

This project is designed to bring the medical resources of the University of Washington to physicians and community hospitals in Yakima, who in turn will act as consultants to surrounding smaller communities through seminars and conferences, educational TV, other audio-visual instruction; and exchange of teachers and practitioners. It will also connect internists in Central Washington to Yakima cardiologists via EKG telephone hot-line, to permit quick analysis (starting with 5 community hospitals). Three general hospitals in Yakima involved are: St. Elizabeth's, Yakima Valley Memorial, and New Valley Osteo-

pathic. Nine other community hospitals to be reached initially are located in Ellensburgh, Moses Lake, Othello, Toppenish, Prosser and Sunnyside.

Southeastern Alaska—Postgraduate education—Direct cost, $27,062

This program will help improve communication between Seattle Medical Community and University to alleviate problems of the isolated physicians in southeast Alaska cities and communities: Juneau, Sitka, Ketchikan (3 largest). As in Central Washington several methods will be used such as telelectures, consultant services, seminars and the EKG hot line to hospitals in Juneau, Sitka, and PHS Native Hospital at Mt. Edgecumbe and Ketchikan community hospital.

Two-way radio conference and slide presentation—Direct cost, $8,445

Six pilot programs on heart, cancer and stroke topics to be transmitted via two-way radio-telephone slide conferences, to physicians and hospital staffs on topics selected by a panel of physicians, starting with 20 hospitals in Washington are underway. It will explore potential for continuing network series with local and remote regions.

V. Western New York Regional Medical Program

Two-way communications network—Direct cost, $170,519

A two-way telephone communication network will link over 40 hospitals of Western New York and Erie County, Pennsylvania to the Continuing Education Departments of the State University of New York at Buffalo and the Roswell Park Memorial Institute. The network will serve several purposes, such as continuing education for physicians and the health-related professions, public education, administrative communication, consultation with experts, and contacts among blood banks.

Mr. ROGERS. I notice you said in the North Carolina program there were some coronary care units. How many coronary care units? I want to know what is happening to the hospitals.

Now, how many hospital administrators or people involved in the actual administration of hospitals where services are delivered? How many are on your national council?

Dr. MARSTON. One, Dr. J. T. Howell, of the Henry Ford Hospital. The executive director of the American Hospital Association, Dr. Edwin Crosby, is also a member, so this is 2 out of 12 directly representing the viewpoint of hospital administration.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON HOSPITAL ADMINISTRATORS PARTICIPATING IN REGIONAL MEDICAL PROGRAMS

	Number of hospital administrators	Percent of total membership
Total	338	10
Regional advisory groups	222	12
Subcommittees	83	7
Boards of directors [1]	33	19

[1] Boards of directors of the 14 new organizations formed as the coordinating agencies for their programs.

HOSPITAL ADMINISTRATORS ON REGIONAL MEDICAL PROGRAM STAFFS

Approximately 40% of the regions have established a Division of Hospital and Facilities Planning. These are, as a rule under the direction of a hospital administrator.

EXAMPLES OF HOSPITAL ADMINISTRATOR PARTICIPATION IN RMP

Georgia

In Georgia, each hospital in the region was encouraged by the Georgia RMP to appoint a local advisory group to work with the Program to advise on local needs

and problems and to serve as the liaison group between the Georgia Central Regional Medical Program office and the local community. To date, 121 hospitals have appointed local advisory groups out of the total 178 hospitals in the region. These represent 90% of the general and limited services hospital beds in the region. These groups consist of a physician, a hospital administrator, a nurse, and at least one interested member of the public.

Connecticut

In Connecticut, four Advisory Conferences have been established to aid the Advisory Board in its work. These four conferences consist of: (a) the Presidents of the Boards of Trustees of the hospitals of Connecticut; (b) the Chiefs of Staff of these hospitals; (c) the Administrators of these hospitals; and (d) representatives of over 50 "health" agencies of Connecticut. Directors of Medical Education from Connecticut hospitals have also been invited to meetings of the Advisory Conferences.

Albany

Part of the Albany operational program is concerned with the equipping of hospitals with two-way radio equipment. The Regional Medical Program personnel have visited the non-participating hospitals and discussed with the administrators and members of the staffs the advantages of joining the radio network. The number of hospitals involved in this network increased by 50% in the first year, bringing to 36 the number of participating hospitals.

Maryland

In Maryland, the RMP staff has devoted considerable effort to developing contacts with the community hospitals. At least 21 of the 38 hospitals in the region have been visited by the Regional Medical Program staff.

In November 1967 a three-day planning workshop was held by the Maryland RMP. Invitations were extended to all the hospitals in the region and over half of the short-term, non-federal hospitals sent one or more representatives. Those who attended expressed a genuine desire to cooperate in the planning process.

OTHER DEVELOPMENTS

Community planning committees have been organized in several other regions including South Carolina, Intermountain, and Greater Delaware Valley. These local planning committees all include hospital administrators in their membership.

HOSPITAL ADMINISTRATORS ON THE NATIONAL ADVISORY COUNCIL AND ON THE REVIEW COMMITTEE

Council:

(1) Edwin L. Crosby, M.D., Director, American Hospital Association, Chicago, Ill.

(2) James T. Howell, M.D., Executive Director, Henry Ford Hospital, Detroit, Mich.

Committee: (1) Mr. John D. Thompson, Director, Program in Hospital Administration, School of Public Health, Yale University, New Haven, Conn.

Formers Members:

(1) Mark Berke, Director, Mount Zion Hospital and Medical Center, San Francisco, Calif.

(2) Howard W. Kenney, M.D., Medical Director, John A. Andrew Memorial Hospital, Tuskegee, Ala.

Mr. ROGERS. It seems to me the thrust of this program has got to get down to that.

How about in your regional medical councils, the local ones?

Dr. MARSTON. Ten percent of those represent hospitals.

Mr. ROGERS. Should there be more?

Dr. MARSTON. I don't know the answer to that, Mr. Chairman.

Mr. ROGERS. Give us your thinking on that. I am concerned that we are not getting enough of the people involved who are meeting the patient and getting care to him.

Dr. MARSTON. The American Hospital Association is having a conference at our request in June to focus on just the problem you are bringing up.

Mr. ROGERS. I would be interested in following the results of that conference and your actions on it.

Now, what other professions are involved in these regional medical programs, and in the field? Could you give me a rundown on that?

If you will let us have this it would be helpful.

Are you really tying them in—nurses, dentists, and so forth—as well as educators?

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON PROFESSIONAL INVOLVEMENT IN REGIONAL MEDICAL PROGRAMS

The scope of professional involvement in Regional Medical Programs is both broad and balanced, and is evident in all facets of the programs across the country. Broad professional involvement is seen in the composition of Regional Advisory Groups, planning committees, program staffs and operational activities. Such involvement reflects the essential cooperative nature of Regional Medical Programs as they work toward harnessing the multiple health and medical resources in local areas in order to help provide high quality care in heart, cancer, stroke and related diseases.

The membership of the Regional Advisory Groups, which currently totals approximately 1900 individuals, includes 21.9% practicing phyicians; 15.6% medical center officials; 13.1% hospital administrators; 11.7% voluntary health agencies; 7% public health officials; 8.1% allied health workers; 15.3% member of the public and 7% others. Planning committees, which currently include about 2500 individuals, also demonstrate broad involvement. The membership includes: 18% practicing physicians; 41% medical center officials; 13% hospital administrators; 6% voluntary health agencies; 6.5% public health officials; 10% allied health workers; 5% members of the public, and 5% others.

In terms of participating organizations, it is estimated that over 1700 organizations are now involved in Regional Medical Programs. These include all of the medical schools, state medical societies, state heart and cancer societies, and state health departments. Almost 60% of the state nursing and dental associations are involved; about 80% of the schools of public health and state hospital associations are involved; and about 35% of the schools of denistry. In addition, many schools of nursing and other allied health professions are involved as well as a broad array of other professional organizations and institutions.

CORE PLANNING AND ADMINISTRATIVE STAFF

Reports from the Regions indicate that approximately 47% of the professional and technical planning staff are physicians. Allied health professionals including nurses, hospitals administrators, dentists, and others account for approximately 12% of the core staff. Related health professionals, including health economists, medical sociologists, statisticians, and others account for approximately 19%; general supportive staff accounts for about 16%; and "other" groups account for 6%.

OPERATIONAL STAFF

The operational staff personnel are concerned with the implementation of specific operational projects. The manpower involved in these projects comes from a broad range of specialities, including physicians (25%); nurses (8%); other allied health (10%); education and communications (5%); computer and other electronics specialists and their supporting personnel (16%); other technicians (14%); administrative and clerical (20%); and other 2%.

Dr. MARSTON. I spoke to 80 nurses in Wisconsin last night, via a telephone lecture system——

Mr. CARTER. Will you yield on that?

Mr. ROGERS. Yes.

Mr. CARTER. I notice this bill provides that dentists may refer patients to some of the regional centers, and I want to say that I think that is very good. I am happy that dentists and oral surgeons are included.

Mr. ROGERS. Thank you.

Do you provide for patient care in hospitals under this program?

Dr. MARSTON. Patient care costs must be limited to those which are incidental to research, training, education, or demonstration activities funded by the regional programs.

We consulted various hospital groups to get advice of how we would administer this, and their advice was that we should be very cautious about the actual payment of patient cost, so we have not spent much.

Mr. ROGERS. Let me have a breakdown on what you have done and where it has gone.

(The following information was received by the committee:)

The Department of Health, Education, and Welfare has determined that the following patient care costs, hospitalization costs, have been supported with regional medical program grant funds:

(1) Missouri Regional Medical Program—$90,050.

Mr. ROGERS. Do you use consultants, and where are these used mainly as far as the regional medical program is concerned?

Dr. MARSTON. We have used consultants at the national program from just about every area of health—hospital planning groups included. We receive a grant request and we use consultants with expertise in the area covered by the request, on the site visit.

Mr. ROGERS. Who determines what the region shall be? Do you determine it?

Dr. MARSTON. Essentially, the Surgeon General must determine this.

Mr. ROGERS. Are they too large now?

Dr. MARSTON. Some are quite large, but I think it will change.

Mr. ROGERS. Are there any plans for changing these?

Dr. MARSTON. There is discussion during the planning period in every region regarding the extent to which the regional approximation has worked, and this is commented on in the grant applications that come in to us.

I think there will be changes over time, but I think many areas are finding they want the advantages of the larger regions and yet the opportunity of breaking down into subregional groups, and we have not discouraged this.

Mr. ROGERS. What has happened in Florida? I don't think they have gotten off the ground there; have they?

Dr. MARSTON. They have a planning grant that was made this year.

Mr. ROGERS. So you would anticipate a year——

Dr. MARSTON. Yes. I take that back, partially. We have had an application from Florida since that planning grant asking for funds for a feasibility study, which the National Advisory Council allows under a planning grant. This application arrived on my desk yesterday.

Mr. ROGERS. I would like the status, if you could give it to us, of all the regions, the 53, what States they are in, when we can expect to see something get down to the local hospitals and into the medical profession there.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON THE STATUS OF REGIONAL MEDICAL PROGRAMS

As indicated in the table below, all Regions except Puerto Rico have embarked upon planning; and 41 of the 54 Regional Medical Programs have been engaged in planning activities for a year or longer. These planning activities have involved a large number of diverse health and health related professionals (e.g., physicians, medical sociologists, hospital administrators, epidemiologists, allied health personnel) representative of a wide spectrum of health institutions and organizations, including community hospitals, local and state medical societies, official and voluntary health agencies, and state hospital associations. These individuals are serving on planning task forces and local advisory committees as well as Regional Advisory Groups. In addition, a number of such individuals are also serving on the central core staffs of many Regional Programs.

Experience to date clearly demonstrates that the involvement of community hospitals and other local health resources, private practitioners, and other health professionals becomes more extensive and intensive as Regional Programs enter the operational phase. At that stage, for example, community hospitals become the sites for coronary care unit demonstration and training programs; local physicians and hospitals undertake the training of cardiopulmonary technicians needed in the community; private practitioners and their patients in rural areas benefit from automated EKG readings utilizing telephone lines; and programs to recruit and train sub-professional health aides required to staff extended care facilities, are initiated.

Initial operational grants have been awarded to 12 Regional Programs to date. Another 12 Regions have submitted initial operational grant requests which are now under review. Based upon the best information currently available, it is anticipated that the other 30 Regions will enter the operational phase before the end of fiscal year 1969. Thus, involvement and participation by community hospitals and private practitioners in Regional Medical Programs should become more widespread and increasingly evident over the next 12–15 months.

STATUS OF REGIONAL MEDICAL PROGRAMS (AS OF MAR. 30, 1968

Regional medical program	Beginning date		Funding				Operational status
			Currently available		Cumulative awards		
	Planning	Operational	Planning	Operational	Planning	Operational	
Alabama—State of Alabama	Jan. 1, 1967		$393,788		$661,756		Initial operational grant request anticipated in fiscal year 1969.
Albany—Northeastern New York, portions of southern Vermont and western Massachusetts.	July 1, 1966	Apr. 1, 1967	384,244	$921,510	707,033	$921,510	
Arizona—State of Arizona	Apr. 1, 1967		119,045		119,045		Do.
Arkansas—State of Arkansas	do		360,174		360,174		Do.
Bi-State—Eastern Missouri, centered around St. Louis and southern Illinois.	do		603,965		603,965		Do.
California—State of California	Nov. 1, 1966		3,226,225		4,079,593		Initial operational grant request under review.
Central New York—Syracuse, New York and 15 surrounding counties.	Jan. 1, 1967		268,634		434,156		Do.
Colorado-Wyoming—States of Colorado and Wyoming	do		339,605		488,359		Initial operational grant request anticipated in fiscal year 1969.
Connecticut—State of Connecticut	July 1, 1966		338,513		419,932		Initial operational grant request under review.
Florida—State of Florida	Nov. 1, 1967		240,000		240,000		Initial operational grant request anticipated in fiscal year 1969.
Georgia—State of Georgia	Jan. 1, 1967		341,824		694,427		Initial operational grant request under review.
Greater Delaware Valley—Philadelphia-Camden (N.J.) metropolitan area and adjacent areas of eastern Pennsylvania, southern New Jersey, and State of Delaware.	Apr. 1, 1967		1,534,494		1,534,494		Initial operational grant request anticipated in fiscal year 1969.
Hawaii—State of Hawaii	July 1, 1966		194,771		212,781		Do.
Illinois—State of Illinois	do		336,366		336,366		Do.
Indiana—State of Indiana	June 1, 1967		496,013		706,889		Do.
Intermountain—Utah and portions of Colorado, Idaho, Montana, Nevada, and Wyoming.	July 1, 1966	Apr. 1, 1967	363,524	2,038,123	608,615	2,038,123	
Iowa—State of Iowa	Dec. 1, 1966		290,591		552,939		Initial operational grant request under review.
Kansas—State of Kansas	July 1, 1966	June 1, 1967	281,627	699,852	371,240	699,852	
Louisiana—State of Louisiana	Jan. 1, 1967		454,445		710,290		Initial operational grant request anticipated in fiscal year 1969.
Maine—State of Maine	May 1, 1967		193,909		193,909		Initial operational grant request under review.
Maryland—State of Maryland	Jan. 1, 1967		770,230		967,459		Initial operational grant request anticipated in fiscal year 1969.

See footnotes at end of table.

STATUS OF REGIONAL MEDICAL PROGRAMS (AS OF MAR. 30, 1968)—Continued

Regional medical program	Beginning date		Funding				Operational status
			Currently available		Cumulative awards		
	Planning	Operational	Planning	Operational	Planning	Operational	
Memphis—Western Tennessee, northern Mississippi and portions of Arkansas, Kentucky, and Missouri.	Apr. 1, 1967		$173,119		$173,119		Initial operational grant request under review.
Metropolitan Washington, D.C.—District of Columbia and surrounding suburban counties in Maryland and Virginia.	Jan. 1, 1967	Apr. 1, 1968	527,089	$418,318	651,171	$418,318	
Michigan—State of Michigan	June 1, 1967		1,294,449		1,294,449		Do.
Mississippi—State of Mississippi	July 1, 1967		322,845		322,845		Do.
Missouri—State of Missouri excluding metropolitan St. Louis.	do	Apr. 1, 1967	324,254	2,887,903	635,967	2,887,903	
Mountain States—States of Idaho, Montana, Nevada, and Wyoming.	Nov. 1, 1966	Mar. 1, 1968	1,082,107	206,913	1,747,370	206,913	
Nebraska-South Dakota—States of Nebraska and South Dakota.	Jan. 1, 1967		349,367		597,609		Do.
New Jersey—State of New Jersey	July 1, 1967		297,466		297,466		Do.
New Mexico—State of New Mexico	Oct. 1, 1966		553,270		803,866		Initial operational grant request under review.
New York metropolitan area—New York City, Nassau, Suffolk, and Westchester Counties.	June 1, 1967		967,010		967,010		Initial opertional grant request anticipated in fiscal year 1969.
North Carolina—State of North Carolina	July 1, 1966	Mar. 1, 1968	773,674	1,652,164	1,000,374	1,652,164	
North Dakota—State of North Dakota	July 1, 1967		188,010		188,010		Do.
Northeastern Ohio—Cleveland and surrounding 12 counties.	Jan. 1, 1968		285,783		385,783		Do.
Northern New England—State of Vermont and 3 counties in northeastern New York.	July 1, 1966		723,920		883,695		Do.
Northlands—State of Minnesota	Jan. 1, 1967		629,887		1,000,791		Do.

Northwestern Ohio—20 counties in northwestern Ohio, centered around Toledo.	Jan.	1, 1968	----------	309, 180	----------	309, 180	----------	Do.
Ohio State—Central and southern ⅔ of Ohio (61 counties) centered around Columbus, excluding Cincinnati metropolitan area.	Apr.	1, 1967	----------	136, 771	----------	136, 771	----------	Do.
Ohio Valley—Greater Dayton-Cincinnati, Ohio, areas and contiguous counties and part of Kentucky.	Jan.	1, 1967	----------	346, 797	----------	472, 096	----------	Do.
Oklahoma—State of Oklahoma	Sept.	1, 1966	----------	282, 100	----------	330, 318	----------	Do.
Oregon—State of Oregon	Apr.	1, 1967	----------	231, 125	----------	353, 760	----------	Award of initial operational grant pending.
Puerto Rico—Commonwealth of Puerto Rico		(1)						Initial operational grant request anticipated in fiscal year 1969.
Rochester—Rochester, N.Y., and 11 surrounding counties.	Oct.	1, 1966	Mar. 1, 1968	318, 286	255, 487	500, 425	255, 487	
South Carolina—State of South Carolina	Jan.	1, 1967	----------	379, 246	----------	502, 773	----------	Initial operational grant request under review.
Susquehanna Valley—24 counties, centered around Harrisburg-Hershey in central Pennsylvania.	June	1, 1967	----------	263, 530	----------			Initial operational grant request anticipated in fiscal year 1969.
Tennessee-Mid-South—Eastern and central Tennessee and contiguous counties of southern Kentucky and northern Alabama	July	1, 1966	Feb. 1, 1968	523, 738	1, 630, 304	673, 421	1, 630, 304	
Texas—State of Texas	do		----------	1, 260, 181	----------	1, 667, 194	----------	Initial operational grant request under review.
Tri-State—States of Massachusetts, New Hampshire, and Rhode Island	Dec.	1, 1967	----------	439, 037	----------	439, 037	----------	Initial operational grant request anticipated in fiscal year 1969.
Virginia—State of Virginia	Jan.	1, 1967	----------	254, 000	----------	545, 454	----------	Do.
Washington-Alaska—States of Washington and Alaska	Sept.	1, 1966	Feb. 1, 1968	655, 148	1, 032, 003	837, 948	1, 032, 003	
West Virginia—State of West Virginia	Jan.	1, 1967	----------	208, 910	----------	282, 663	----------	Do.
Western New York—Buffalo and 7 surrounding New York counties and Erie, Pa.	Dec.	1, 1966	Mar. 1, 1968	283, 717	357, 761	313, 033	357, 761	
Western Pennsylvania—Pittsburgh, Pa., and 28 surrounding counties.	Jan.	1, 1967	----------	340, 556	----------	340, 556	----------	Do.
Wisconsin—State of Wisconsin	Sept.	1, 1966	Sept. 1, 1967	----------	[2] 630, 149	344, 418	630, 149	

[1] Initial planning grant application has been received and is under review.

[2] Combined planning and operational grant; includes some $340,000 for planning.

ILLUSTRATIVE EXAMPLES OF CURRENT STATUS

In addition to this listing of grant awards and the projected initiation of operational activities by the 54 regions, some specific examples of activities can serve to illustrate the status of activities in the Regional Medical Program and how these activities relate to achieving some of the major objectives of the program.

P.L. 89–239 makes clear that activities under it are to be considered part of, and contributors to the evolution of a system which establishes and strengthens, on a regional basis, functional relationships among the elements of the health system. The law assumes that only through such regional arrangements can the health status of the patient benefit fully from the accomplishments of medical science. The following examples show how these mechanisms have been effective or give promise of being effective in influencing the quality of health care under the following headings: 1) Cooperative Arrangements; 2) The Relationship of Science to Service; 3) Education and Training; 4) Demonstrations of Patient Care; and 5) Experimental Projects.

1. Cooperative Arrangements

Regional Medical Programs are based upon voluntary cooperative arrangements among all the health resources in each Region. These cooperative arrangements characterize the type of regionalization with which this program is concerned. The word "regionalization" in the context of Regional Medical Programs does not refer to the development of a rigid plan which has been imposed from above. Rather, it stresses the *process* whereby local resources are joined together to identify needs and opportunities, to assess resources, to define objectives, to set priorities, and then finally to implement a program and to establish methods of self-evaluation. Here are some specific examples of how such arrangements can be expected to affect patient services directly.

Four hospitals in Lafayette, Louisiana, are pooling resources in cooperation with the State Heart Association and one of the medical schools, to improve the care of patients with myocardial infarction in that area of the Region through the establishment of a coronary care demonstration and training unit. The local decision was made to concentrate on developing a high quality coronary care unit in a single hospital. These varied institutions joined with the public to raise private funds, recruit and train staff, and equip the unit. Although the investment of Regional Medical Program funds was limited, the cooperation engendered by the program not only accomplished much, but also has served as a model of cooperative action to the Region.

The community of Anchorage, Alaska, in response to the needs identified by the Washington-Alaska Regional Medical Program for a high energy radiation source closer than Seattle, Washington, is now conducting a fund raising campaign. Solicited private funds will be used to construct housing for the equipment, which will be purchased by the Regional Medical Program. The treatment center will be operated as a regional resource by the Providence Hospital, as planned and approved by local and regional advisory groups. The decision to support this activity involves cooperative arrangements at another level also, for the National Cancer Institute conducted the on-site visit which gave assurance of the sound scientific and professional basis of this project. The Anchorage Building and Construction Trades Council, comprising some 14 unions have taken on the construction of the building as a project, thus contributing more than one half the total cost from this one source.

One of the most meaningful associations sponsored by Regional Medical Programs is between Vanderbilt University Medical School and Meharry Medical College on the one hand, and the Neighborhood Health Center supported by the Office of Economic Opportunity, located near Meharry on the other. Consultants from Vanderbilt are working with the faculty of Meharry and the staff of the Health Center to provide comprehensive health care for impoverished communities formerly without adequate care. In many other Regions similar collaborations between institutions of varying maturity and strength have resulted in achievements heretofore difficult, if not impossible.

2. The Relationship of Science to Service

The complex problem of relating the more sophisticated and advanced activities available in only a few institutions within a Region to the broader needs of people of the Region is a significant mandate for the programs. This task is being carried out in a variety of ways.

The computer expertise and facilities of the University of Missouri and the previous work of the Public Health Services' National Center for Chronic Disease Control, are being used by local physicians to test the effect of the availability of computer-assisted and semiautomated interpretation of electrocardiograms on the care of patients.

The Intermountain Region has an outstanding multidisciplinary research group investigating computer application to clinical problems. Automated physiological monitoring has been extended from the Latter-day Saints Hospital in Salt Lake City to four other hospitals in the Region, through the use of remote computer consoles, allowing a more sophisticated level of treatment in these hospitals. In this case, as in many others, the developmental work was supported by the National Heart Institute, which now is jointly funding with Regional Medical Programs the application of the technologic advances.

The latest and best in medical science exists also in institutions other than universities and research institutes. Wisconsin has a death rate from pulmonary embolism higher than the nation's average, and in Wisconsin, the Marshfield Clinic has a group especially knowledgeable about thromboembolic disease. The Wisconsin Regional Medical Program is supporting a unit at the Marshfield Clinic for the demonstration of the best techniques for diagnosis and non-surgical management of patients with pulmonary embolism. The Marchfield Clinic has established referral routes from five hospitals in the Region for emergency care of patients suspected of having pulmonary embolism. The effect of this unit has already been made apparent by the increased demand from physicians throughout the Region for educational services there. The unit already has treated more than 30 patients, with results better than the national average—a distinct improvement in patient care.

Research institutions are anxious that medical practice benefit from research efforts. For several years, the Memorial Sloan-Kettering Cancer Center has extened its consultation and teaching programs out to the practicing community in six hospitals. Now, through the New York Metropolitan Regional Medical Program it is able to expand its coverage to surrounding areas, and is planning to include 28 additional hospitals so that the knowledge and talent of the Memorial Sloan-Ketering Cancer Center can be made available to practitioners throughout the area.

In many similar projects, Regional Medical Programs serves as a vehicle for transmission of the latest scientific advances to the bedside.

3. Education and Training

Education and Training have been traditional methods of improving quality in all fields. The emphasis in Regional Medical Programs has been to support education and training, not as separate isolated activities, but rather in terms of recognized needs for the improvement of patient care services and as an integral part of other activities.

An example of the development of this type of training and educational program arose in the Rochester Region, where 29 hospitals were faced with the problem of establishing coronary care units. Through their Regional Medical Program, they have been able to focus instead on the problems of giving the best diagnosis and treatment to all patients with myocardial infarction in the Region. A recently awarded operational grant will support training and continuing educational programs for physicians and nurses to staff the units, the development of evaluation techniques, and the establishment of a coagulation resource in a community hospital.

The California Region plans to anticipate the needs for education and training in a new community hospital to be completed within the next three years in the Watts area of Los Angeles. A Post-Graduate faculty will be recruited now and sponsored jointly by the Charles Drew Medical Society, the University of California in Los Angeles, and the University of Southern California. Once built, the hospital itself will support the faculty, but Regional Medical Program funds are being sought for interim assistance.

Numerous programs are seeking to provide expert consultation on request. These include making consultation available by telephone or two-way radio on a 24-hour basis, a dial access telephone-audio tape system in Wisconsin, and a medical jukebox in Albany which will show a variety of single concept films on demand.

4. Demonstrations of Patient Care

Demonstrations of patient care are proving to be effective in serving the goals of the program, and have been a major expression of cooperative arrangements for the betterment of a particular situation.

Resources in Mississippi for the management of stroke patients are limited. Four intensive care beds for the demonstration of latest advances and modern potential of stroke care have been established under Regional Medical Programs. The usual hospital costs are being supported from other sources but with this newly funded demonstration unit, physicians, nurses, and all allied health professionals have access to excellent training. The result of such training and "on line" experience is already leading to improved care for stroke patients.

In Iowa, a different demonstration pattern is being used. Through the Iowa Regional Medical Program, a stroke team with physicians and allied health competence is available for on-site consultation. This unit, taken to the patient, provides specific consultation and comprehensive education for those responsible for continuing care.

In Smithville, Missouri, an entire community has enthusiastically become a "demonstration project." With the funding of a much needed rehabilitation unit in that town of 2,500, which serves a population of 50,000, the imagination of the community was captured. Impressed by the potential of Regional Medical Programs, the town leaders sought and became a "demonstration sub-region" for the Missouri program. Thus, over a dozen regional projects are now being tested in Smithville.

There are many examples of units demonstrating care of patients with acute myocardial infarction. The units are varied. Some are in small and some in large hospitals. Some represent joint efforts between "Medical Centers" and outlying hospitals. Some are administered by physicians while others are administered by nurses. These models recognize the realities of manpower shortages, and of the significant differences in the locales where patients are treated.

5. Experimental Projects

Regional Medical Programs are offering an excellent opportunity for the use of information coming out of research into better methods for making available the advances of medical science.

North Carolina is paying considerable attention to the special problems of an area in the western part of the state known as the "State of Franklin." For example, seven hospitals in as many different communities are testing the feasibility of a common Board of Trustees and a coordinated program to the extent that they will request accreditation as one hospital by the Joint Commission on Accreditation of Hospitals. Separately these hospitals, plagued with manpower and facility shortages, face not only an uncertain future, but the knowledge that they will have increasing difficulty in maintaining quality patient care. As a result of the Regional Medical Program, these hospitals are now testing the concept of a unique regional hospital organization which will make possible the implementation of improved care in heart disease, cancer, and stroke.

The University of Michigan School of Engineering is cooperating with the Intermountain Regional Medical Program in a systems and operations study of coronary care. Here we see recognition of the need for the health system to increase the effectiveness and efficiency of care modalities. In this era when national attention is directed to rising medical care costs, many resources and types of expertise will be needed to minimize needless expense. Vermont is involved in a modified cost benefit analysis of several health activities being initiated. The data collected should provide not only the Vermont Regional Medical Program, but the health industry in general with information upon which decisions can be made on substantive rather than intuitive bases.

Mr. ROGERS. Is there any particular emphasis given in the regional programs to the core city problem?

Dr. MARSTON. Yes, sir. The program has tended to go more slowly in the very large, complex urban areas, I think, probably for the same reason some other programs there have gone more slowly. But there are some key examples of our activities in urban areas.

In the California region, the Watts group is working on a program with UCLA, the local chapter of the National Medical Association, and USC.

The Tennessee-Midsouth region, in Nashville, is supporting a program in combination with OEO—I could give you a list of these.

Mr. ROGERS. Let us have a list of these, and what hospitals in these areas are involved and the personnel involved.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON REGIONAL MEDICAL PROGRAM EFFORTS DIRECTED AGAINST THE HEALTH PROBLEMS OF THE INNER CITY

In August 1967, the National Advisory Council on Regional Medical Programs issued a statement which gave consideration to the health problems of metropolitan areas and their inner cities. While recognizing the complexities of the urban environment, the Council stressed the responsibility of Regional Medical Programs to contribute to the solution of health problems there. In addition, it recommended that an appropriate group of national leaders be named and called together to consider how the attention of Regional Medical Programs could best be focused on the issue.

In response to the statement and to the Surgeon General's memorandum of October 9, 1967 "Improving the Health Status of the Urban Poor," a meeting was held on November 16, 1967 to consider the problem. Among those persons invited to attend were hospital representatives, RMP coordinators from urban areas, health planners, representatives from OEO, medical school officials and physicians with responsibility for the provision of care to the urban poor. The discussion concerned the need for immediate action to reduce the health status differential which now exists, the need for experimentation in the methods of delivering health care, and the need for coordinating the activities of diverse groups which provide health care services in the inner city as well as specific approaches and projects which might be undertaken.

At the local level, Regional Medical Programs which include major metropolitan areas have developed varied approaches to solving these problems. These efforts include cooperative arrangements between hospitals, health departments, medical schools, voluntary agencies and practicing physicians to meet the health needs of the poor. Examples of these approaches now under development or in operation can be summarized as follows:

California Regional Medical Program has established a subregion covering the Watts-Willowbrook area of Los Angeles which will facilitate the development of activities aimed at meeting the specific needs of the people there. Through the Regional Medical Program, the University of Southern California School of Medicine and the UCLA School of Medicine are cooperating with the local Charles R. Drew Medical Society (an affiliate of the National Medical Association) in establishing a post-graduate medical school at the Southeast General Hospital now under construction in Watts. This school will provide back-up services to the OEO neighborhood health center in the area, develop training programs for allied health personnel, provide stimulus for additional physicians to enter the practice within the community and will develop training programs for physicians already there. California Regional Medical Program has requested funds for partial support of the school in the early stages of development. In addition, work is now underway at the University of Southern California School of Medicine on the application of cancer case finding methodology to poverty groups.

New Jersey Regional Medical Program has organized an urban health unit within their office and has established a Task Force on Urban Health Services under the chairmanship of Mrs. Anne Somers, a member of their Regional Advisory Group. Membership on the Task Force includes representatives of the New Jersey Hospital Association, the New Jersey State Department of Community Affairs, county medical societies, local OEO CAP programs and other groups. The function of the group will be to stimulate and review projects for improving the availability of health services to persons living in urban areas of the state, particularly low income groups. The group currently is working on the development of hospital based group practices at Middlesex General Hospital in New Brunswick and at West Jersey Hospital in Camden, as demonstrations of improved systems for patient care for heart disease, cancer and stroke.

The New Jersey Regional Medical Program will assign a coordinator/planner to the Model Cities offices in Trenton, Newark, and Hoboken. The function of

these persons will be to gather data on services and the facilities available for people suffering from heart disease, cancer and stroke; to provide liaison between Regional Medical Programs and the Model Cities programs; and to assist the Model Cities offices in developing a program of health services for the community which will be consistent with the overall goals and objectives of the Regional Medical Program.

Tennessee-midsouth Regional Medical Program has developed a number of projects which affect the health care of the poor in Nashville. Coronary care units will be established at Nashville Metropolitan General Hospital and Hubbard Hospital, which serve patients largely drawn from an indigent population. Meharry Medical College will conduct continuing education programs for Negro physicians and will establish a supervoltage radiation unit to improve cancer therapy in the community and improve graduate and under-graduate radiology training. In addition, there is a project to test the effectiveness of multiphasic screening examinations in the early diagnosis of heart disease, cancer and stroke. Meharry will establish a screening center which will operate in support of a comprehensive neighborhood health center funded by OEO and will serve a population of 18,000 people. The test population and a control group will be evaluated and compared with reference to changes in morbidity, patterns of utilization of health services, health attitudes and cost per patient diagnosed.

Tri-State Regional Medical Program received a planning grant in late 1967 and is only now becoming completely organized. Since that time Dr. Norman Stearnes, Program Coordinator, has been involved in a number of meetings where he has made known Regional Medical Program's interest in working to improve the availability of health services to the urban poor. He also is serving on an ad hoc committee formed in Boston by Blue Shield to discuss the planning of home services and will sit on the Health Services Advisory Committee to the Boston City Department of Health and Hospitals. At this time, there are two projects for earmarked funds under development in the Boston area, a stroke project at the New England Medical Center which will have a tie-in with the Columbia Point Neighborhood Health Center and a hypertension project being developed by Dr. Edward Kass of the Channing Laboratory, Boston Department of Health and Hospitals.

Illinois Regional Medical Program has established a number of formal and informal contacts with persons in the Chicago area responsible for providing health services to the inner city including Dr. David Greeley, Associate Director, Chicago Board of Health and Dr. Mark Lepper, Vice President, Presbyterian-St. Luke's Hospital which operates an OEO financed neighborhood health center. Now in the planning stage at Presbyterian-St. Luke's Hospital is a community hypertension detection program which will be focused on the Mile Square area of Chicago. Included would be evaluation of case finding methodology, effectiveness of treatment, nurse interviews with patients and an analysis of the interaction of the program to the community.

Michigan Regional Medical Program: At its recent February meeting the Regional Advisory Group of this program formally adopted a statement for priorities for Regional Medical Program action which reads in part "the first priority for Regional Medical Program support will be given to those projects which are concerned with the improvement of the delivery system of health care including such aspects as (a) improvement of the delivery system of health care to low income groups; and (b) innovations and improvements in the utilization of manpower . . ." Underway is a planning project supported jointly by Regional Medical Programs and the State Health Department (Project ECHO) for gathering data on the health needs in depressed areas of Wayne County, Michigan.

Wayne County General Hospital has submitted a project to study the use of subprofessional workers to assist the physician in patient care and will design and establish training for such persons recruited from the local community. Wayne County General Hospital serves the indigent population of Wayne County and is located adjacent to a large indigent group in western and southern Wayne County, Michigan.

In addition, Regional Medical Program staff at Wayne State University School of Medicine is working to establish liaison with urban health programs in Detroit including OEO and Model Cities. The Executive Director of the Detroit Urban League has been named to the Wayne State Advisory Group.

Indiana Regional Medical Program is working with Flanner House, a voluntary community agency in Indianapolis to develop a multiphasic health screening program for low income population groups. With State and local support the

Regional Medical Program is conducting planning and feasibility studies to determine the types of screening procedures which will most effectively reach target population groups and which can in part be administered by previously untrained persons from the community who have received on-the-job training.

New York Metropolitan Regional Medical Program has made specific assignments to members of their core staff for maintaining liaison with community mental health programs, OEO and Model Cities. Particular effort has been made to develop a working relationship with the Provident Clinical Society, the moving force behind an OEO health center in Brooklyn and as a result the president of this organization has recently been appointed to the Regional Advisory Group. In upper Manhattan, the Regional Medical Program is practicing with representatives of the National Medical Association, Columbia University College of Physicians and Surgeons, Mount Sinai School of Medicine and St. Luke's Hospital in the development of continuing education programs for unaffiliated physicians. The Regional Medical Program is also taking leadership in co-sponsoring a conference on health careers for the underprivileged to bring together all interested forces in the area to develop a coordinated program. Also in the developmental stage, are several projects for earmarked funds including a pediatric pulmonary disease center at Babies Hospital, a feasibility study for the development of screening and treatment of stroke patients at Harlem Hospital, and a mobile coronary care unit to operate out of St. Vincent's Hospital in Greenwich Village.

Metropolitan Washington, D.C., Regional Medical Program will establish a stroke station at Freedman's Hospital, the teaching hospital of Howard University Medical School. The project will improve the care of patients from a predominantly Negro population group by setting up an intensive care stroke unit in the hospital and by developing extensive follow-up services for stroke patients. The unit will be used for training medical students, area physicians, nurses and paramedical personnel in the latest techniques of stroke management. There will be research studies undertaken on diagnostic methods, epidemiology and the cultural, behavioral and socio-economic consequences of stroke. Also submitted for review are stroke projects to be operated at George Washington University Hospital, D.C. General Hospital and Glenn Dale Hospital which would combine university and D.C. Department of Public Health efforts.

Missouri Regional Medical Program will establish at Kansas City General Hospital a special diagnostic and treatment unit for patients with cerebrovascular disease. Approximately 500 patients a year will be referred from the emergency room, outpatient department, clinical services of the hospital and from physicians in the surrounding communities. Kansas City General Hospital serves the majority of indigent patients in the Kansas City, Missouri area and will provide the back-up to an OEO neighborhood health center now under development in the community. Missouri Regional Medical Program and Kansas Regional Medical Program have also established a greater Kansas City liaison committee to review and coordinate the activities of both programs in the metropolitan area.

Georgia Regional Medical Program has submitted for review a project for the development of a community hypertensive control program, to determine the most effective methods to identify symptomatic hypertension in an urban racially mixed community in Atlanta. The project which would be conducted by the Georgia State Health Department would assess the most effective methods to achieve good blood pressure control in these hypertensives, train lay blood pressure aids, and determine whether a community program in hypertension control is economically feasible using public health methods.

Mr. ROGERS. What about the rural areas?

Dr. MARSTON. I think things have tended to move more rapidly in the rural areas.

Mr. ROGERS. Let us have a breakdown there, too, please.

(The following information was received by the committee:)

Department of Health, Education, and Welfare Statement on Operational Projects Affecting Rural Areas

ALBANY REGIONAL MEDICAL PROGRAM

Many of the Albany operational activities will serve to enhance the capabilities of health professionals in the rural areas. By bringing professionals from small communities into the medical center for continuing education and by improving communications between the medical center and the communities they hope to raise the level of patient care in those communities. The following projects involve rural areas:

Operational Projects

1. *Two-way Radio Communication System: Direct Cost, $144,100*

This project will expand an existing two-way radio network to include 57 hospitals and 24 high schools. It will provide continuing education for physicians and allied medical personnel. It will also provide information and education programs for administrators, members of boards of trustees, voluntary health agencies, adult education classes, and selected civic groups.

2. *Community Information Coordinators: Direct Cost, $73,800*

Former pharmaceutical representatives will be used to contact local physicians to tell them about Regional Medical Programs and to evaluate their attitudes towards RMP.

3. *Community Hospital Learning Centers: Direct Cost, $75,800*

This project will establish learning centers at community hospitals using "Self Instruction Units" and audio-visual equipment for rapid dissemination of new medical knowledge. Eventually, the directors of this project hope to evaluate physician progress. Initially, 8 hospitals will be involved.

4. *Community Hospital Coronary Care Training and Demonstration Program: Direct Cost, $55,400*

This project will establish coronary care units of three beds each at three community hospitals: Pittsfield General, St. Lukes, and Vassar Brothers. These will serve as demonstration and educational projects for other hospitals in the region. A continuing educational program will serve the permanent Unit Staff and staffs from smaller hospitals.

5. *Training and Demonstration Project, Intensive Cardiac Care Unit Herkimer Memorial Hospital: Direct Cost, $3,500*

The initial phase of this project is to train 6 or 8 nurses from small community hospitals in cardiac anatomy and physiology, coronary disease, the principals and staffing of a cardiac intensive care unit, and in handling the complex equipment. These nurses will also be sent to Albany Medical Center for active training with specialized equipment.

INTERMOUNTAIN REGIONAL MEDICAL PROGRAM

The Intermountain Regional Medical Program has essentially three types of projects for remote communities. Several projects are educational involving the training of health professionals who are brought into the medical center. Other projects send specialists from the medical center to the small communities to aid local physicians with specific areas of patient care. A third type involves the use of electronic monitoring equipment which transmits physiological signals from patients in remote areas to the medical center for interpretation. A listing of these projects follows.

Operational Projects

1. *Network for Continuing Education in Heart Disease, Cancer, Stroke and Related Diseases: Direct Cost, $243,000*

The objectives of this program are to develop a communications network between patient-care and research institutions to encourage liaison between health care personnel in the area. The currently existing 2-way radio systems, including 11 hospitals in 7 communities in or near Salt Lake City, will be extended to remote hospitals to serve as one link. Closed circuit TV and use of KVED (University of Utah education TV) is also planned. This may establish the community hospital as the locus of continuing education.

2. Information and Communications Exchange Service: Direct Cost, $40,300

The CIES is a region-wide clearing house for information about IRMP. Staff will be put in local communities to act as public relations representatives and also to distribute information to medical personnel and the public. The community staff will also gather information on community needs and resources and serve as a station for collecting economic, social, and medical data.

3. Cardiopulmonary Resuscitation Training Program: Direct Cost, $63,400

The University of Utah will give a 3-day course in resuscitative techniques to selected physicians from small communities. Each physician will then be responsible for teaching the techniques to health personnel in his community. This resuscitation consultant will also collect data about the number of times resuscitation is employed and the results.

4. A Training Program in Intensive Cardiac Care: Direct Cost, $118,600

A core faculty of experts in using Cardiac Care Units and diagnosing and treating heart disease will teach short courses in their subjects. The students will be interested physicians and nurses from community hospitals building coronary care units.

5. Training for Nurses in Cardiac Care and Cardiopulmonary Resuscitation:Direct Cost, $34,000

This is an integral part of both the cardiac care and cardiopulmonary resuscitation programs for physicians (#3, #4). Nurses trained in Salt Lake City will return to their communities to serve as a core faculty for teaching the techniques at the local level. The nurses will work closely with the similarly trained physicians.

6. Visiting Consultants and Teacher Program for Small Community Hospitals: Direct Cost, $14,800

Small communities will be given the option of requesting one or two-day clinics. A minimum number of four cardiac patients will be required. These clinics will upgrade the level of care of victims of heart disease living in a remote area. Visiting physicians will assist the local physician in a precise diagnosis of his patients.

7. A Regional Computer-Based System for Monitoring Physiologic Data on-line from Remote Hospitals in the Regional Medical Program: Direct Cost, $637,100

This project's purpose is to test the feasibility of using a central computer to process a variety of physiological signals generated by patients in remote hospitals, feeding the results of calculations from these signals back to stations within the hospitals, and using the information for diagnosis.

8. Cancer Teaching Project: Direct Cost, $94,300

This project attempts to upgrade the level of care available to local communities. The co-ordinator will direct a program of physician education to create trained cancer specialists who, in turn, will become centers of cancer information in their local communities. The physicians will receive a small stipend for teaching and obtaining information. A region-wide tumor registry will be started as will a training program in new techniques for pathologists.

9. Stroke and Related Neurological Diseases: Direct Cost, $98,700

This project will establish clinics to bring expert consultation service in stroke and related neurological diseases to local communities; will provide continuing education to local physicians and nurses; will collect data about stroke patients seen and the problems they present to the practitioner. A 24-hour telephone consultation service and information library service will be maintained at the Utah Medical Center to provide community physicians with immediate advice. In addition, practicing physicians will be trained at the medical center in the latest diagnostic and treatment techniques. The courses will last from 4 weeks to one year.

KANSAS REGIONAL MEDICAL PROGRAM

The Kansas Region is emphasizing cardiovascular care in its rural programs. In addition it is setting up a comprehensive model training program in a small community. The project descriptions follow:

Operational Projects

1. Education Programs—Great Bend, Kansas: Direct Cost, $261,000

To develop a model educational program in this small community a full-time faculty, which will be affiliated with the Kansas Medical Center, will be in residence. Included in this comprehensive program are plans for continuing physician and nurse education and clinical traineeships for health-related personnel. Studies will be made of community needs, resources, etc.

2. Cardovascular Nurse Training: Direct Cost, $98,500

To develop an in-service training program to prepare nurses, who are the mainstay of coronary care units in community hospitals, with basic physiological knowledge of coronary care, ability to use instruments and equipment in coronary care units, experience in home care, and familiarity with social agencies that can aid in the rehabilitation of patients.

3. Cardiovascular Work Evaluation: Direct Cost, $21,100

This project will demonstrate the Cardiac Work Evaluation Unit and show its usefulness for the evaluation and rehabilitation of the patient. It is developing an effective technique for showing physicians and the community at large the ability of patients to return to work after receiving the appropriate rehabilitation.

MISSOURI REGIONAL MEDICAL PROGRAM

The Missouri Regional Medical Program operational activities involve projects directed toward improved screening techniques, early disease detection and rapid diagnosis, and more effective delivery of services. These are coordinated with automated systems for transmission of information and health data to aid physicians and community hospitals in the treatment of patients with heart disease, cancer, stroke and related diseases. Six projects focus on the health needs, the care of patients, and training of staff for rural communities.

Operational Projects

1. Smithville Community Health Service Program: Direct Cost, $200,957

To establish a model community health service program including continuing education and training programs and health education for the public; emergency intensive and restorative care facilities; home care programs; public health, preventive medicine, and school health; coordinated with voluntary health agencies. Program centered around Smithville (population of 3,500) and to include about 50,000 persons in Clay County. Activities are centered around *Smithville Community Hospital (75 beds)*, and the group practice clinic as a nucleus.

2. Multiphasic Testing of an Ambulant Population: Direct Cost, $421,471

To establish centers for performing series of diagnostic laboratory tests to identify the most useful tests feasible for screening large rural population groups; determine the different patterns for ill and healthy populations as an aid in detection of heart disease, cancer, and stroke in preclinical stages. Model test centers will be established at the University Medical Center, Columbia, the State Mental Hospital and a third is planned for the *Smithville* complex.

3. Mass Screening—Radiology: Direct Cost, $54,814

To improve the accuracy of radiologic diagnosis of heart disease, cancer and stroke through electronic communications media. Three small rural hospitals will be hooked into the University of Missouri computer and Department of Radiology; to evaluate diagnostic efficiency and determine applicability of ultrasound and thermography in diagnosis and therapy.

4. Comprehensive Cardiovascular Care Units—Springfield, Missouri: Direct Cost, $69,347

To develop a comprehensive care unit for grouping patients with heart disease or other circulatory system illness or who have been admitted for other purposes but require close cardiac observation. The project is to be undertaken at *hospitals without a house staff*, where it is hoped that grouping of patients will relieve the workload for nurses on general medical and surgical wards. Springfield (a community of over 100,000) has 4 general community hospitals

ranging in size from 34 to 511 (a total of about 1,200 beds). St. John's Hospital medical staff and Greene County Medical Society are coordinating activities with 3 local hospitals in Springfield.

5. Automated Electrocardiography in a Rural Area: Direct Cost, $369,000

To provide hospitals and physicians in rural areas with automated facilities for transmitting electrocardiograms and an automated system for analyses of ECG's; to demonstrate the feasibility of such systems where this service is limited or non-existent, and to develop, test and implement the use of bioengineering signals as an aid in diagnosis.

6. Operations Research and Systems Design: Direct Cost, $39,055

To develop systems concerned with testing "early detection" hypothesis-develop operational methods of early detection tests for a large rural population.

MOUNTAIN STATES REGIONAL MEDICAL PROGRAM

Operational activity in the Mountain States Region is specifically designed to benefit small hospitals in rural areas and to train health professionals from rural areas.

Operational Projects

1. Intensive Coronary Care in Small Hospitals in the Region: Direct Cost, $206,913

Hospitals in the region will send registered nurses into St. Patrick's Hospital, Missoula, Montana, for coronary care training. This three-week course will be offered three times a year for 21 nurses, and there will be follow-ups at the home hospitals four times a year. In addition, a 4-day training program especially designed for small town physicians will be held at the University of Montana four times a year.

NORTH CAROLINA REGIONAL MEDICAL PROGRAM

In North Carolina there are 10 funded operational projects all of which have a direct effect upon hospitals, health professionals, and patients in rural areas. Some are concerned with education and training of physicians and allied health personnel, and others with patient care. All of them are designed to bring the latest scientific advances down to the community level. The projects are listed as follows:

Operational Projects

1. Education and research in community medical care—direct cost, $209,200

To develop resources for training more medical and allied medical students; to provide new types of educational experiences which will make family practice more attractive; to have a postgraduate education program at the medical school; to strengthen ties between the medical school faculty and practicing physicians; and to have the medical school become involved in community planning for improving the quality and availability of medical care. Affected by this project are the following groups: the University Community; the Caswell County Rural Health Services Project; the Regional Health Council of Eastern Appalachia, Inc.; the State of Franklin Health Council, Inc.; the Charlotte Memorial Hospital; the Moses Cone Memorial Hospital, Greensboro; and the Dorothea Dix Neuromedical Service.

2. Coronary care training and development—direct cost, $55,938

To use the project as a medium for developing cooperative arrangements among the various elements in the health care community. Initial and continuing education will be provided to nurses and physicians in community hospitals, consultation will be available to hospitals in establishing CCU's, and a computer-based system of medical record keeping will be developed. This project has led to new working arrangements: (1) between the university medical centers; (2) between medical and nurse educators; (3) between doctors and nurses in community hospitals; (4) between university medical centers and community hospitals.

3. Diabetic consultation and educational services—direct cost, $132,081

To establish three medical teams to deliver services throughout the state; to assist in expansion of diabetic consultations and teaching clinics; to provide

seminars for physicians and teaching sessions for nurses and patients; to assist in organization of a State Diabetes Association and local chapters; to test techniques of data collection. Many people of different disciplines in many communities are involved in this project.

4. Development of a central cancer registry—direct cost, $66,615

To devise a uniform region-wide cancer reporting system, integrated with the PAS, the computer-stored data from which can be retrieved to serve a broad range of educational, research, statistical, and other purposes. The following hospitals are participating in the first year of the project: Duke University Medical Center, North Carolina Memorial Hospital, North Carolina Baptist Hospital, Charlotte Memorial Hospital, Veterans' Administration Hospital, Watts Hospital, Hanover Memorial Hospital, Southeastern General Hospital, Craven County Hospital. In subsequent years the registry will be expanded to include all hospitals and physicians in the region.

5. Medical library extension service—direct cost, $25,839

To bring medical library facilities of the three medical schools into the daily work of those engaged in medical practice. Local hospital personnel will be trained to assist medical staff; libraries will be organized into a functional unit for responding to requests for services. Bibliographic request service will be established.

6. Cancer information center—direct cost, $41,716

To provide practicing physicians with immediate consultation by telephone and follow-up literature. Each of the three medical schools will be responsible for providing service in its geographic locale. The aims of this project are twofold: (1) to assist physicians in providing optimum care of patients with cancer; and (2) to continue the education of the physicians by giving new information in a patient-centered experience.

7. Continuing education in internal medicine—direct cost, $33,313

To bring practicing internists from all over the state to the Medical Center for a month of up-to-date training in their subspecialties. They will share responsibilities with attending physicians and make ward rounds with students, staff, and together. This experience should enhance the appreciation in the University, both at faculty and student levels, for the expanding role of the medical center for the quality of care in the community.

8. Continuing education in dentistry—direct cost, $67,508

To provide physicians and dentists with the knowledge of mutual concern which will enable them to be more effective members of the health team. Courses will be given at the University of North Carolina and in communities. Studies will be made of facilities needed to provide dental care in hospitals. The purpose of this project is to insure that as many patients as possible who suffer from heart disease, cancer, stroke, or a related disease receive appropriate dental care as a part of their comprehensive treatment.

9. Continuing education for physical therapists—direct cost, $27,838

To develop and establish regional continuing education programs for physical therapists in order to strengthen physical therapy services for patients in all parts of the state. Subregions will be delineated where needs and interests will be identified and committees will be organized to arrange local activities.

10. The establishment of a network of coronary care units in small community hospitals in Appalachia, North Carolina—direct cost, $93,019

This is a proposal to develop coronary care units in seven hospitals in this rural, mountainous area. RMP will supply the monitoring equipment (the hospital provides suitable space) when adequately trained physicians and nurses are available. An intensive training course for physicians will be conducted in the geographic region, and continuing education programs will be conducted when necessary.

TENNESSEE MID-SOUTH REGIONAL MEDICAL PROGRAM

Due to the geographical diversity of the region, the Tennessee Mid-South Regional Medical Program has been concerned with both the health problems of the urban poor as well as the health problems of remote rural areas. The Tennessee program has sought solutions to these and other regional programs

through a system of linkages between the medical centers and the rural areas. In addition to providing programs to allow medical personnel and practicing physicians from rural community hospitals to come to the medical center for training courses, the Tennessee program has endeavored, through the use of modern communication techniques, to create medical education resources in the rural areas. The Hopkinsville Education Center and the deployment of coronary care units are two examples of such projects.

Operational Projects

1 and 2. Hopkinsville Education Center and Chattanooga Education Center—direct cost, $73,700

These are the first of the local continuing education centers specified in the Vanderbilt plan. At each hospital, a full-time Director with an appointment at Vanderbilt and an assistant director will supervise resident and physician education in their area. Their services will be available to physicians at smaller community hospitals in each area, as will the enlarged hospital library facilities. The Chattanooga and Hopkinsville locations provide the basis for looking at problems in continuing education in urban and rural settings.

3. Franklin Coronary Care Unit—Williamson County Hospital—Franklin—direct cost, $31,400

This is one of the subsidiary units mentioned in the Vanderbilt proposal. This is primarily a pilot project to study the feasibility and usefulness of establishing a center in a small community hospital.

4. Clarksville Coronary Care Unit—Clarksville Memorial Hospital—direct cost, $19,000

As the Franklin program, this project is a subsidiary of the Vanderbilt proposal. Since this hospital has been operating a unit, the plan calls for its expansion, continuing education and a phone hook-up to Vanderbilt.

5. Murray Coronary Care Unit—Murray-Calloway (Ky.) County Hospital: Direct Cost, $38,800

Murray-Calloway County Hospital, the training center for Murray State University school of nursing, will serve as a demonstration center for the sub-region. Direct phone communication will be established with Vanderbilt, which will send consultants from its school of continuing education. This project has the dual objective of relating the Murray State Nursing program to an established medical center and providing regional training resources to a remote area.

6. Crossville Coronary Care Unit—Uplands Cumberland Medical Center Crossville: Direct Cost, $28,300

This project has two purposes: (1) to establish a two-bed coronary care unit in the hospital; and (2) to determine the feasibility of operating acute coronary care units in rural areas. The hospital will cooperate with Mid-State Baptist Hospital and Vanderbilt.

7. Tullahoma Coronary Care Unit—Harton Memorial Hospital, Tullahoma, Tenn.: Direct Cost, $28,800

See Baptist Hospital Program.

8. Project to Improve Patient Care in a Remote Mountain Community by Recruiting and Training Health Aides for a New Extended Care Facility—Scott County Hospital—Oneida, Tenn.: Direct Cost, $10,300

Manpower shortage in this isolated mountain hospital is critical. Personnel to man an extended care facility now under construction will be obtained by two methods: (1) In-service training for hospital personnel; (2) an educational director (an RN) to serve as a liaison to the high schools to encourage young people to enter the medical field and come back home to practice. In addition a training program leading to the LPN would be initiated. Clinical training will be supervised by the Educational Director while local high schools provide basic training.

9. Hopkinsville Coronary Care Unit—Jennie Stuart Memorial Hospital—Hopkinsville, Ky.: Direct Cost, $49,500

This plan is similar to the Franklin plan, except that it mentions establishing links to smaller community hospitals by helping set up smaller care units in them,

thus providing for the grouping of rural community hospitals for more efficient use of existing resources.

WASHINGTON-ALASKA REGIONAL MEDICAL PROGRAM

The Washington-Alaska Regional Medical Program operational projects concern themselves largely with continuing education and training activities to enhance the medical and paramedical capability. They focus on communications techniques and instruction materials and methodologies which are adaptable to the far flung and remote communities in the vast State of Alaska and the many scattered rural communities in Washington State. Several projects are being conducted to improve the health manpower resources in communities with limited or no specialty health services, which are distant from a major medical center.

Operational Projects

1. *Central Washington—Communication System for Continuing Education for Physicians: Direct Cost, $18,181*

To bring the medical resources of the University of Washington to physicians and community hospitals in Yakima, who in turn will act as consultants to surrounding smaller communities through seminars and conferences, educational TV, other audio-visual instruction; and exchange of teachers and practitioners. To connect internists in Central Washington to Yakima cardiologists via EKG telephone hot-line, to permit quick analysis (starting with 5 community hospitals). Yakima is a community of about 45,000. The total population in 6 Central Washington counties exceeds 300,000. In addition to three general hospitals in Yakima—St. Elizabeth, Yakima Valley Memorial, and New Valley Osteopathic—nine other community hospitals to be reached initially are located in small rural communities of Ellensburg, Moses Lake, Othello, Toppenish, Prosser and Sunnyside, (population ranges from 500 in Moses City to some 8,600 in Ellensburg.)

2. *Southeast Alaska—Postgraduate Education: Direct Cost, $27,062*

To improve communication between Seattle Medical Community and the university to alleviate problems of the isolated physicians in southeast Alaska cities and communities: Juneau, Sitka, Ketchikan (3 largest). As in Central Washington several methods will be used such as telelectures, consultant services, seminars and the EKG hot line to hospitals in Juneau, Sitka and Ketchikan. The population in these 3 cities totals about 17,000.

3. *Postgraduate Preceptorship for Physicians—Coronary Care: Direct Cost, $17,610*

A pilot project to provide opportunity for practitioners from remote and isolated communities to spend a week or more under a preceptor at major medical centers to study advances in care of coronary heart disease and carry out these practices in their communities. The 4 major medical centers in Seattle are Providence Hospital, Swedish Hospital, Virginia Mason Hospital and Medical Center, and University Hospital and Medical Center and two in Spokane are Deaconess Hospital and Sacred Heart Hospital.

4. *Cardiac Pulmonary Technician Training: Direct Cost, $41,554*

Develop a formal program for training cardio-pulmonary technicians to perform non-critical function in coronary care units and free physicians for other duties. Four larger general hospitals in Spokane—Deaconess, Holy Family, Sacred Heart, and St. Luke's—will participate in this training program with Spokane Community College.

5. *Two-way Radio Conference and Slide Presentation: Direct Cost, $8,445*

Six pilot programs on heart, cancer and stroke topics to be transmitted via two-way radio-telephone slide conferences, to physicians and hospital staffs on topics selected by panel of physicians, starting with 20 hospitals in Washington. To explore potential for continuing network series with local and remote regions.

6. *Alaska Medical Library Facilities: Direct Cost, $21,754*

To develop a community medical library for Alaska at the PHS Alaska Native Medical Center, Anchorage for Alaska physicians and health related staffs and agencies; to have close ties with community agencies, Arctic Health Research, University at Fairbanks and to supplement continuing education project for Southeast Alaska and the Anchorage cancer project.

WESTERN NEW YORK REGIONAL MEDICAL PROGRAM

Both of the programs in the Western New York region have a direct effect upon hospitals, health professionals, and patients in the rural areas. Particular emphasis will be placed upon involving community hospitals and on training nurses from community hospitals in rural areas. The projects are listed as follows:

Operational Projects

1. Two-Way Communications Network: Direct Cost, $170,519

A two-way communication network will link hospitals of Western New York and Erie County, Pennsylvania to the Continuing Education Departments of the State University of New York at Buffalo and the Roswell Park Memorial Institute. The network will serve several purposes, such as continuing education for physicians and the health-related professions, public education, administrative communication, consultation with experts, and contacts among banks. It will assist both the physician and community hospital in either the rural or urban environment in having at their fingertips the latest advances in the diagnosis and treatment of heart disease, stroke, and cancer. Particular emphasis will be placed upon involving rural hospitals in this program thereby improving both their didactic and restorative function.

2. Coronary Care Program: Direct Cost, $127,544

This project will test a training technique for providing qualified nurses who will be required to staff developing coronary care units in the Region. Approximately 80 nurses will be selected from all parts of the Region for a combined academic and clinical course. It is planned that the nurses receiving this training will return to both rural and urban hospitals for the purpose of providing a diagnostic and didactic function. While the program will be housed at the medical center, the community hospitals of this region will be the benefactors of the project. Since there are few nurses trained to work in coronary care units, particularly in the rural environment, special attention will be paid to attracting nurses who will return to the community hospital.

WISCONSIN REGIONAL MEDICAL PROGRAM

Four of the Wisconsin projects have relevance to the improvement of health care in a rural setting, through the provision of education and information. Physicians and allied health personnel in community hospitals will benefit from the following projects:

Operational Projects

1. A pilot demonstration program for pulmonary thromboembolism: direct cost, $84,600

In this project a center is being established at Marshfield Hospital in Marshfield, Wisconsin, for demonstration diagnostic techniques and the available therapy for pulmonary thromboembolism. The project has a continuing education component which will reach physicians from many hospitals in the Region. This will involve a 24-hour consultation service, the preparation of a movie on the topic, and special training sessions for groups of physicians.

The project will demonstrate a comprehensive program which will encompass diagnostic, preventive, therapeutic, and rehabilitation procedures for patients, postgraduation education, a rapid transportation system for patients from Northern sections of the state, and cooperation between the clinic and other hospitals and medical schools in the State.

2. Telephone dial access tape recording library in the areas of heart disease, cancer, stroke, and related diseases: direct cost, $18,950

This feasibility study will be carried out by the University of Wisconsin which will record and store short, 4–6 minute, tapes on various aspects of treating patients with the three diseases. Any physician anywhere in the Region can dial the library at any time and request a tape relevant to a problem in which he is interested.

3. Nursing telephone dial access tape recording library in the areas of heart disease, cancer, stroke and related diseases: direct cost, $18,800

This feasibility study, similar to the one above, will establish a central tape library with information recorded on nursing care in emergencies, new pro-

cedures and equipment, and recent developments in nursing. Nurses from any hospital in the region will be able to call at any time to have a tape played to them.

4. Development of medical and health related single concept film program in community hospitals: direct cost, $33,250

This education feasibility project involves ten community hospitals in its first phase. Fifteen films on procedures and techniques used in treating heart, cancer, and stroke, will be developed. Projectors and the films will be installed in the hospitals for use by physicians and other health personnel at their convenience as a continuing education device. After four to six months the materials will be relocated in ten additional hospitals.

Mr. ROGERS. When do you expect to have your first evaluation of a regional medical program?

Dr. MARSTON. We have evaluations each time a region applies for a supplement, and we require an annual progress report.

In one of the regions, as the funding was beginning to get up to a sizable level, we decided that in addition to these normal reviews that we should mount a special site visit and evaluate the region's status from the standpoint of the program. We now are doing this all of the time, picking out times of program movement, particularly the shift from planning to an operational grant and upon receipt of a supplemental request for an enlarged activity. We go back and review the entire history of the grant.

Mr. ROGERS. What is the oldest region?

Dr. MARSTON. The first four operational programs were funded at approximately the same time, Intermountain, Kansas, Missouri, and Albany, N.Y.

Mr. ROGERS. Could you let us have your evaluation of how effective these have been, for the record.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON EFFECTIVENESS OF REGIONAL MEDICAL PROGRAMS

The effectiveness of Regional Medical Programs is determined in the following ways:

Evaluation of the effectiveness of each Regional Medical Program is a continuous process which involves review by the Federal Government, its non-Federal advisors, and the grantee itself. These review activities are specifically intended to determine the extent to which the region has implemented the process of regionalization which includes seven essential elements: involvement, identification of needs and opportunities, assessment of resources, definition of objectives,, setting of priorities, implementation of program activities, and self-evaluation.

This process of regionalization is the means by which the region moves toward its ultimate objective—the assurance of easily accessible improved patient care for heart disease, cancer, stroke, and related diseases.

A systematic and comprehensive review of the scientific and administrative aspects of each Regional Medical Program has been designed in order to determine the extent to which each Regional Medical Program implements this process of regionalization for the purpose of achieving its goal of improved patient care.

This review process includes surveillance at the regional and Federal level, and is conducted by both non-Federal and Federal experts. By law each operational activity must be approved by the Regional Advisory Group prior to its submission to the Federal Government for review and approval. Frequently the regions themselves have elaborated on this requirement by establishing local, in addition to regional, advisory bodies and/or scientific review bodies which also carefully examine proposed activities.

A site visit by members of the Review Committee and the National Advisory Council on Regional Medical Programs to the region is included as an integral part of approving an operational program for a region. As the operational program develops and is expanded additional site visits are made. Finally each Regional Medical Program is required to submit an annual progress report which describes in detail the region's program.

Any proposed modification in program direction by the grantee must be justified in writing and subjected to these review procedures.

Within the context of this comprehensive review process it is possible to determine whether or not a regional program is in fact evolving a regional system intended to improve patient care.

The Missouri, Kansas, Albany, New York, and Intermountain Regional Medical Programs were the first to enter the operational phase of development. The determination of their readiness to begin operations was a result of the review process described above, including a site visit by members of the National Advisory Council and members of he staff of the Division of Regional Medical Programs. The progress of these regions has been further evaluated during the review of supplemental grant requests which have been received from all four regional programs. Further site visits by Council and/or staff to review the first year's progress have either just been carried out or are scheduled for the immediate future. The results of these reviews carried out to date indicate that these Regional Medical Programs are making substantial progress toward the goals set forth a year ago as the basis for the operational grant award. The major problems encountered have been difficulties in recruiting personnel and slowness in the delivery of important equipment. These factors have caused some delays in implementing particular projects.

In addition to this evaluation at the national level, the regional programs are developing their own capabilities for self-evaluation. Special staff has been added to the central staff of the regional programs with specific competence in evaluation techniques. These techniques are being further developed and applied to the operational activities.

Mr. ROGERS. In Kansas, is Kansas City General Hospital involved in that?

Dr. MARSTON. In Kansas City, there is a joint committee from Kansas and Missouri to work together in the Kansas City area, and the Kansas City General Hospital has been involved; yes.

Mr. ROGERS. Could you let us know to what extent?

Dr. MARSTON. Yes, sir.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON THE INVOLVEMENT OF THE KANSAS CITY GENERAL HOSPITAL IN THE MISSOURI REGIONAL MEDICAL PROGRAM

The Kansas City General Hospital is directly involved in the planning for and development of the Missouri Regional Medical Program. The Missouri Regional Medical Program has allocated $82,926 for planning in Kansas City with headquarters located at the Kansas City General Hospital. Several staff share responsibilities for Kansas City General Hospital operations and Missouri Regional Medical Program planning, including the Executive Director of the Kansas City General Hospital. Several proposals related to the Kansas City General Hospital have been submitted by the Missouri Regional Medical Program to the Federal Government for review. A project to develop programmed comprehensive cardiovascular care at Kansas City General Hospital is pending final review by the Review Committee and the National Advisory Council on Regional Medical Programs. Planning studies are underway on manpower training and postgraduate medical education in heart disease, cancer, and stroke.

Mr. ROGERS. How do you evaluate your regional medical program? Could you let us know the criteria used for evaluation? I think the committee would be interested in that.

Dr. MARSTON. Yes, sir.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON THE CRITERIA FOR THE EVALUATION OF REGIONAL MEDICAL PROGRAMS

Each planning and operational activity of a Region, as well as the overall Regional Program, receives continuous, quantitative and qualitative evalution wherever possible. Evaluation is in terms of attainment of interim objectives, the process of regionalization, and the Goal of Regional Medical Programs, easily accessible improved patient care for heart disease, cancer, stroke, and related diseases. The criterion for judging the success of a region in implementing the process of regionalization is the degree to which it can be demonstrated that the Regional Program has implemented the seven essential elements of that process: involvement, identification of needs and opportunities, assessment of resources, definition of objectives, setting of priorities, implementation, and evaluation. Ultimately, the success of any Regional Medical Program must be judged by the extent to which it can be demonstrated that the Regional Program has assisted the providers of health services in developing a system which makes available to everyone in the Region improved care for heart disease, cancer, stroke, and related diseases.

It is also important to note that each Regional Medical Program is encouraged to build self-evaluation methodologies into its ongoing program. These evaluation methodologies then form an integral part of the total evaluation of the Region's program.

A fuller description of the process of regionalization is contained in the *Progress Report on Regional Medical Programs* (see p. 13) which was submitted for the Record during the hearings on H.R. 15758 and is the process upon which interim evaluations of each program are based.

Mr. ROGERS. I know on page 2, section 103, it is simply a correction to allow the District of Columbia, Commonwealth of Puerto Rico, and so forth, in. This amends the public health law itself.

Doesn't this go to the entire act?

Dr. LEE. Yes.

Mr. ROGERS. So that this would affect every program of the Public Health Service, would it?

Well, perhaps you can give us the information.

Mr. KARL YORDY (Deputy Director, Regional Medical Programs, HEW). Actually, there is a general definition in the Public Health Act which does not include these additions. These additions have been made to certain other programs in the act. This is bringing the regional medical programs into line on that.

Mr. ROGERS. Thank you. I am delighted to see the Department support this program for migrant health, which I have been interested in and helped to write the original law. And I took a very active part since then in following this program.

I have been very pleased with it, Miss Johnston. I think you have done a good job, and I think it is very essential that we recognize this is a program that should be continued rather than letting it get into the partnership as yet, because I don't think this has been well planned for in many of the States.

Dr. LEE. We would agree with that, Mr. Rogers, and also at the time the partnership for health comes up for review again, this would come up for review at the same time. And we would be able to then recommend, and you would be able to decide whether it should continue as a separate special program or whether it could, in fact, be incorporated within the fabric of the partnership-for-health program.

Mr. ROGERS. When you look over a partnership plan from a State, will the Department see that this plan has in it the necessary guidelines to carry out this type of health program?

Dr. LEE. As we develop, and as the States develop the capability for planning, the purpose, of course, of the partnership for health will continue to be to create a mechanism in the States and permit the States to set their own priorities. We then review that in relation to the priorities that have been set within the States; and certainly in terms of national needs and national priorities, those are also looked at as they relate to these State plans.

But we want to have the States make these determinations. And this, of course, presents unique problems with the migrants, because they do move from State to State, and it is difficult to encompass that within any single State plan.

Mr. ROGERS. Our time is running out. I would like to have a run-down on the migrant health programs, what is being done, how many people are being affected, and how many people are involved, and in what areas of the country.

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON MIGRANT HEALTH PROGRAM STATUS, MARCH 1968

Goal.—To improve the health status of migrants through improving their opportunities for health services and a healthful environment.

Guidelines.—

Help the migrant help himself.

Help communities recognize and assume responsibility for including migrants in total community health planning.

Promote adaptations of community services to migrants' needs and situation.

Establish continuity of care as people move.

Utilize fully all available resources.

Get migrants included in—not further isolated from—community life.

Status (see also attached directory (p. 88) and report (the PHS report, entitled "Migrant Health Programs—Current Operations and Additional Needs" has been placed in committee files)).—

115 single or multi-county projects are operating with migrant health grant assistance in 36 States and Puerto Rico.

285 project counties offer migrants personal health and sanitation services.

155 additional project counties provide sanitation services only.

More than 200 family health service clinics operate seasonally or year round.

1,000 physicians provide migrants medical care in the clinics, in their own offices and in hospitals.

300,000 migrant workers and famly dependents were in counties served by projects for at least part of 1967. They made—

215,000 medical visits; and

24,000 dental visits.

125,000 visits were made by nurses to migrant camps, other farm labor housing, and migrant schools and day care centers.

125,000 visits were made by project sanitarians and aides to home and work sites for inspection and follow-up.

$7.2 million—the total funds appropriated for grants—was obligated in 1967 and tentative commitments for continued grant support were made at the same level. Most projects have submitted expanded requests for continued grant support. These requests could not be met since the 1968 appropriation was the same as that in 1967. In each year since the program started the total amount available for grants has been obligated and approved projects have had to be carried to the next year.

Hospital Component (As of January 1968).—

55 of the 115 grant-assisted projects have hospital service components. These projects are located in 25 States.

162 hospitals have signed agreements with projects to provide migrants hospital care.

190,000 migrant workers and dependents are included in project areas covered by hospital service.

3,000 migrant workers and dependents have had bills paid under the program. (This is an underestimate due to the time-lag in getting paid bills in for processing.)

$1,307,836 has been obliated thus far (1967 and 1968 funds) for in-hospital services, including hospitalization ($946,576) and physician's services ($361,260).

Program Needs.—

441 more counties need to be covered with personal health care and 286 more counties with sanitation services in order to meet the needs in all 726 counties with an annual influx of migrants.

Approximately 700,000 additional migrant people need to be brought into contact with services.

Medical and dental services need to be expanded. At present migrants in project areas are using medical services at about one-fifth and dental services at about one-twenty-fifth the rate for the general population.

Undiagnosed and untreated conditions among migrants as the result of inadequate access to care need to be brought under treatment. Present estimates indicate that among migrants outside project areas there are—

5,600 with diabetes;
5,000 with tuberculosis;
9,800 children with iron deficiency anemia;
3,000 children under 18 with cardiac damage as a result of rheumatic fever; and
many thousands of children and adults with visual, hearing, dental, and other uncorrected defects.

A Directory of Migrant Health Projects Assisted by Public Health Service Grants

INTRODUCTION

The Migrant Health Act of 1962, as amended in 1965, authorizes the Public Health Service to make grants to assist communities in extending local health services to migrants. After local plans are approved, grants are made to public or private nonprofit organizations to pay part of the cost of health services for migrant farmworkers and family members.

The 115 projects listed here were receiving grant assistance from the Public Health Service in August 1967. Located in 36 States and Puerto Rico, these projects provide both sanitation services and personal health care in some 330 counties and sanitation services alone in 150 additional counties. The information for each project is from the project's application and report.

PURPOSE

The directory can assist project staff members and others concerned with migrants in identifying places where projects offer services to migrants along the major migratory streams. It can also facilitate intrastate and interstate patient referrals, as well as interproject communication for the exchange of information and ideas.

Each project description includes a reference to the duration of the migrant season. Projects in the northern work area are operational only during the months shown. However, many have one or two key staff members available throughout the year to answer questions between seasons, and to do the necessary postseason followup and preseason planning and negotiation.

ARRANGEMENT

The States are arranged alphabetically, and the projects are listed numerically by project grant number within the State.

The location of family health service centers is included in the description of projects which operate one or more such centers. Typically the centers are temporary facilities, open periodically at times and places conveniently accessible to migrants. At the centers, physicians provide medical treatment, immunizations, and other health services with the assistance of project staff members.

DEFINITIONS

The estimated number of migrants includes workers and family dependents present in the project area. The estimate shown for each project is that made by the project itself. It includes both persons moving within the State and those moving out of the State.

Health services provided are listed by type. The various types are defined as follows:

Medical care.—Care of the type usually provided by a family physician, including both remedial and preventive services. It may be provided in a family health service center set up for the purpose in or near a large concentration of farm migrants, or it may be provided upon referral to a cooperating physician's private office, to a hospital outpatient department, or to a preexisting clinic or health service center. Mobile units are occasionally used.

Hospitalization.—Hospital and related professional care for up to 30 days for any one admission in a general, short-stay hospital.

Dental care.—Care to remove infection and relieve pain. Some projects also provide limited restorative care, especially for children.

Nursing care.—Home visiting for casefinding, family counseling about health problems, and related purposes. Nurses and aides working under their supervision also refer migrants to sources of needed care and make followup visits to determine the outcome of referrals. In addition, nurses work in family health service centers.

Sanitation services.—Inspecting living and work sites of migrant workers and families to determine health and safety deficiencies and obtaining their correction.

Health education.—Formal or informal teaching of good personal or family health practices. Health education is shown as a service component only for projects which have a planned program of health education with part- or full-time assistance from a professional health educator. However, informal health counseling is considered as part of the job of every project staff member. The educational work of the health educator and other professional staff also extends into the community to help develop understanding of migrants, and of their needs for health care and a safe, healthful environment.

Nutrition counseling, and social work.—Only a few projects with sufficient funds and professional manpower are able to provide these important services.

PREPARATION

This directory was prepared by the Migrant Health Branch, Public Health Service. All Regional Migrant Health Representatives and project directors cooperated in providing the basic information.

ARIZONA

Project Title: Maricopa County Migrant Family Health Clinic Project (MG 29).
Sponsor: Maricopa County Health Department, 1825 East Roosevelt, Phoenix, Ariz. 85001; Telephone 602–258–6381.
Director: Raymond Kaufman, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 16,671.
County served by project: Maricopa.
Health services provided: Medical care, dental care, nursing care, sanitation services, nutrition counseling, and health education.
Location of family health service centers: Avondale*, Buckeye*, El Mirage, Glendale*, Guadalupe, Harquahala, Queen Creek, Tanitas Farm, and Tolleson*.

Project Title: Assistance to Pima County Migrants (MG 49).
Sponsor: Pima County Health Department, 161 West Alameda Street, Tucson, Ariz. 85701; Telephone 602–623–5071.
Director: Frederick J. Brady, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 1,200.
County served by project: Pima.

*Mobile clinic.

Health services provided: Medical care, dental care, nursing care, sanitation services, nutrition counseling, and health education.
Location of family health service centers: Continental, Marana, and Sahuarita.

Project Title: Yuma County Migrant Health Project (MG 66).
Sponsor: Yuma County Health Department, 145 Third Avenue, Yuma, Ariz. 85364; Telephone 602–782–9221.
Director: J. C. Pinto, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 14,400.
County served by project: Yuma.
Health services provided: Medical care, hospitalization, nursing care, and sanitation services.
Location of family health service centers: Roll, Somerton, and Yuma.

Project Title: Pinal County Migrant Family Health Service Project (MG 94).
Sponsor: Pinal County Health Department, Post Office Box 807, Florence, Ariz. 85232; Telephone 602–868–5844.
Director: William C. Carpenter, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 5,230.
County served by project: Pinal.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.

Project Title: Arizona State Migrant Health Program (MG 111).
Sponsor: Arizona State Department of Health, Arizona State Office Building, 1624 West Adams Street, Phoenix, Ariz. 85007; Telephone 602–291–4549.
Director: Robert C. Martens.
Duration of migrant season: Year round.
Estimated number of migrants: 39,700.
Counties served by project: All counties with migrants.
Health services provided: Nursing services in Cochise County; consultation services to local migrant health projects in nursing, sanitation, health education, and nutrition.

ARKANSAS

Project Title: Northwest Arkansas Area Migrant Committee Project to Establish Springdale Family Health Service Clinic (MG 50).
Sponsor: Northwest Arkansas Area Migrant Committee, 1401 Vista Drive, Fayetteville, Ark.; Telephone 501–442–9481.
Director: Mr. Bill E. Parette.
Duration of migrant season: April–October.
Estimated number of migrants: 1,459.
Counties served by project: Benton and Washington.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, health education, and nutrition counseling.
Location of family health service centers: Springdale School and labor camp.

CALIFORNIA

Project Title: Health Program for Farmworkers' Families in California (MG 06).
Sponsor: California State Department of Health, 2151 Berkeley Way, Berkeley, Calif. 94704; Telephone 415–843–7900x201.
Director: Robert W. Day, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 80,000.
Counties served by project: Butte, Colusa, Fresno, Kern, Merced, Monterey, Riverside, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Sutter, Yolo, and Yuba.
Health services provided: Medical care, hospitalization (Riverside County), nursing care, sanitation services, and health education through county projects; consultation services to county projects in nursing, sanitation, health education, medical care, and social work.
NOTE.—See following table for county detail.

COUNTY COMPONENTS OF CALIFORNIA HEALTH PROGRAM FOR FARMWORKERS, FAMILIES (MG 06)

County	Project title	Director	Sponsor	Number of migrants	Services	Family health service centers
Butte	Butte County-Gridley Camp Clinic Migrant Health Project.	Irena Heindl, M.D.	Butte County Health Department, 2430 Bird Street, Oroville, Calif. 95965; Telephone 916-533-1230.	1,500	Medical care, nursing care	Gridley Camp.
Colusa	Seasonal Agricultural Workers Program—Colusa County.	J. Raymond Beeson, M.D.	Colusa County Health Department, 85 East Webster Street, Colusa, Calif. 95932; Telephone 916-458-2919.	1,000	Medical care, nursing care, sanitation services.	None.
Contra Costa [1]	Field Public Health Program for Seasonal Farmworkers.	Glen W. Kent, M.D.	Health Department, Contra Costa County, Martinez, Calif. 94553; Telephone 415-228-3000.	750	Medical care, dental care, nursing care, sanitation services.	Do.
Fresno	Migrant Health Project	W. A. DeFries, M.D.	Fresno County Health Department, 515 South Cedar Avenue, Fresno, Calif. 93702; Telephone 209-485-8000x371.	27,000	Medical care, sanitation services, health education.	Firebaugh, Five Points, Huron, Parlier Housing Project.
Kern [2]	Seasonal Farmworker Health Education Project (Community Aides).	Carl Miller	Kern County Health Department, Post Office Box 997, Bakersfield, Calif. 93302, Telephone 805-325-5051x218.	9,500	Nursing care, sanitation services, nutrition counseling, health education.	None.
Merced	Merced County Agricultural Workers Project (Seasonal Farmworkers).	A. Frank Brewer, M.D.	Merced County Health Department, Post Office Box 1350, 240 East 15th Street, Merced, Calif. 95340; Telephone 209-723-2861x531.	7,000	Medical care, nursing care, sanitation services, nutrition counseling.	Planado, South Dos Palos
Monterey	Monterey County Health Project for Agricultural Laborers.	R. S. Fraser, M.D.	Monterey County Health Department, 1270 Natividad Road, Post Office Box 2137, Salinas, Calif. 93901; Telephone 408-424-7627.	6,000	Medical care, nursing care, sanitation services.	Pajaro.
Riverside	Family Health Services for Migrant Farmworkers in Riverside County.	Everett M. Stone, M.D.	Riverside County Department of Public Health, 3575 11th Street, Riverside, Calif. 92501; Telephone 714-683-4000.	4,000	Medical care, hospitalization, nursing care, sanitation services.	Blythe, Indio.
San Benito	San Benito County Migrant Health Project.	R. L. Hull, M.D.	San Benito County Health Department, 439 Fourth Street, Hollister, Calif. 95023; Telephone 408-637-5367.	4,000	Medical care, nursing care, sanitation services.	None.
San Bernardino [1]	Migrant Farmworkers Project	M. E. Cosand, M.D.	San Bernardino County Health Department, San Bernardino, Calif. 94201; Telephone 714-889-0111x482.	260	Dental care, nursing care, health education.	Do.

See footnotes at end of table, p. 92.

COUNTY COMPONENTS OF CALIFORNIA HEALTH PROGRAM FOR FARMWORKERS, FAMILIES (MG 06)—Continued

County	Project title	Director	Sponsor	Number of migrants	Services	Family health service centers
San Joaquin [1] [3]	Environmental Health Services for Migrant Agricultural Workers.	J. Don Layson	San Joaquin Local Health District, San Joaquin, Calif. 93660; Telephone 209–466–6781.	13,000	Sanitation services	None.
Santa Barbara	Migrant Health Project	Frank Cline, Jr., M.D	Santa Barbara County Health Department, 117 East Carrillo Street, Santa Barbara, Calif. 93102; Telephone 805–966–1611x-385.	3,844	Nursing care, sanitation services	Nipomo.
Santa Cruz	Farm Labor Health Services Project.	G. L. Dunnahoo, M.D	Santa Cruz County Health Department, 1060 Emeline Avenue, Post Office Box 962, Santa Cruz, Calif. 95060; Telephone 408–423–6020.	2,800	Medical care, nursing care	Watsonville.
San Luis Obispo	Farm Labor Family Health Project	George L. Harper, M.D	Department of Public Health, County of San Luis Obispo, Post Office Box 1489, San Luis Obispo, Calif. 93401; Telephone 805–543–1200.	5,000	Medical care, nursing care, sanitation services.	Nipomo.
Sutter	Health Services to Migrant Farmworkers and Their Families.	Thomas E. Leavenworth, M.D.	Sutter County Hospital, 1965 Live Oak 28000 Boulevard, Yuba City, Calif. 95991; Telephone 916–743–4609.		Medical care, nursing care	Yuba City.
Sutter-Yuba	Migrant Health Project	Leon M. Swift, M.D	Sutter-Yuba Health Department, 370 Del Norte Avenue, Yuba City, Calif. 95991; Telephone 916–742–6407.	3,600	Medical care, nursing care, sanitation services.	Do.
Yolo	Nursing Care and Health Supervision for Families of Migrant Workers.	Herbert Bauer, M.D	Yolo County Health Department, Post Office Box 1157, Woodland, Calif. 95695; Telephone 916–662–3241x 250.	7,500	Medical care, nursing care, sanitation services.	None.

[1] Supported by State funds only.
[2] See also Kern County Seasonal Medical Care Clinic Project—MG 158.
[3] See also Provision of Mobile Health Services for Migrant Agricultural Workers and Families in San Joaquin County (MG 157).

Project Title: Provision of Mobile Health Services for Migrant Agricultural Workers in San Joaquin County (MG 157).
Sponsor: San Joaquin County Medical Society, 445 West Acacia Street, Post Office Box 230, Stockton, Calif. 95201; Telephone 209–466–6781.
Director: Virgil Gianelli, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 6,000.
County served by project: San Joaquin.
Health services provided: Medical care, dental care, and nursing care.
*Location of family health service centers:** Acampo, Linden, Terminous, Thornton, and Vernalis.

Project Title: Kern County Seasonal Medical Care Clinic for Migrant Workers (MG 158).
Sponsor: Kern County Medical Society, 2603 G Street, Bakersfield, Calif.; Telephone 325–5051x218.
Director: Carroll Goss, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 2,000 (in Sunset Camp and nearby Weedpatch and Lamont).
County served by project: Kern.
Health services provided: Medical care and nursing care.
Location of family health service centers: Sunset Labor Camp.

Project Title: South County Migrant Medical Treatment Clinic (MG 159).
Sponsor: Santa Clara County Medical Society, 700 Empey Way, San Jose, Calif. 95128; Telephone 408–286–5050.
Director: Stanley A. Skillicorn, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 7,300.
County served by project: Santa Clara.
Health services provided: Medical care, nursing care, and social services.
Location of family health service centers: San Martin.

Colorado

Project Title: State Migrant Plan for Public Health Services (MG 09).
Sponsor: Colorado State Department of Health, 4210 East 11th Avenue, Denver, Colo. 802220; Telephone 303–388–6111.
Director: R. A. Downs, D.D.S.
Duration of migrant season: April-November; year round in San Luis Valley.
Estimated unmber of migrants: 20,400.
Counties served by project: Adams, Alamosa, Baca, Bent, Conejos, Costilla, Delta, Kit Carson, Larminer, Mesa, Montrose, Morgan, Otero, Prowers, Pueblo, Rio Grande, Saguache, and Weld.
Health services provided: Medical care, dental care, nursing care, health education, nutrition counseling. Sanitation services only in 4 counties: Baca, Bent, Prowers, and Pueblo.
Location of family health service centers: Fort Lupton.

Connecticut

Project Title: Improved Migrant Farm Labor Sanitation Program (MG 82).
Sponsor: Connecticut State Department of Health, 79 Elm Street, Hartford, Conn. 06115; Telephone 527–6351x816.
Director: Marvin L. Smith.
Duration of migrant season: March–November.
Estimated number of migrants: 7,000.
Counties served by project: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, and Windham.
Health services provided: Sanitation services.

*Mobile clinic.

DELAWARE

Project Title: Delaware Migrant Health Project (MG 83).
Sponsor: Delaware State Council of Churches, 217 North Bradford Street, Dover, Del.; Telephone 302–736–6919.
Director: Rev. Samuel A. Snyder, Jr.
Duration of migrant season: June–August.
Estimated number of migrants: 4,800.
Counties served by project: Kent, New Castle, and Sussex.
Health services provided: Medical care, hospitalization, dental care, nursing care, and sanitation services.

FLORIDA

Project Title: A Project to Develop a Statewide Program of Health Services for Migrant Farmworkers and Their Dependents in Florida (MG 18).
Sponsor: Florida State Board of Health, Post Office Box 210, Jacksonville, Fla. 32201; Telephone 904–354–3961.
Director: E. Henry King, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 130,000.
Counties served by project: Alachua, Broward, Collier, Flagler, Glades, Hendry, Highlands, Lee, Manatee, Martin, Orange, Polk, Putnam, Saint Lucie, Sarasota, and Seminole.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, health education, and nutrition counseling through county migrant health projects; consultation at State level to local projects on general administration.

NOTE.—See following table for county detail.

COUNTY COMPONENTS OF FLORIDA STATE PROJECT (MG 18)—A PROJECT TO DEVELOP A STATEWIDE PROGRAM OF HEALTH SERVICES FOR MIGRANT WORKERS AND THEIR FAMILIES IN FLORIDA

County	Director	Organization	Number of migrants	Services	Family health service centers
Alachua	Edward D. Byrne, M.D.	Alachua County Health Department, 816 Southwest 4th Ave., Gainesville, Fla.	1,500	Nursing care, sanitation services	Alachua.
Broward	Paul W. Hughes, M.D.	Broward County Health Department, 2421 Southwest 6th Ave., Fort Lauderdale, Fla.	14,000	Medical care, hospitalization, dental care, nursing care, sanitation services.	Pompano Beach.
Collier	Clyde L. Brothers, M.D.	Collier County Health Department, Post Office Box 477, Naples, Fla.	19,000	Medical care, hospitalization, nursing care, sanitation services.	Immokalee.
Highlands	J. Dillard Workman, M.D.	Highlands County Health Department, Sebring, Fla.			
Glades	do	Glades County Health Department, Post Office Box 274, Moore Haven, Fla.	11,500	Medical care, hospitalization, nursing care, sanitation services, health education.	Moore Haven, LaBelle.
Hendry	do	Hendry County Health Department, Post Office Box 278, LaBelle, Fla.			
Lee	Joseph W. Lawrence, M.D.	Lee County Health Department, Post Office Box 1226, 2115 2d St., Court House Annex, Fort Myers, Fla.	10,625	Medical care, hospitalization, nursing care, sanitation services.	Harlem Heights, Teter Rd., Charleston Park.
Manatee	George M. Dame, M.D.	Manatee County Health Department, 202 6th Ave. West, Post Office Box 2029, Bradenton, Fla.	5,000	Medical care, nursing care, sanitation services, health education.	None.
Martin	Niel D. Miller, M.D.	Martin County Health Department, Post Office Box 1846, 442 Flagler Ave., Stuart, Fla.	1,100	Medical care, dental care, nursing care, sanitation services.	Indiantown.
Orange	Wilfred N. Sisk, M.D.	Orange County Health Department, 832 West Central Ave., Post Office Box 3187, Orlando, Fla.	10,000	Medical care, nursing care, sanitation services, health education.	Apopka, Winter Garden, Winter Park, Zellwood.
Polk	William F. Hill, M.D.	Polk County Health Department, 229 Avenue D NW., Post Office Box 1480, Winter Haven, Fla.	20,000	Nursing care, sanitation services, health education.	None.
Putnam	Julius C. Brooks, Jr., M.D.	Putnam County Health Department, Post Office Box Drawer 1070, Palatka, Fla.			
Flagler	do	Flagler County Health Department, Post Office, Box 57, Bunnell, Fla.	800	Nursing care	Do.
St. Lucie	Niel D. Miller	St. Lucie County Health Department, Post Office Box 580, Fort Pierce, Fla.	10,000	Medical care, dental care, nursing care, sanitation services.	Fort Pierce.
Sarasota	David L. Crane, M.D.	Sarasota County Health Department, Post Office Box 2658, Sarasota, Fla.	2,000	Medical care, nursing care, sanitation services	Fame.
Seminole	Frank Leone, M.D.	Seminole County Health Department, French Ave. and 9th St., Post Office Box 1856, Stanford, Fla.	12,500	do	Midway, Oviedo.

Project Title: Comprehensive Health Services for Domestic Agricultural Migrants in Palm Beach County (MG 11).
Sponsor: Florida State Board of Health, Palm Beach County Health Department, 826 Evernia Street, Post Office Box 29, West Palm Beach, Fla. 33402; Telephone 305–832–2441.
Director: D. N. Logsdon, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 22,100.
County served by project: Palm Beach.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Delray,* Belle Glade, and Pahokee.

Project Title: Comprehensive Health Care for Migrant Farmworkers in Dade County (MG 34).
Sponsor: Dade County Department of Public Health, 1350 Northwest 14th Street, Miami, Fla. 33125; Telephone 305–377–0341.
Director: W. R. Stinger, M.D., Acting Director.
Duration of migrant season: October–May.
Estimated number of migrants: 12,580.
County served by project: Dade.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Krome Ave. Center, Perrine, South Dade, and Tally.

IDAHO

Project Title: Idaho's Migrant Health Services (MG 124).
Sponsor: Idaho Department of Health, Statehouse, Boise, Idaho 83701; Telephone 208–344–5811x370.
Director: Terrell Carver, M.D.
Duration of migrant season: May–October.
Estimated number of migrants: 19,000.
Counties served by project: Ada, Bannock, Bingham, Bonneville, Butte, Canyon, Caribou, Cassia, Elmore, Franklin, Gem, Gooding, Jefferson, Jerome, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, Teton, Twin Falls, and Washington.
Health services provided: Sanitation services.

ILLINOIS

Project Title: An Action Program for Agricultural Migrant Workers and Families (MG 105).
Sponsor: Illinois Department of Public Health, Division of Preventive Medicine, State Office Building, Springfield, Ill. 62706; Telephone 217–525–7577.
Director: Donaldson F. Rawlings, M.D.
Duration of migrant season: June–September.
Estimated number of migrants: 7,800.
Counties served by project: Lee, Ogle, and Vermilion.**
Health services provided: Medical care, dental care, nursing care, health education (Lee, Ogle, and Vermilion Counties, primarily); Statewide coordination and limited nursing, health education, vision and hearing, and school health consultation to all counties with migrants.

Project Title: Princeville Migrant Health Services (MG 150).
Sponsor: Princeville Migrant Council, Princeville, Ill. 61559; Telephone 309–385–4370 or 309–385–4994.
Director: Rev. William Smith.
Duration of migrant season: April–October.
Estimated number of migrants: 635.
County served by project: Peoria.
Health services provided: Medical care and nursing care.

Project Title: Jones Memorial Community Center, Migrant Health Clinic (MG 151).

*Mobile clinic.
**At least limited health services through volunteers or supported from State and local sources are provided in the following counties: Bureau, De Kalb, Grundy, Henderson, Iroquois, Jackson, Kane, Marion, Union, Will, and Winnebago.

Sponsor: Jones Memorial Community Center, 220 East 15th Street, Chicago Heights, Ill. 60411; Telephone 312–756–7000.
Director: Dr. E. G. Wygant.
Duration of migrant season: June–October.
Estimated number of migrants: 700.
County served by project: Cook.
Health services provided: Medical care, dental care, and nursing care.
Location of family health service centers: Jones Memorial Community Center and St. James Hospital.

Project Title: Northwest Church Council Migrant Aid Services (MG 152).
Sponsor: Northwest Church Council for Migrant Aid, Inc., 3109 Swallow Lane, Rolling Meadows, Ill. 60008; Telephone 312–255–3667.
Director: Virgil J. Bass.
Duration of migrant season: April–November.
Number of migrants: 685.
Counties served by project: Cook, Du Page, Kane, Lake, and McHenry.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, health education, and nutrition counselling.
Location of family health service centers: Evanston and Elk Grove Village.

Project Title: Rock Island-Mercer Migrant Family Health Service (MG 153).
Sponsor: Migrant Ministry Committee of the Council of Churches of Scott and Rock Island Counties, 639 38th Street, Rock Island Ill. 61201; Telephone 309–786–4451x327.
Director: Rev. Donald F. Bautz.
Duration of migrant season: July–September.
Estimated number of migrants: 958.
Counties served by project: Mercer and Rock Island.
Health services provided: Medical care, hospitalization, dental care, nursing care, and health education.
Location of family health service centers: Rock Island.

INDIANA

Project Title: Health Services for Migrant Workers (MG 20).
Sponsor: Indiana State Board of Health, 1330 West Michigan Street, Indianapolis, Ind. 46207; Telephone 317–633–6671.
Director: Verne K. Harvey, Jr., M.D.
Duration of migrant season: April–September.
Estimated number of migrants: 10,000.
Counties served by project: Adams, Delaware, Grant, Huntington, Jay, Lake, Marshall, Miami, and Wells.
Health services provided: Medical care, nursing care, and sanitation services in above listed counties; sanitation services only in 19 other counties.
Location of family health service centers: Huntington County.

IOWA

Project Title: Muscatine Area Migrant Families Health Services (MG 23).
Sponsor: Muscatine Neighborhood Center for Migrants, 421 East Second Street, Muscatine, Iowa 52761; Telephone 319–264–1155 or 319–263–5040.
Director: Mrs. Thomas Manton.
Duration of migrant season: May–October.
Estimated number of migrants: 1,200.
Counties served by project: Cedar, Louisa, Muscatine, and Scott.
Health services provided: Medical care, hospitalization, nursing care, sanitation services, and health education.
Location of family health service centers: Muscatine.

Project Title: Health Services for Migrant Families in the North Iowa Area (MG 116).
Sponsor: Migrant Action Program, Box 717, Mason City, Iowa 50401; Telephone 515–423–3984 or 515–423–7572.
Director: Mrs. Richard E. Sandage.
Duration of migrant season: May–August.
Estimated number of migrants: 600.
Counties served by project: Black Hawk, Cerro Gordo, Floyd, Franklin, Grundy, Hancock, Kossuth, Marshall, Mitchell, Winnebago, and Worth.

Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Buffalo Center, Clear Lake, Latimer, Manley, Northwood, and Reinbeck.

KANSAS

Project Title: Plan to Provide Health Services to Kansas Migrants (MG 64).
Sponsor: Headquarters: Kansas State Department of Health, State Office Building, Topeka, Kans. 66612, Telephone 913–321–0011x729; Local: Migrant Health Services, 317 North Seventh Street, Garden City, Kans. 67846; Telephone 316–276–2131.
Director: Patricia Schloesser, M.D.
Duration of migrant season: March–November.
Estimated number of migrants: 6,000.
Counties served by project: Finney, Grant, Greeley, Haskell, Kearney, Meade, Scott, Seward, Sherman, Stanton, Stevens, Wallace, and Witchita.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation, and health education services in 7 counties; nursing care provided in 3 additional counties; health education and sanitation services in 3 additional counties.
Location of family health service centers: Garden City, Goodland, Johnson, Lakin, Scott City, Sublette, Tribune, and Ulysses.

Project Title: Plan to Provide Public Health Services for Migrants in Wyandotte County, Kansas (MG 74).
Sponsor: Kansas City-Wyandotte County Health Department, 619 Ann Avenue, Kansas City, Kans. 66101; Telephone 913–321–4803.
Director: N. G. Walker, M.D.
Duration of migrant season: April–November.
Estimated number of migrants: 2,120.
County served by project: Wyandotte.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Edwardville and Wolcott.

KENTUCKY

Project Title: Migrant Worker Health Project (MG77).
Sponsor: Kentucky State Department of Health, 275 East Main Street, Frankfort, Ky. 40601; Telephone 502–564–3970.
Director: Jorge DeJu, M.D.
Duration of migrant season: May–June.
Estimated number of migrants: 1,000.
Counties served by project: Carlisle and Hickman.
Health services provided: Medical care, hospitalization, nursing care, dental care, sanitation services, health education, and nutrition counseling.
Location of family health service centers: Bardwell and Clinton.

LOUISIANA

Project Title: New and Improved Medical, Dental, and Nursing Services to Migratory Workers and Their Families (MG 54).
Sponsor: Health Subcommittee, Tangipahoa Migrant Committee, Route 2, Box 257, Ponchatoula, La. 70454; Telephone 504–386–6749.
Director: Milburn R. Fletcher.
Duration of migrant season: March–June.
Estimated number of migrants: 3,400.
County served by project: Tangipahoa.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.

MARYLAND

Project Title: Frederick County Migrant Health Project (MG 80).
Sponsor: Frederick County Migrant Health Council, Inc., 1415 West Seventh Street, Frederick, Md. 21701; Telephone 301–663–3344.
Director: Rev. Carrol L. Boyer.
Duration of migrant season: June–September.
Estimated number of migrants: 170.

County served by project: Frederick.
Health services provided: Medical care, dental care, and nursing care.
NOTE.—This project is now supported entirely by local funds.

Project Title: Field Oriented Migrant Health Services (MG 155).
Sponsor: Worcester County Community Action Committee, Inc., Post Office Box 67, Snow Hill, Md. 21863; Telephone 301–632–2160.
Director: David M. McAllister.
Duration of migrant season: June–October.
Estimated number of migrants: 800 (300 home-based).
County served by project: Worcester.
Health services provided: Medical care, hospitalization, nursing care, and health education.

MASSACHUSETTS

Project Title: Massachusetts Migrant Health Project (MG 68).
Sponsor: Massachusetts Health Research Institute, Inc., Somerset Street, Boston, Mass. 02108; Telephone 617–727–2662.
Director: Leon Sternfield, M.D.
Duration of migrant season: May–October.
Estimated number of migrants: 5,000.
Counties served by project: Barnstable, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, and Worcester.
Health services provided: Medical care, sanitation services, and health education.

MICHIGAN

Project Title: Improvement and Expansion of Health Services to Migrant Agricultural Workers and Their Families (MG30).
Sponsor: Michigan Department of Health, 3500 North Logan, Lansing, Mich. 48914; Telephone 517–373–1406.
Director: Douglas H. Fryer, M.D.
Duration of migrant season: April–November.
Estimated number of migrants: 79,400.
Counties served by project: All counties having migrants (40 counties).
Health services provided: Coordination of all migrant health activities within the Michigan Department of Health; provision of consultation and direct assistance in the development, administration, and evaluation of migrant health projects in Michigan.

Project Title: Cooperative Migrant Project (MG 31).
Sponsor: Ottawa County Health Department, Grand Haven, Mich. 49417; Telephone 616–842–0100.
Director: Ralph Ten Have, M.D.
Duration of migrant season: July–September.
Estimated number of migrants: 2,500.
County served by project: Ottawa.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Holland.

Project Title: Migrant Family Health Clinic—Nursing, Sanitation, and Dental Services (MG 79).
Sponsor Monroe County Health Department, Courthouse, Monroe, Mich. 48161; Telephone 313–241–9434.
Director: Paul W. Sundin, M.D.
Duration of migrant season: April–September.
Estimated number of migrants: 1,630.
County served by project: Monroe.
Health services provided: Medical care, hospitalization, dental care, nursing care, and sanitation services.
Location of family health service centers: Erie and Ida.

Project Title: Environmental Health Camp Sanitation Project for Migrant Agricultural Workers and Their Families (MG 91).
Sponsor: Michigan Department of Health, 3500 North Logan, Lansing, Mich. 48914; Telephone 517–373–3720.
Director: John E. Vogt.

Duration of migrant season: April–December.
Estimated number of migrants: 79,400.
Counties served by project: All counties having migrants (40 counties).
Health services provided: Sanitation services through inspections of labor camps, providing technical assistance to growers in construction of camp housing and sanitation facilities, and providing consultation with local health department sanitarians.

Project Title: Tri-County Associated Health Departments Migrant Health Program (MG 107).
Sponsor: Tri-County Associated Health Departments, 505 Pleasant Street, St. Joseph, Mich. 49085; Telephone 616–983–6396.
Director: Robert P. Locey, M.D.
Duration of migrant season: April–October.
Estimated number of migrants: 23,400.
Counties served by project: Berrien, Cass, and Van Buren.
Health services provided: Medical care, hospitalization, nursing care, sanitation services, and health education.
Location of family health service centers: Baroda*, Berrien Springs*, Grand Junction*, Keeler, and Sodus*.

Project Title: Comprehensive Care for Migrant Population of Grand Traverse, Leelanau, and Benzie Counties (MG 112).
Sponsor: Grand Traverse-Leelanau-Benzie County Health Department—In cooperation with the Grand Traverse Migrant Labor Council, care of Grand Traverse Medical Care Facility, Traverse City, Mich. 49684; Telephone 616–947–5606.
Director: Loren Bensley, Acting.
Duration of migrant season: July–September.
Estimated number of migrants: 23,820.
Counties served by project: Antrim, Benzie, Grand Traverse, and Leelanau.
Health services provided: Medical care, hospitalization, dental care, and nursing care.
Location of family health service centers: Cherry Farms—Grand Traverse; Munson Medical Center—Traverse City; and Leelanau County.

Project Title: Migrant Family Medical Care, Nursing, and Hospital Program (MG 131).
Sponsor: Manistee-Mason District Health Department, 401 East Ludington Avenue, Ludington, Mich. 49431; Telephone 616–843–3994.
Director: Gladys J. Kleinschmidt, M.D.
Duration of migrant season: April–September.
Estimated number of migrants: 11,000.
Counties served by project: Manistee and Mason.
Health services provided: Medical care, hospitalization, nursing care, sanitation services (through MG 91), and health education.
Location of family health service centers: Ludington.

Project Title: District Health Department No. 4 Migrant Family Health Clinic and Hosptial Program (MG 138).
Sponsor: District Health Department No. 4, 318 South Third Street, Rogers City, Mich. 49779; Telephone 517–734–2042.
Director: William F. Jackson, M.D.
Duration of migrant season: June–November.
Estimated number of migrants: 1,500.
Counties served by project: Alpena, Cheboygan, Montmorency, and Presque Isle.
Health services provided: Medical care, hospitalization, nursing care, sanitation services (through MG 91), health education, and nutrition counseling.
Location of family health service centers: Wilson Township School—Alpena.

Project Title: Benzie Migrant Family Health Services Project (MG 149).
Sponsor: Benzie Migrant Ministry Committee, Frankfort, Mich. 49635; Telephone 616–352–9286.
Director: Mrs. Grant Papineau.

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*Mobile.

Duration of migrant season: June–November.
Estimated number of migrants: 4,000.
County served by project: Benzie.
Health services provided: Medical care, hospitalization (through MG 112), dental care, nursing care, and sanitation services (through MG 91).
Location of family health service centers: Beulah.

MINNESOTA

Project Title: Migrant Labor Environmental Health and Nursing Service, and Health Education Project (MG 67).
Sponsor: Minnesota Department of Health, University Campus, Minneapolis, Minn. 55440; Telephone: 612–339–7751.
Director: D. S. Fleming, M.D.
Duration of migrant season: March–September.
Estimated number of migrants: 10,000.
Counties served by project: Anoka, Big Stone, Chippewa, Clay, Faribault, Freeborn, Hennepin, Kandiyohi, Kittson, Lac Qui Parle, Marshall, Martin, Mower, McLeod, Norman, Polk, Redwood, Renville, Sibley, Steele, Swift, Wilkin, Yellow Medicine, and Waseca.
Health services provided: Nursing service where it is lacking locally; health aides to work with project nurses; medical care, hospitalization and dental care in two locations; sanitation services in all migrant areas; coordination of migrant health activities of State Health Department with those of state and local official and voluntary agencies, growers' associations, and OEO-sponsored projects.

MISSOURI

Project Title: Family Health Education Services for Home-Based Migrants (MG 104).
Sponsor: Delmo Housing Corp., Box 354, Lilbourn, Mo. 63862; Telephone 314–688–2565.
Director: Mrs. Charlotte Ragan.
Duration of migrant season: June–September; December–May.
Estimated number of migrants: 10,000.
Counties served by project: Dunklin, Mississippi, New Madrid, Pemiscot, Scott, and Stoddard.
Health services provided: Medical care, hospitalization, dental care, nursing care, and health education.
Location of family health service centers: Lilbourn.

NEBRASKA

Project Title: Nebraska Plan To Provide Health Education and Other Public Health Services for Migrant Families (MG 88).
Sponsor: Headquarters: Nebraska Department of Health, Capitol Building, Lincoln, Nebr. 68509, Telephone 402–477–5211; Local: Migrant Health Project Office, 1422½ Tenth Street, Gering, Nebr. 69341; Telephone 308–436–2695.
Director: T. R. Dappen.
Duration of migrant season: April–August; September–May.
Estimated number of migrants: 5,485.
Counties served by project: Box Butte, Chase, Garden, Morrill, Perkins, Scotts Bluff, and Sioux.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Alliance, Bayard, Bridgeport, and Gering.

NEVADA

Project Title: Moapa Valley Migrant Health Program (MG 133).
Sponsor: Clark County District Health Department, 625 Shadow Lane, Las Vegas, Nev. 89106; Telephone 702–385–1291x201.
Director: Otto Ravenholt, M.D.
Duration of migrant season: December–September.
Estimated number of migrants: 700.
County served by project: Clark.
Health services provided: Medical care, hospitalization, dental care, and nursing care.
Location of family health service centers: Logandale and Overton.

NEW JERSEY

Project Title: Health Services for Migrant Agricultural Workers (MG 08).
Sponsor: New Jersey State Department of Health, Health and Agriculture Building, John Fitch Plaza, Trenton, N.J. 08625; Telephone 609–292–5470.
Director: Thomas Gilbert.
Duration of migrant season: March–November.
Estimated number of migrants: 26,300.
Counties served by project: Atlantic, Burlington, Camden, Gloucester, Mercer, Middlesex, Monmouth, Ocean, and Salem.
Health services provided: Medical care, hospitalization, dental care, nursing care, and health education.
Location of family health service centers: Freehold, Mt. Holly, Salem, and Woodbury.

Project Title: Migrant Health Services, Cumberland County (MG 118).
Sponsor: Board of Chosen Freeholders of Cumberland County, Cumberland County Courthouse, Bridgeton, N.J. 08302; Telephone 609–451–8000.
Director: William P. Doherty, V.M.D.
Duration of migrant season: April–September.
Estimated number of migrants: 1,300.
County served by project: Cumberland.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, social services, and health education.
Location of family health service centers: Bridgeton.

NEW MEXICO

Project Title: Las Cruces Migrant Health Project (MG 15).
Sponsor: Las Cruces Committee on Migrant Ministry, 2930 Huntington Drive, Las Cruces, N. Mex. 88001; Telephone 505–526–8637.
Director: George H. Ross.
Duration of migrant season: May–September.
Estimated number of migrants: 3,000.
County served by project: Dona Ana.
Health services provided: Medical care, hospitalization, dental care, and nursing care.
Location of family service centers: Las Cruces.

Project Title: Migrant Health Project—Health Districts 1 and 5 (MG 134).
Sponsor: New Mexico Department of Public Health, 408 Galisteo Street, Santa Fe, N. Mex. 87501; Telephone 505–983–6345.
Co-Directors: Marion Hotopp, M.D., and Edith F. Millican, M.D.
Duration of migrant season: May–October.
Estimated number of migrants: 23,000.
Counties served by project: Guadalupe, Mora, Rio Arriba, San Miguel, and Taos.
Health service provided: Medical care, dental care, and nursing care.
Location of family health service centers: Anton Chico, Cleveland, El Rito, Espanola, Las Vegas, Lindrith, and Parkview.

Project Title: New Mexico Migrant Health Project, Health District 10 (MG 154).
Sponsor: New Mexico Department of Public Health, 408 Galisteo Street, Santa Fe, N. Mex. 87501; Telephone 505–983–6345.
Director: George W. Prothro, M.D.
Duration of migrant season: June–December.
Estimated number of migrants: 2400.
Counties served by project: Curry, DeBaca, Quay, and Roosevelt.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service centers: Ranchos de Laos, Questa, and Penasco.

NEW YORK

Project Title: Family Service Clinics, Emergency Dental Care, Eye Examinations, and Provision of Glasses (MG 38).
Sponsor: New York State Department of Health, Utica District Office, 1512 Genesee Street, Utica, N.Y. 13502; Telephone 315–732–5137.
Director: Evelyn F. H. Rogers, M.D.
Duration of migrant season: September–October.
Estimated number of migrants: 2,600.
Counties served by project: Chenango, Herkimer, Madison, and Oneida.
Health services provided: Medical care, dental care, nursing care, eye examinations and glasses if needed, sanitation services, and health education.
Location of family health service centers: Bridgewater and Clinton.

Project Title: Suffolk County, N.Y., Migrant Health Project (MG 60).
Sponsor: Suffolk County Department of Health, Suffolk County Center, Riverhead, Long Island, N.Y. 11901; Telephone 516–727–4700 x 355.
Director: Robert Specht, R.N.
Duration of migrant season: July–November.
Estimated number of migrants: 4,750.
County served by project: Suffolk.
Health service provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service centers: Riverhead.

Project Title: Monroe County Migrant Project (MG 103)
Sponsor: University of Rochester, River Campus Station, Rochester, N.Y. 14627; Telephone 716–473–440x3271.
Director: John F. Radebaugh, M.D.
Duration of migrant season: June–November.
Estimated number of migrants: 1,250.
County served by project: Monroe.
Health services provided: Medical care, dental care, nursing care, and health education.
Location of family health service centers: Hilton, Martin's Camp, and Scottsville.

Project Title: Cayuga County Migrant Health Services Program (MG 106).
Sponsor: Cayuga County Health Department, Box 219, 5 James Street, Auburn, N.Y. 13021; Telephone 315–253–9731.
Director: C. Harold Warnock, M.D.
Duration of migrant season: June–November.
Estimated number of migrants: 828.
County served by project: Cayuga.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: King Ferry and Moravia.

Project Title: New Paltz Migrant Health Project (MG 125).
Sponsor: Ulster County Department of Health, 244 Fair Street, Kingston, N.Y. 12401; Telephone 914–331–9300x330.
Director: Vernon B. Link, M.D.
Duration of migrant season: July–November.
Estimated number of migrants: 1,000.
County served by project: Ulster.
Health services provided: Medical care, dental care, nursing care, and sanitation services.
Location of family health service centers: New Paltz.

Project Title: Orange County Migrant Health Project (MG 135).
Sponsor: Migrant Committee of the Warwick Valley Council of Churches, South Street and Second, Warwick, N.Y. 10990; Telephone 914–986–1725.
Director: Mrs. Valerie Maize.

Duration of migrant season: July–November.
Estimated number of migrants: 1,500.
County served by project: Orange.
Health services provided: Medical care, dental care, nursing care, and health education.
Location of family health service centers: Pine Island.

Project Title: Migrant Health Services Coordination Project (MG 148).
Sponsor: New York State Health Department, 84 Holland Avenue, Albany, N.Y. 12208; Telephone 518–472–2030.
Director: Arthur G. Baker, M.D.
Duration of migrant season: May-August.
Estimated number of migrants: 25,000.
Counties served by project: Broome, Cayuga, Chautauqua, Columbia, Delaware, Dutchess, Erie, Genesee, Herkimer, Livingston, Monroe, Niagara, Oneida, Ontario, Orange, Orleans, Oswego, Rockland, Steuben, Suffolk, Ulster, Wayne, Wyoming, and Yates.
Health services provided: Consultation and coordination of county projects, dental care in Wayne County, and sanitation services in all counties.

NORTH CAROLINA

Project Title: Carteret Area Mobile Migrant Clinic (MG 27)
Sponsor: Carteret County Migrant Committee, care of First Presbyterian Church, Morehead City, N.C. 28557; Telephone 919–726–4449.
Director: Rev. Charles L. Kirby.
Duration of migrant season: April–August.
Estimated number of migrants: 500.
County served by project: Carteret.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Beaufort*.

Project Title: Henderson County Migrant Family Health Service (MG 28).
Sponsor: Henderson County Migrant Council, Inc., Post Office Box 65, Hendersonville, N.C. 28739; Telephone 704–692–2815.
Director: Mrs. Frank B. Burson, P.H.N.
Duration of migrant season: July–September.
Estimated number of migrants: 1,500.
County served by project: Henderson.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Hendersonville.

Project Title: Migrant Health Project (MG 56).
Sponsor: North Carolina State Board of Health, 225 North McDowall Street, Post Office Box 2091, Raleigh, N.C. 27602; Telephone 919–829–3446.
Director: W. Burns-Jones, Jr., M.D.
Duration of migrant season: April–November; November–April (home-base).
Estimated number of migrants: 6,500.
Counties served by project: All counties having migrants (35 counties).
Health services provided: State level consultation, demonstration, and education are provided to existing migrant health programs; assistance is given in initiation of migrant health services in other areas of need; coordination between projects is developed.

Project Title: Albemarle Migrant Health Service Project (MG 57).
Sponsor: District Health Department, Elizabeth City, N.C. 27909; Telephone 919–335–5429.
Director: Isa C. Grant, M.D.
Duration of migrant season: June–November.
Estimated number of migrants: 1,200.
Counties served by project: Camden, Currituck, and Pasquotank.
Health services provided: Medical care, hospitalization, dental care, nursing care, and health education.
Location of family health service centers: Elizabeth City.

*Mobile.

Project Title: Sampson Migrant Health Service Project (MG 122).
Sponsor: Community Action Council, Inc., Sampson County Health Department, Clinton, N.C. 28328; Telephone 919–592–6177.
Director: Caroline H. Callison, M.D.
Duration of migrant season: June–August.
Estimated number of migrants: 685.
County served by project: Sampson.
Health services provided: Medical care, dental care, nursing care, and health education.
Location of family health service centers: Clinton.

OHIO

Project Title: Migrant Health Clinics, Nursing and Sanitation Services Program (MG 21).
Sponsor: Sandusky County-Fremont City, General Health District, Fremont, Ohio 43420; Telephone 419–332–6411.
Director: William J. Boswell, M.D.
Duration of migrant season: April–November.
Estimated number of migrants: 3,000.
County served by project: Sandusky.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, health education, and nutrition counseling.
Location of family health service centers: Fremont.

Project Title: Environmental Health Project (Migrants) (MG 24).
Sponsor: Ohio Department of Health, 450 East Town Street, Post Office Box 118, Columbus, Ohio 43216; Telephone 614–469–3543.
Director: Ray B. Watts.
Duration of migrant season: April–November.
Estimated number of migrants: 14,730.
Counties served by project: Darke, Fulton, Henry, Mercer, Putnam, Seneca, Stark, and Wood.
Health services provided: Sanitation services.

Project Title: Family Health Education Project for Migrants (MG 35).
Sponsor: Lucas County Health Department, 416 North Erie Street, Toledo, Ohio 43624; Telephone 419–248–5911.
Director: Dorothy M. Van Ausdal, M.D.
Duration of migrant season: February–November.
Estimated number of migrants: 1,200.
County served by project: Lucas.
Health services provided: Medical care, hospitalization, nursing care, sanitation services, health education, and nutrition counseling.
Location of family health service centers: East side of county, West side of county, and Toledo.

Project Title: Health Aide, Nursing, and Nutrition Consultation Project (MG 36).
Sponsor: Ohio Department of Health, 450 East Town Street, Post Office Box 118, Columbus, Ohio 43216; Telephone 614–469–3543.
Director: Miss Helen Massengale.
Duration of migrant season: June–October.
Counties served by project: Darke, Fulton, Hancock, Henry, Lucas, Mercer, Ottawa, Putnam, Sandusky, Seneca, and Wood.
Health services provided: Consultation in health education, nursing, and nutrition; coordination of training and work of health aides in various local migrant health projects.

Project Title: Migrant Labor Family Care Program (MG 61).
Sponsor: Putnam County General Health District, Court House, Ottawa, Ohio 45875; Telephone: 419–527–1616.
Director: Milo B. Rice, M.D.
Duration of migrant season: April–October.
Estimated number of migrants: 3,260.
County served by project: Putnam.

Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, health education, and nutrition counseling.
Location of family health service centers: Ottawa.

Project Title: Migrant Health Clinic and Nursing Services Project (MG 78).
Sponsor: Darke County General Health District, Courthouse, Greenville, Ohio 45331; Telephone: 513–548–4196.
Director: Giles Wolverton, M.D.
Duration of migrant season: June–October.
Estimated number of migrants: 1,400.
County served by project: Darke.
Health services provided: Medical care, dental care, nursing care, health education, and sanitation services.
Location of family health service centers: Union City.

Project Title: Ottawa County Migrant Family Health Service Clinic (MG 126).
Sponsor: Ottawa County Ministry to Migrants, 159 North Church Street, Oak Harbor, Ohio 43449; Telephone 419–898–8486.
Director: Rev. Robert Lamantia.
Duration of migrant season: June–October.
Estimated number of migrants: 1,400.
County served by project: Ottawa.
Health services provided: Medical care, hospitalization, dental care, nursing care, health education, sanitation services, and nutrition counseling.
Location of family health service centers: Oak Harbor.

Project Title: Migrant Health Study Project and Dental Care Program (MG 136).
Sponsor: Hartville Migrant Council, Inc., Box 682, Hartville, Ohio 44632; Telephone 216–454–4719.
Director: Mrs. Ralph McFadden.
Duration of migrant season: April–October.
Estimated number of migrants: 680.
County served by projects: Stark.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, health education, and nutrition counseling.
Location of family health service centers: Hartville.

OKLAHOMA

Project Title: Project To Furnish and Supplement Existing Public Health and Medical Care Service to Migrant Labor Families (MG 59).
Sponsor: State Department of Health, 3400 North Eastern, Oklahoma City, Okla.; Telephone 405–427–6561. Project Office: Jackson County Health Department, 201 South Lee, Altus, Okla.; Telephone 405–482–7308.
Director: J. K. Leavitt, M.D.
Duration of migrant season: May–December.
Estimated number of migrants: 6,100.
Counties served by project: Greer, Harmon, and Jackson.
Health services provided: Nursing care, dental care, sanitation services, and health education.

OREGON

Project Title: Clinic Care, Public Health Nursing, and Sanitation Services to Migrant Farm Labor (MG 05).
Sponsor: Orgeon State Board of Health, 1400 Southwest Fifth Avenue, Portland, Oreg. 97201; Telephone 503–226–2161.
Director: Ralph R. Sullivan, M.D.
Duration of migrant season: March–September.
Estimated number of migrants: 28,900.
Counties served by project: Clackamas, Hood River, Jackson, Klamath, Linn, Malheur, Marion, Polk, and Washington.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education through county migrant health projects; consultation to projects from State level includes nursing, sanitation, and health education.

NOTE.—See following table for county detail.

COUNTY COMPONENTS OF OREGON MIGRANT HEALTH PROJECT (MG 05)

County	Director	Number of migrants	Services
Clackamas	Hollister M. Stolte, M.D., 1425 South Kaen Rd., Oregon City, Oreg.	3,000	Medical care, hospitalization, dental care, nursing care, and sanitation services.
Hood River	Leonard L. Hoffman, M.D., County Courthouse, Room 104, Hood River, Oreg.	2,500	Do.
Jackson	A. Erin Merkel, M.D., 1313 Maple Grove Dr., Medford, Oreg.	1,645	Do.
Klamath	Seth M. Kerron, M.D., Klamath County Health Department, Post Office Box 1886, 3300 Vandenberg Rd., Klamath Falls, Oreg	500	Do.
Linn	John W. Guepe, M.D., Courthouse, Albany, Oreg	1,838	Do.
Malheur	Kenneth Pfaff, M.D., Courthouse, Vale, Oreg	2,705	Do.
Marion	Peter J. Batten, M.D., Post Office Box 2028, 2455 Franzen St., Salem, Oreg.	10,700	Do.
Polk	E. G. Bossatti, M.D., Post Office Box 34, 102 Courthouse, Dallas, Oreg.	2,850	Do.
Washington	James Stewart, M.D., 150 North 3d St., Hillsboro, Oreg	2,500	Do.

Project Title: Yamhill County Migrant Health Project (MG 63).
Oreg. 97128; Telephone 503–472–5161.
Sponsor: Yamhill County Health Department, Courthouse, McMinnville, Oreg. 97128; Telephone 503–472–5161.
Director: H. Grant Skinner, M.D.
Duration of migrant season: May–October.
Estimated number of migrants: 6,000.
County served by project: Yamhill.
Health services provided: Medical care, nursing care, sanitation services, mental health services, and health education.
Location of family health services centers: Eola Village.

Pennsylvania

Project Title: Health and Medical Services for Migrants (MG 33).
Sponsor: Pennsylvania Department of Health, Post Office Box 90, Harrisburg, Pa. 17120; Telephone 717–787–6967.
Director: A. L. Chapman, M.D.
Duration of migrant season: June–November.
Estimated number of migrants: 6,300.
Counties served by project: Adams, Berks, Chester, Columbia, Franklin, Lackawanna, Lancaster, Lehigh, Luzerne, Montour, Northumberland, Potter, Schuylkill, Snyder, Union, Wyoming, and York.
Health services provided: Medical care, dental care, nursing care, and sanitation services. Sanitation services only are provided in four additional counties.
Location of family health service centers: Coatesville, Danville, Gettysburg, Lancaster, and Scranton.

Puerto Rico

Project Title: Health Needs for Migrant Workers Project (MG 58).
Sponsor: University of Puerto Rico, School of Medicine, San Juan, P.R. 00905; Telephone 723–0410.
Office: Migrant Health Regional Office, Puerto Rican Medical Center, Barrio Monacillo, Rio Piedras, P.R.; Telephone 765–0038.
Director: Ruben Nazario, M.D.
Duration of migrant season: October–December.
Estimated number of migrants: 2,178.
County served by project: Northeast Health Region.
Health services provided: Medical care nursing care, sanitation services, health education, and social services.
Location of family health service centers: Puerto Rican Medical Center.

South Carolina

Project Title: Health Services for Migratory Agricultural Workers and Their Families—Charleston County (MG 26).
Sponsor: South Carolina State Board of Health, 2600 Bull Street, Columbia, S.C. 29201; Telephone 803–723–9251.

Director: L. P. Varn, M.D.
Duration of migrant season: April–October.
Estimated number of migrants: 2,130.
County served by project: Charleston.
Health services provided: Medical care, hospitalization, nursing care, and health education.
Location of family health service centers: Edisto, Johns Island, Medical College Clinic, and Mount Pleasant.

Project Title: Comprehensive Health Program for Agricultural Migrants—Beaufort County, S.C. (MG 121).
Sponsor: South Carolina State Board of Health, 2600 Bull Street, Columbia, S.C. 29201; Telephone 803–524–3446.
Director: H. Parker Jones, M.D.
Duration of migrant season: May–September.
Estimated number of migrants: 2,255.
County served by project: Beaufort.
Health services provided: Medical care, dental care, nursing care, and sanitation services.
Location of family health service centers: Beaufort, Frogmore, and Sheldon.

TEXAS

Project Title: Technical Assistance in Approaches to Health Problems Associated with Migratory Labor (MG 03).
Sponsor: Texas State Department of Health, 1100 West 49th Street, Austin, Tex. 78756; Telephone 512–453–6631.
Director: Robert L. Cherry, M.D., Medical Director.
Duration of migrant season: Year round.
Estimated number of migrants: 129,000.
Health services provided: State level consultation to counties with local migrant health projects in nursing, sanitation, health education; assistance to communities without local projects in arranging for provision of health services to migrants, including nursing, sanitation, health education, and other technical and consultation services; also limited direct services in communities without local projects.

Project Title: Hale County Migrant Health Service (MG 37).
Sponsor: Plainview-Hale County Health Department, 10th and Ash Street, Post Office Box 1776, Plainview, Tex. 79072; Telephone 806–224–4359.
Acting Director: Carl P. Weidenbach, M.D.
Duration of migrant season: July–November.
Estimated number of migrants: 9,300.
County served by project: Hale.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Mobile unit.

Project Title: Laredo-Webb County Family Health Service Clinic (MG 42).
Sponsor: Laredo-Webb County Health Department, 400 Arkansas Avenue, Laredo, Tex. 78040; Telephone 512–722–2481.
Director: Jose L. Gonzales.
Duration of migrant season: November–March.
Estimated number of migrants: 13,000.
County served by project: Webb.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service center: Laredo-Webb County Health Department.

Project Title: Southwestern Texas Health Department Migrant Project (MG 44).
Sponsor: Southwestern Texas Health Department, Post Office Box K, Eagle Pass, Tex. 78852; Telephone 512–773–2718.
Director: B. Oliver Lewis, M.D.
Duration of migrant season: September–May.
Estimated number of migrants: 10,000.

Counties served by project: Dimmitt, Kinney, Maverick, and Zavala.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.
Location of family health centers: One each in counties listed above.

Project Title: Technical Assistance in Developing Techniques and Approaches to Health Problems Associated with Seasonal Farm Labor in Public Health Education, Sanitation, and Public Health Nursing—Countywide (MG 46).
Sponsor: Lubbock City-County Health Department, 1202 Jarvis, Lubbock, Tex. 79408; Telephone 806–762–6411.
Director: David M. Cowgill, M.D.
Duration of migrant season: April–January.
Estimated number of migrants: 9,500.
County served by project: Lubbock.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Services provided at or coordinated by City-County Health Department.

Project Title: Calhoun County Migrant Health Services Program—Port Lavaca-Calhoun County Health Unit (MG 96).
Sponsor: Port Lavaca-Calhoun County Health Department, 111 West Ash Street, Port Lavaca, Tex. 77979; Telephone 512–524–4341.
Director: L. E. Silverthorn, M.D.
Duration of migrant season: January–September.
Estimated number of migrants: 4,000.
County served by project: Calhoun.
Health services provided: Medical care, hospitalization, dental care, nursing care, and sanitation services.
Location of family health service centers: County Hospital.

Project Title: Cameron County Migrant Health Project (MG 97).
Sponsor: Cameron County Health Department, 186 North Sam Houston Boulevard, San Benito, Tex. 78586; Telephone 512–399–2781.
Director: John R. Copenhaver, M.D.
Duration of migrant season: November–May.
Estimated number of migrants: 25,000.
County served by project: Cameron.
Health services provided: Medical care, hospitalization, nursing care, sanitation services, and health education.
Location of family health service centers: Brownsville.

Project Title: Jim Wells County Migrant Health Project (MG 99).
Sponsor: Jim Wells Commissioners' Court, Jim Wells County Courthouse, 200 North Almond Street, Alice, Tex. 78332; Telephone 512–664–5582.
Director: Gonzalo V. Trevino.
Duration of migrant season: October–April.
Estimated number of migrants: 10,500.
County served by projects: Jim Wells.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service centers: Alice.

Project Title: Zapata County Migrant Health Project (MG 100).
Sponsor: Zapata County Commissioners' Court, Post Office Box 272, Zapata, Tex. 78076; Telephone 512–765–4342.
Director: Pedro Ramirez, Jr.
Duration of migrant season: April–November.
Estimated number of migrants: 2,000.
County served by project: Zapata.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service centers: Zapata.

Project Title: Crosby County Migrant Health Service Project (MG 108).
Sponsor: Crosby County Commissioners' Court, Crosbyton, Tex.; Telephone 806–675–2924.

Director: T. J. Taylor.
Duration of migrant season: March–December.
Estimated number of migrants: 6,300.
County served by project: Crosby.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Crosbyton, Ralls, and Lorenzo.

Project Title: Greenbelt Medical Society Migrant Health Project (MG 109).
Sponsor: Greenbelt Medical Society, 306 Third NE., Childress, Tex. 79201; Telephone 817–937–3636—Fox; 817–259–3516—Stevenson.
Director: Jack F. Fox, M.D., Harold R. Stevenson, M.D. (co-directors).
Duration of migrant season: June–December.
Estimated number of migrants: 5,000.
Counties served by project: Childress and Hall.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service centers: (Services coordinated at Childress and Memphis).

Project Title: Spur-Dickens County Health Service Project (MG 110).
Sponsor: Spur City Alderman (City Commissioners), City Hall, Post Office Box 356, Spur, Tex. 79370; Telephone 915–272–4535.
Director: Robert Alexander, M.D.
Duration of migrant season: November–January.
Estimated number of migrants: 4,000.
County served by project: Dickens.
Health services provided: Medical care, nursing care, and sanitation services.
Location of family health service centers: Spur.

Project Title: Yoakum County Migrant Health Service Project (MG 113).
Sponsor: Yoakum County Commissioners' Court, Yoakum County Courthouse, Box 516, Plains, Tex. 79355; Telephone 806–592–2121.
Director: Mrs. Helen V. McMahan.
Duration of migrant season: March–December.
Estimated number of migrants: 4,000.
County served by project: Yoakum.
Health services provided: Medical care, hospitalization, nursing care, and sanitation services.
Location of family health service centers: Denver City.

Project Title: Goliad County Migrant Health Project (MG 114).
Sponsor: Goliad Project for Handicapped Children, Box 53, Goliad, Tex. 77963; Telephone 512–645–3291.
Director: Dr. L. W. Chilton.
Duration of migrant sason: June–August, October–May.
Estimated number of migrants: 1,250.
County served by project: Goliad.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service centers: Goliad.

Project Title: Gonzales County Migrant Project (MG 115).
Sponsor: Gonzales County Medical Society, Gonzales, Tex. 78629; Telephone 512–672–2824.
Director: Louis J. Stahl, M.D.
Duration of migrant season: June–February; September–June.
Estimated number of migrants: 3,000.
County served by project: Gonzales.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Gonzales and Waelder.

Project Title: Hidalgo County Migrant Health Grant (MG 117).
Sponsor: Hidalgo County Health Department, Room 427, Courthouse, Edinburg, Tex. 78539; Telephone 512–383–2751.
Director: John R. Copenhaver, M.D.
Duration of migrant season: Year round.

Estimated number of migrants: 4,500.
County served by project[1] Hidalgo.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.

Project Title: Hudspeth County-Dell City Migrant Health Project (MG 119).
Sponsor: Hudspeth County Commissioners' Court, Hudspeth County Courthouse, Sierra Blanca, Tex. 79851; Telephone 915–369–2321.
Director: Hon. Tom H. Neely.
Duration of migrant season: April–June; October–December.
Estimated number of migrants: 4,000.
County served by project: Hudspeth.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Dell City, Fort Hancock, and Sierra Blanca.

Project Title: LaSalle County Migrant Health Project (MG 120).
Sponsor: LaSalle County Commissioners' Court, LaSalle Courthouse, Center at Stewart Street, Cotulla, Tex. 78014; Telephone 512–879–2342.
Director: J. M. Barton, M.D.
Duration of migrant season: Year round.
Estimated number of migrants: 3,000.
County served by project: LaSalle.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Cotulla.

Project Title: Del Rio-Val Verde County Health Department—Migrant Health Project (MG 128).
Sponsor: Del Rio-Val Verde County Health Department, Dodson Building, Del Rio, Tex. 78840; Telephone 512–775–5985.
Director: B. Oliver Lewis, M.D.
Duration of migrant season: September–May.
Estimated number of migrants: 4,000.
County served by project: Val Verde.
Health services provided: Medical care, dental care, nursing care, and sanitation services.
Location of family health service centers: Del Rio.

Project Title: Littlefield-Lamb County Migrant Health Project (MG 139).
Sponsor: City Council, City of Littlefield, Post Office Box 1267, Littlefield, Tex. 79339; Telephone 806–385–4411.
Director: D. W. Still, M.D.
Duration of migrant season: July–November.
Estimated number of migrants: 9,000.
County served by project: Lamb.
Health services provided: Medical care, hospitalization, dental care, nursing care, and sanitation services.

Project Title: Leon Valley Migrant Health Project (MG 140).
Sponsor: DeLeon Municipal Hospital, 407 Texas Avenue, DeLeon, Tex. 76444; Telephone 817–2944, 817–7111.
Director: F. A. Eisenrich, M.D.
Duration of migrant season: October–May.
Estimated number of migrants: 1,675.
County served by project: Comanche.
Health services provided: Medical care, hospitalization, nursing care, sanitation services, and health education.
Location of family health service centers: DeLeon.

Project Title: Floyd County Migrant Health Project (MG 141).
Sponsor: Floyd County Commissioners, Floyd County Courthouse, Floydada, Tex. 78076; Telephone 806–983–3534.
Director: Hon. J. K. Holmes.
Duration of migrant season: Year round.
Estimated number of migrants: 3,000.
County served by project: Floyd.
Health services provided: Medical care, dental care, nursing care, and sanitation services.

Project Title: Jim Hogg County Migrant Health Project (MG 142).
Sponsor: Jim Hogg County Commissioners' Court, County Courthouse, Hebbronville, Tex. 78361; Telephone 512–527–3015.
Director: Hon. H. T. Martinez.
Duration of migrant season: June–July; September–April.
Estimated number of migrants: 1,120.
County served by project: Jim Hogg.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service center: Hebbronville.

Project Title: Castro County Migratory Health Project (MG 143).
Sponsor: Castro County Commissioners' Court, Courthouse, Dimmitt, Tex.; Telephone 806–647–5552, 806–647–2191—Hospital.
Director: R. D. Newman.
Duration of migrant season: March–December.
Estimated number of migrants: 6,000.
County served by project: Castro.
Health services provided: Medical care, hospitalization, nursing care, and sanitation services.
Location of family health service centers: Community Hospital, Dimmit.

Project Title: Live Oak County Migrant Health Project (MG 146).
Sponsor: Live Oak County Health Department, Courthouse, George West, Tex. 78022; Telephone 512–449–2201.
Director: G. W. Sansom, M.D.
Duration of migrant season: April–December.
Estimated number of migrants: 2,200.
County served by project: Live Oak.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, and health education.

Project Title: San Marcos-Hays County Migrant Project (MG 147).
Sponsor: San Marcos-Hays County Health Department, Courthouse, San Marcos, Tex. 78666; Telephone 512–392–5831.
Director: B. M. Primer, M.D.
Duration of migrant season: August–November.
Estimated number of migrants: 2,700.
County served by project: Hays.
Health services provided: Medical care, sanitation services, and health education.

Project Title: Starr County, Texas, Migrant Health (MG 160).
Sponsor: Hidalgo County Health Department, Room 427, Courthouse, Edinburg, Tex.; Telephone 512–383–2751—Station 234.
Director: John R. Copenhaver, M.D.
Duration of migrant season: November–May.
Estimated number of migrants: 45,000.
County served by project: Starr.
Health services provided: Medical care, hospitalization, nursing care, and sanitation services.
Location of family health service centers: Grulla, Rio Grande City, and Roma.

UTAH

Project Title: Utah Migrant Health Service (MG 98).
Sponsor: Utah State Department of Health, 44 Medical Drive, Salt Lake City, Utah 84113; Telephone 801–322–2431.
Director: Robert W. Sherwood, M.D.
Duration of migrant season: May–October.
Estimated number of migrants: 5,000.
Counties served by project: Box Elder, Cache, Carbon, Davis, Garfield, Grand, Piute, Salt Lake, Sanpete, Sevier, Utah, Washington, Wayne, and Weber.
Health services provided: Medical care, dental care, nursing care, sanitation services, and health education.
Location of family health service centers: Mobile clinic in Weber County.

VIRGINIA

Project Title: Migrant Health Project—Virginia (MG 41).
Sponsor: Division of Local Health Services, State Department of Health, Richmond, Va. 23219; Telephone: 703–644–4111.
Director: R. W. Moseley, M.D.
Duration of migrant season: June–September.
Estimated number of migrants: 8,180.
Counties served by project: Accomack, Amherst, Albemarle, Augusta, Botetourt, Clarke, Fauquier, Frederick, Loudoun, Madison, Nelson, Northampton, Rappahannock, Roanoke, Shenandoah, and Warren.
Health services provided: Medical care, hospitalization, nursing care, dental care, sanitation services, and health education in Accomack and Northampton Counties; nursing care and sanitation services in other counties.
Location of family health service centers: Mobile unit is used at points in Northampton and Accomack Counties during crop season.

WASHINGTON

Project Title: Health Services for Migrant Workers in Puyallup-Stuck Valley; Medical Nursing, Environmental, and Study of Health Needs (MG 19).
Sponsor: Tacoma-Pierce County Health Department, 649 County-City Building, Tacoma, Wash. 98402; Telephone 206–383–331x347.
Director: Ernst K. W. Kredel, M.D.
Duration of migrant season: June–October.
Estimated number of migrants: 2,000.
County served by project: Pierce.
Health services provided: Medical care, nursing care, sanitation services, and health education.
Location of family health service centers: Puyallup.

Project Title: Whatcom County Migrant Health Program (MG 132).
Sponsor: Bellingham-Whatcom County District Health Department, 509 Girard Street, Bellingham, Wash. 98225; Telephone 206–733–9520.
Director: Philip Jones, M.D.
Duration of migrant season: April–October.
Estimated number of migrants: 1,100.
County served by project: Whatcom.
Health services provided: Medical care, dental care, nursing care, and sanitation services.

Project Title: Skagit County Migrant Health Project (MG 144).
Sponsor: Skagit County Health Department, Courthouse, Mt. Vernon, Wash. 98273; Telephone 206–336–2106.
Director: J. K. Neils, M.D.
Duration of migrant season: March–October.
Estimated number of migrants: 6,100.
County served by project: Skagit.
Health services provided: Medical care, hospitalization, dental care, nursing care, sanitation services, health education, and social services.

Project Title: Washington State Department of Health—Migrant Health Project (MG 145).
Sponsor: Washington State Department of Health, Public Health Building, Olympia, Wash. 98501; Telephone 206–352–1667.
Director: Rhesa Penn, M.D.
Duration of migrant season: April–November.
Estimated number of migrants: 25,000.
Counties served by project: Statewide.
Health services provided: Consultant services in medical and dental care, nursing, sanitation, health education, nutrition, and social work to local projects; coordination of needs and services for migrants within State; stimulation of services in areas of heavy migrant concentration.

WEST VIRGINIA

Project Title: Berkeley-Morgan Counties Migrant Workers Project (MG 123).
Sponsor: District No. 6 Health Department, 209 East King Street, Martinsburg, W. Va. 25401; Telephone 304–263–5131.
Director: R. C. Hood, M.D.

Duration of migrant season: June–September.
Estimated number of migrants: 885.
Counties served by project: Berkeley and Morgan.
Health services provided: Medical care, hospitalization, dental care, nursing care, and health education.
Location of family health service centers: Berkeley Springs and Martinsburg.

WISCONSIN

Project Title: Migrant Medical Aid Program (MG75).
Sponsor: Catholic Diocese of Madison, Elm Acre, Guadalupe House, Endeavor, Wis. 53939; Telephone 608–587–2033.
Director: Mrs. Clayton S. Mills.
Duration of migrant season: April–October.
Estimated number of migrants: 900.
County served by project: Marquette (with some influx from Columbia).
Health services provided: Medical care, hospitalization, dental care, nursing care, health education, and nutrition counseling.
Location of family health service centers: Endeavor.

Project Title: St. Joseph Migrant Family Health Clinic (MG 129).
Sponsor: St. Joseph Hospital, 707 South University Avenue, Beaver Dam, Wis. 53916; Telephone 414–885–4975.
Director: Sister M. Virginia.
Estimated number of migrants: 650.
Counties served by project: Columbia and Dodge.
Health services provided: Medical care, hospitalization, dental care, nursing care, and health education.
Location of family health service centers: Beaver Dam.

Project Title: Waushara County Migrant Health Clinic (MG 130).
Sponsor: Waushara County Committee for Economic Opportunity, Box 310, Wautoma, Wis. 54982; Telephone 414–787–2648.
Director: Mr. Walter Brudnowski.
Duration of migrant season: May–November.
Estimated number of migrants: 8,000.
County served by project: Waushara.
Health services provided: Medical care, hospitalization, dental care, nursing care, health education, and nutrition counseling.
Location of family health service centers: Wautoma.

Project Title: Migrant Labor Camp Sanitation Services (MG 137).
Sponsor: The Industrial Labor and Human Relations Commission of Wisconsin, Hill Farms State Office Building, Post Office Box 2209, Madison, Wis. 53701; Telephone 608–266–1704.
Director: Roger Oftrem.
Duration of migrant season: May–September.
Estimated number of migrants: 19,687.
Counties served by project: Columbia, Dodge, Door, Fond du Lac, Jefferson, Kenosha, La Crosse, Marquette, Oconto, Outagamie, Racine, Waukesha, Waushara, and Winnebago.
Health services provided: Sanitation services.

Mr. ROGERS. Do you coordinate programs for migrants that are carried on by other branches of the Federal Government, such as OEO?

Dr. LEE. I think there has been excellent coordination, and the migrant health program has served as a mechanism to make other services available to the migrants, such as crippled children's programs and infant care. There has been good cooperation with OEO, for example. OEO has developed a neighborhood health center program in King City, through the county medical society. That program is also serving migrants in the southern part of that country.

There are other areas where they have been working on the education side and helping in housing construction, where we have been involved in sanitation and health services. I think there has been good cooperation.

Mr. ROGERS. I have been interested in the program carried out in my area by Dr. Carl Brumback, in the county of Palm Beach. He has made excellent headway. Let me ask you about the hospital funds that the committee authorized, I believe, in 1965.

Dr. LEE. First available in 1966.

Miss JOHNSTON. The first funds for hospital care became available in January of last year. Up to the present time, 55 projects have made application for hospital funds. They are scattered over 25 different States. They have agreements with about 170 hospitals at the present time.

Mr. ROGERS. Would you let us have a rundown on the ones that were approved, and what amounts, and the people involved?

(The following information was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON MIGRANT HOSPITALIZATION

As of January 1968, 55 migrant health projects in 25 States had added inpatient hospital care to their existing services in an attempt to provide as broad a scope of comprehensive health care as possible. The hospitalization component includes an intensified program of early casefinding, a referral system for medical care outside the hospital, and a system for predischarge planning.

State	Project sponsor and location	Amount currently awarded for hospitalization component, Fiscal Year 1967–68
Arizona	Pinal County Health Department Florence, Ariz	$29,500
	Yuma County Health Department, Yuma, Ariz	107,445
Arkansas	Northwest Area Migrant Committee, Fayetteville, Ark	2,400
California	California State Department of Public Health, Berkeley, Calif	[1] 14,158
Delaware	Delaware State Council of Churches, Dover, Del	7,200
Florida	Florida State Board of Health, Jacksonville, Fla	125,319
	Dade County Department of Public Health, Miami, Fla	25,000
	Palm Beach County Health Department, West Palm Beach, Fla	33,176
Illinois	Jones Memorial Community Center, Chicago Heights, Ill	1,900
	Illinois Department of Public Health, Springfield, Ill	7,359
	Northwest Church Council for Migrant Aid, Inc., Rolling Meadows, Ill.	4,500
	Migrant Ministry Committee, Rock Island, Ill	3,800
Iowa	Neighborhood Health Center for Migrants, Muscatine, Iowa	3,300
	Migrant Action Program, Inc., Mason City, Iowa	2,835
Kansas	Kansas State Department of Health, Topeka, Kans	13,200
Kentucky	Kentucky State Department of Health, Frankfort, Ky	1,262
Maryland	Worcester County Community Action Committee, Inc., Snow Hill, Md.	500
Michigan	Ottawa County Health Department, Grand Haven, Mich	2,330
	Manistee-Mason District Health Department, Ludington, Mich	6.006
	Monroe County Health Department, Monroe, Mich	5.404
	Tri-County Associated Health Departments, St. Joseph, Mich	92,359
	Health Department-Grand Traverse Migrant Labor Council, Traverse City, Mich	43,520
Minnesota	Minnesota Department of Health, Minneapolis, Minn	5,100
Missouri	Delmo Housing Corporation, Lilbourn, Mo	19,500
Nevada	Clark County District Health Department, Las Vegas, Nev	2,200
New Jersey	New Jersey State Department of Health, Trenton, N.J	16,348
	Board of Chosen Freeholders of Cumberland County, Bridgeton, N.J.	8,720
New Mexico	Las Cruces Committee on Migrant Ministry, Las Cruces, N.M	17,025
North Carolina	District Health Department, Albemarle, N.C	2,230
	Henderson County Migrant Council, Inc., Hendersonville, N.C	4,993
Ohio	Hartville Migrant Council, Inc., Hartville, Ohio	3,700
	Sandusky County-Fremont City General Health District, Fremont, Ohio.	9,100
	Ohio Department of Health, Columbus, Ohio	2,600
	Darke County General Health District, Greenville, Ohio	2,000
	Ottawa County Ministry to Migrants, Oak Harbour, Ohio	4,700
	Putnam County General Health District, Ottawa, Ohio	8,000
	Lucas County Health Department, Toledo, Ohio	4,540
Oregon	Oregon State Board of Health, Portland, Oreg	111,159
South Carolina	South Carolina State Board of Health (Charleston County), Columbia, S.C.	20,341

[1] Riverside County only.

State	Project sponsor and location	Amount currently awarded for hospitalization component, Fiscal Year 1967–68
Texas	Jim Wells County Commissioners Court, Alice, Tex	$19,000
	Crosby County Commissioners Court, Crosbyton, Tex	17,100
	Castfro County Commissioners Court, Dimmitt, Tex	89,372
	DeLeon Municipal Hospital, DeLeon, Tex	7,200
	Hidalgo County Health Department (Starr and Hidalgo Counties, Edinburg, Tex.	101,340
	Gonzales County Medical Society, Gonzales, Tex	16,250
	Plainview-Hale County Health Department, Plainview, Tex	18,984
	Yoakum County Commissioners' Court, Plains, Tex	6,700
	Cameron County Health Department, San Benito, Tex	175,612
	Hudspeth County Commissioners' Court, Sierra Blanca, Tex	13,700
Virginia	Virginia State Department of Health, Richmond, Va	35,558
Washington	Skagit County Health Department, Mount Vernon, Wash	13,691
West Virginia	District No. 6 Health Department (Berkeley-Morgan Counties), Martinsburg, W. Va.	5,400
Wisconsin	Catholic Diocese of Madison, Wis., Endeavor, Wis	4,400
	St. Joseph Hospital, Beaver Dam, Wis	2,000
	Waushara County Committee for Economic Opportunity, Wautoma, Wis.	6,800
	Total amount currently awarded for hospitalization	1,307,836

Mr. ROGERS. What are the needs now of the migrant program, any need that you have?

Miss JOHNSTON. Well, you ask for a rundown of the migrant health program. I could give it to you briefly right now.

At the present time we have 115 single or multicounty projects, They are providing personal health care in nearly 300 counties, personal health care plus sanitation services.

There are about 155 counties in which sanitation services only are being provided.

You have to realize that about 700 counties have a migrant influx during the year, so, roughly, we are providing personal health care in 300 of the 700 counties.

The personal health care is accessible to about 300,000 of the 1 million migrants. The level of care that we are able to support with the funds that we now have available is considerably less than that for the general population. The number of medical visits in the project areas for migrants is about one-fifth of the number for the general population. The number of dental visits is about one twenty-fifth of the general population.

The funds have been obligated to the last cent in every fiscal year since the program started. We started out this year with every cent obligated from last year, and as you will recall, our appropriation this year is exactly the same as last year's.

Mr. ROGERS. Thank you very much. If there are any additions you may want to make, the committee would like to have that. I think you have done a great job with the program.

Miss JOHNSTON. Thank you.

Mr. ROGERS. Is alcoholism a mental problem?

Dr. YOLLES. I think the experts in the field would say there is a large element of emotional problem in the alcoholic. I don't think all the experts agree as to the percentage of emotional problems in

each alcoholic, but for a long time it has been handled by the field of mental health.

Mr. ROGERS. For the confirmed alcoholic, would you say there is basically a mental problem involved, generally?

Dr. YOLLES. Certainly there is a basic mental and behavioral problem involved in the chronic alcoholic.

Dr. LEE. Mr. Chairman, I would like to add a personal comment on that because I had, when I was in practice, a particular concern with the problems of the chronic alcoholic, and I would agree with what I think is the general professional judgment. These patients often have serious emotional problems, and their families are also involved. It is a complex problem that doesn't just affect the alcoholic, but also affects his family and the interaction between the husband and wife and also the children, and they are all involved.

So it is a social behavioral problem, and there are many people who have sought for many, many years evidences of some physical cause, and we know there are certain biochemical derangements that occur with chronic alcoholism; but we have never been able to demonstrate any cause and effect relationship. You cannot treat the chronic alcoholic without assisting his family and mental health services are an important component in the treatment.

Mr. ROGERS. I assume that would apply to the narcotic addict as well.

Dr. YOLLES. That is quite true.

Mr. ROGERS. Why aren't they now covered under the Comprehensive Mental Health Act?

Dr. YOLLES. They are covered, Mr. Rogers.

Mr. ROGERS. It was our intent to cover them when we wrote that law.

Dr. YOLLES. Yes. The communities have been less than interested in providing treatment for alcoholics, and particularly for narcotic addicts. Their treatment has a lower priority than treatment for other patients. The cost of treating such patients runs high, and very often the patients cannot pay for it.

Dr. LEE. They are often discriminated against. An alcoholic often cannot be treated in a hospital because he is an alcoholic, so he is denied access to community health care institutions, and this just compounds the problem.

Mr. ROGERS. I would be concerned about increasing the percentage for staffing. Ninety percent, I notice you have changed it to in the proposal, 80 percent, 60 and 50, for each of the 6 years, which is a considerable change from the formula we had for the community health hospital, and also for the mentally retarded facilities.

Dr. YOLLES. Mr. Rogers, by raising the Federal matching in this level, and extending the length of the program from 4 years and 3 months to a period of 8 years, we are offering incentives to communities to pick up treatment programs that are vitally necessary. These communities at the present time are involved in supporting and financing general mental health services which have the first priority. To add another treatment program which, in their eyes, and which we have seen from evidence over the years has a lesser priority, at the same matching ratio, without any special incentive, does not encourage them to pick up those programs.

Mr. ROGERS. I think there is a growing concern on the problems of alcoholism and narcotics addiction, and the communities are becoming

more aware of that and the needs for treatment. I think the Supreme Court will probably make a decision soon that will affect this situation, as far as alcoholism is concerned.

If we are building community health centers now, I would like to see us get into this before we start building alcoholic centers and narcotic centers. I would think maybe simple additions—if it is necessary, and it may not be necessary in many areas—I would hope this could be tied in more rather than just setting up two new programs to start out with almost.

Dr. YOLLES. Mr. Rogers, this is exactly what we are trying to achieve in this legislation through the project approach. You see, only those communities which are ready to fund and ready to go with a new program such as this will be coming in for such project grant funds. These will be added to the community mental health center as an integral part of it, but it will allow those who are ready to do it now to come in and be supported at a higher rate, now.

Mr. ROGERS. I would like you to furnish us what your projection will be, your cost over the next 6 years, so let's give a projection of 6 years, if you can, if this is possible. And what it would require in personnel, money, and possible projected results.

(The following information was subsequently received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ESTIMATED NEW OBLIGATION AUTHORITY REQUIRED UNDER H.R. 15758 FOR FISCAL YEARS 1969–77

New obligation authority	Fiscal year 1969	Fiscal year 1970	Fiscal year 1971	Fiscal year 1972	Fiscal year 1973	Fiscal year 1974	Fiscal year 1975	Fiscal year 1976	Fiscal year 1977
I. Regional medical programs	$65,000,000	$140,000,000	$200,000,000	$275,000,000	$350,000,000				
II. Special grants for health of migratory workers	9,000,000	15,000,000							
III. Alcoholic and narcotic addict rehabilitation									
A. Construction grants and staffing, operation, and maintenance grants	15,000,000	25,000,000							
1. Alcoholic rehabilitation	(7,000,000)	(15,000,000)							
2. Narcotic addict rehabilitation	(8,000,000)	(10,000,000)							
B. Continuation costs for staffing, operation, and maintenance grants			15,309,000	13,276,000	11,242,000	$10,176,000	$10,176,000	$10,176,000	$5,330,000
1. Alcoholic rehabilitation			(10,424,000)	(9,050,000)	(7,675,000)	(6,877,000)	(6,877,000)	(6,877,000)	(3,988,000)
2. Narcotic addict rehabilitation			(4,885,000)	(4,226,000)	(3,567,000)	(3,299,000)	(3,299,000)	(3,299,000)	(1,342,000)
Total NOA required	89,000,000	180,000,000	215,309,000	288,276,000	361,242,000	10,176,000	10,176,000	10,176,000	5,330,000

Note: The projections contained in this table represent departmental predictions and do not represent the administration position on the future program or budget requirements. Personnel requirements will be dependent on program developments and budget factors which at this time cannot be fully predicted.

Dr. YOLLES. In terms of community health center staffing, the States are beginning to comment about the shortness of the time with the very rapidly decreasing rate of Federal support, and there has been some talk of the need for a longer period, hence the approach in this legislation for an incentive that continues for a longer period before tailing off after 8 years.

Mr. ROGERS. I thought this might lay a basis for the comprehensive mental health and mental retardation. That is why I wanted to make the record clear that we need it.

Specialized facilities: Do you mean we are going to start building homes or housing for homeless alcoholics?

Dr. YOLLES. These are treatment facilities for the homeless alcoholics so that he can be kept in the treatment atmosphere, so that we can reach him. As you know, these homeless alcoholics are a transient group, and the biggest difficulty in maintaining them in treatment is that they move on to some other place as they feel like it. Most communities do not have the facilities to maintain them in a treatment environment. These funds would provide basic residential areas for them to live, such as "Halfway Houses."

Mr. ROGERS. Hostels?

Dr. YOLLES. Hostels, yes.

Mr. ROGERS. I would like to know more about that.

Dr. LEE. We feel this would be related to purchase of some existing facilities and remodeling, rather than building new facilities, except where this was essential.

Mr. ROGERS. How long are you going to give him a home?

Dr. LEE. We would hope for some it might not be too long. Some could be returned to the community and in some cases to their own families.

Mr. ROGERS. Suppose he doesn't want to stay there, except overnight?

Dr. LEE. You can't require them to stay, but by providing this environment, and the support of services, we would hope they would stay and that this would be a much more productive approach than periodically sending them to jail.

Mr. ROGERS. Has this been tried in any of the other cities where you have any considerable number of homeless alcoholics?

Dr. YOLLES. It has been tried on an experimental basis. As you know, the District of Columbia is trying it at the present time. These programs are experimental. They offer hope of success, especially in working with the skid row alcoholic, as he is called. When a community treatment program becomes involved with the individual and works with him, it is remarkable how many of these individuals can be brought into treatment.

Mr. ROGERS. How many do you estimate there are?

Dr. YOLLES. Nobody knows for sure, but somewhere between 250,000 and 500,000, primarily in the large cities.

Mr. ROGERS. If you would, let us have a rundown of what research has been done in this area.

(The following material was received by the committee:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE STATEMENT ON THE EXTENT OF "HOMELESS ALCOHOLIC" PROBLEM

1. The national total for the estimated number of homeless alcoholics is between 250,000 and 500,000.

2. The vast majority of homeless alcoholics are located in the larger American cities.

3. Estimates for the number of homeless alcoholics in some major cities are given below:

(*a*) New York City—25,000–30,000
(*b*) Chicago—15,000
(*c*) Los Angeles—10,000
(*d*) Philadelphia—7,000
(*e*) Washington—6,000
(*f*) Detroit—5,000
(*g*) Houston—5,000
(*h*) Cleveland—4,500
(*i*) Baltimore—4,000
(*j*) Atlanta—4,000
(*k*) St. Louis—3,000
(*l*) Pittsburgh—3,000
(*m*) Seattle—3,000

EFFECTIVENESS OF VOLUNTARY TREATMENT WITH HOMELESS ALCOHOLICS

1. There now is increasing evidence that many homeless chronic alcoholics can be helped through voluntary treatment efforts. The development of new treatment approaches—and programs particularly attuned to the needs of these patients—are rapidly overcoming the past belief that homeless alcoholics could not be helped. Treatment programs for homeless alcoholics must deal with the interrelated medical, psychiatric, social and vocational problems of these men.

For example, Dr. William T. Hart, Director of the Monroe County Psychiatric Hospital Center (Rochester, New York), has recently written, "I had formerly believed that only a system involving physical restraint or threat of it would control the confirmed alcoholic. If, however, the reduction of admissions to the Penitentiary is due to increased use of treatment facilities, it is obvious that voluntary agencies have made significant inroads into the involuntary care provided by judicial commitment to the Penitentiary." In *Quarterly Journal of Studies on Alcohol*—March 1968, Vol. 29, p. 100.

2. Below are listed five communities that have recently been pioneering in developing various treatment services for homeless alcoholics.

(*a*) *St. Louis.*—Alcoholics, formerly arrested for being drunk in public, are now brought to a special detoxification service in an abandoned general hospital. Without exception these men have been willing to come to this facility and the vast majority have remained in this hospital on a voluntary basis until such time as the staff felt they were ready to be discharged. The special training the police have received in handling these persons has made it completely unnecessary for them to use any force or physical restraint in bringing them in to this facility.

(*b*) *New York City.*—Through funds from the Vera Foundation, an entirely voluntary program of removing seriously intoxicated alcoholics from the street was recently initiated. As reported in the *New York Times* last month, the vast majority of persons offered assistance have voluntarily accompanied the treatment team to the rehabilitation facility. Furthermore, most of such persons have remained in the facility during the period of time designated for the program.

(*c*) *Philadelphia.*—Through a grant from the National Institute of Mental Health, the Diagnostic and Relocation Center has been intensively studying and providing assistance to homeless alcoholics in a "Skid Row" part of Philadelphia. This program has been on an entirely voluntary basis and well over 2,000 men and women have been interviewed and provided assistance through this service. This agency has experimented with the use of former "Skid Row" men as a means of contacting other homeless alcoholics. This approach appears to have been extremely successful.

(*d*) *Iowa.*—A comprehensive program in the city of Des Moines—relying entirely on voluntary approaches—has already succeeded in significantly reducing the arrest rate among Skid Row alcoholics. It has been possible to place a significant number of these persons in positions of employment and to modify their living habits sufficiently so that they are no longer arrested for public drunkenness and become less of a cost to the community.

(*e*) *California.*—At the Mendocino State Mental Hospital there is in operation an extremely large treatment program for alcoholics. All persons are admitted to this program on a voluntary basis and are free to leave the hospital grounds at any time. A sizeable proportion of the patients in this program are Skid Row alcoholics from the city of San Francisco. Through the imaginative use of professional as well as nonprofessional staff, it has been possible to create a strong sense of morale and dedication in the treatment unit so that large numbers of homeless alcoholics remain for a substantial period of time and participate in a wide range of different treatment approaches. This experiment also has tended to dissipate the stereotype that alcoholics will not use psychiatric agencies.

Mr. ROGERS. I believe you would also have construction, operating and staffing, maintenance and treatment facilities for narcotic addicts.

Dr. YOLLES. Yes, sir. This is merely a continuation of the program under section 402 of the Narcotic Addict Rehabilitation Act of 1966 (Public Law 89–793).

Mr. ROGERS. Would this be in every community mental health center?

Dr. YOLLES. No, I would expect they would not be in every center, only in certain ones.

Mr. ROGERS. What does the Bureau of Narcotics estimate is the population of our hard narcotics users?

Dr. YOLLES. The estimate is that there are 62,000 hard narcotics users in the United States, as of 1967. We estimate these figures are only roughly 80 percent of the total group. We have no true figure, so it may be as high as 100,000 hard core narcotics addicts.

Mr. ROGERS. I don't know if we want to get into a big building program, but it seems to me this could be incorporated in your mental health centers. You may need certain staffing, but I would hope you could give us some more——

Dr. LEE. This is really the purpose of the effort to integrate them, particularly in the communities wherein this is a major problem. It isn't a general problem, so we felt it was better to use the project-grant approach rather than a formula grant that would go to all the States.

Mr. ROGERS. I perhaps will submit some additional questions, because our time is up. Members of the committee may want to ask additional questions in writing. We very much appreciate your coming. It is a most important program, and I think we are off to a good start. We need to have some details, and I think the committee would want them before we take action.

Dr. LEE. We would be pleased to provide whatever you want, Mr. Chairman.

Mr. ROGERS. Our next witness is Dr. Carleton Chapman, dean of the Dartmouth Medical School, who will be appearing for the Association of American Medical Colleges, and he will be accompanied by Dr. Lloyd Elam, of the Meharry Medical College, Nashville, Tenn.

Doctor, it is a pleasure to have both of you here. We appreciate your giving your time so that the committee may benefit from your testimony.

STATEMENT OF DR. CARLETON B. CHAPMAN, REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ACCOMPANIED BY DR. LLOYD ELAM

Dr. CHAPMAN. Thank you, Mr. Chairman. I am Carleton B. Chapman, dean of Dartmouth Medical School, and on my right is Dr. Lloyd Elam, who is president of Meharry Medical College. We are on this occasion spokesmen for the Association of American Medical Colleges. Our association represents the 88 medical schools in the United States as institutions, a large proportion of the Nation's medical educators as individuals, and 330 major teaching hospitals.

Mr. Chairman, I would like to point out that we would like to speak to the regional medical programs, because medical schools are intimately involved in these programs, and while we favor in general the other provisions of the bill, we can claim special expertise in these areas.

We spoke before this group in favor of the adoption of the heart disease, cancer, and stroke amendments in February 1965, but emphasized that the Nation did not then possess enough trained personnel to carry out the provisions of the proposal. At the time, our spokesman noted that our medical schools, originally set up solely to train physicians, were already developing into medical service centers with constantly expanding responsibilities in the health field. He went on to say:

> This experience makes it clear that the professional and institutional relations are complex and delicate. It also makes it clear that it is painfully difficult to procure and maintain an adequate supply of trained manpower. A functioning regional complex . . . would make the efforts of the practicing physician more effective, but the development and operation . . . will require a marked increase in trained manpower.

He also noted that the success of a regional complex is heavily dependent on the continued and growing effectiveness of the medical school and the medical center.

At this time, 3 years later, we consider these observations still highly pertinent.

But, in general, we believe the discernible effects of Public Law 89–239 to date have been salutary. It has created a mechanism by means of which the Nation's medical schools have begun to relate to community and consumer health needs, and to work with many lay and professional groups in designing new methods of coping with these needs. It has initiated the organization of the Nation into regions, for the purpose of delivery of health services, very effectively. And although this organizational process has not yet proceeded to completion, the results to date more than justify the passage of the law.

We are well aware that efforts to implement the legislation have been associated with many problems. Regional organizational structures and, for that matter, the definitions of regional boundaries, are in some instances unduly complex and clumsy. Some health professionals complain that they do not understand the intent of the law and some are suspicious of it. Lay and professional groups which, in some regions, are attempting to reach joint decisions for the first

time, are having some difficulties. And occasionally one hears the view that the medical schools are attempting to use the law as a means of gaining control of the Nation's health care system.

But in our view, these difficulties were to an extent predictable and inevitable. The important point is that the law, by mobilizing local initiative, is effecting a cooperative attack on health problems which, although highly necessary, had not been operative before. In our view the general consensus lay and professional is highly favorable to the law.

The medical schools themselves have had difficulties in discharging their obligations under the law. Many of them, when the law was passed, had no administrative personnel that was capable of dealing with these new responsibilities. In some instances programs developing under the law involved commitment of professional personnel that is already fully committed. Far from attempting to take over control of the program many, and perhaps most, medical schools have been slow to become involved largely owing to shortage of personnel.

This has been especially acute as the schools move to begin to meet the growing shortage of physicians. Yet there is no doubt in our minds that our medical schools wish to be involved as effectively as possible, not to gain control but, in keeping with the intent of the law, to make their talents and facilities more readily available to all who need them.

But this vital matter, and the equally vital matter of improving and expanding our educational function, together constitute an obligation that cannot be met optimally in a few months, or even perhaps in 2 or 3 years. The medical schools seek no special privilege under the regional medical program law but wish, on the contrary, to assist materially in its successful implementation.

We believe that the original law has operated exceedingly smoothly, considering the nature of the planning processes it has initiated. We also believe, however, that enough experience has been or soon will be gathered to justify a few minor procedural alterations. When the law first began to be implemented, there were no generally applicable prototypes for regional organizations of the general types specified. A number of different patterns have now emerged, some more effective than others. It may, in our view, soon be appropriate for more definitive organizational guidelines to be provided by the Division or Regional Medical Programs. It will also be appropriate in the future to reconsider critically the geographic structure of the various regions. The responsibility and authority of advisory groups, many of which are too large to function effectively, require clearer definition. And the main thrust of the legislation requires, in our view, to be restated and clarified.

It has been frequently noted that its central focus of the law is the patient and his needs. This is unquestionably true. But a more relevant way of saying the same thing is to indicate that the law proposes to "* * * afford to the medical profession and the medical institutions of the Nation, through cooperative arrangements. the opportunity of making available to their patients the latest advances in the diagnosis and treatment of the diseases named in the law."

In other words, the law provides us with the means and authority to find ways of assisting physicians and other health workers to pro-

vide American citizens, wherever they may be, with better health care and to provide that care more efficiently.

Cooperation between lay and professional groups in designing such methods has, in general, been most impressive, but the balance has not invariably been ideal. Good faith and understanding between such groups cannot be created overnight, but one of the most striking accomplishments of the original law is that it has set the stage for the development of effective cooperation between these groups.

The original law is accomplishing what it set out to do but the pace at which such developments can proceed must be viewed realistically. We are not in agreement with those who say that the pace is unsatisfactory; on the contrary, the rate at which planning has proceeded has, to date, been very impressive, owing in no small measure to the understanding and wisdom which have characterized the administration of the law.

The next 3 years will be critical ones in that what has been done will have to be critically evaluated; that which is successful must then be encouraged; that which is ineffective discarded. At this stage, as in the planning phase, the medical schools can and no doubt will render signal service.

We believe, Mr. Chairman, the law should continue to operate for the present without substantive change but that the results it is producing must soon begin to be critically evaluated and scrutinized. The Nation's medical schools are now involved, for the most part, to the extent of their capabilities, not in an effort to gain control, but rather to help to provide the Nation a critical service. And as we go about meeting our obligations under the law, we seek the understanding of our critics; those who feel that we are reaching for dominance, no less than those who feel that we are not moving fast or vigorously enough on the other. We are, Mr. Chairman, placed squarely in the middle but we recognize that the essence of the regional medical program activity is vital to the welfare of the Nation. It is one of several major obligations which we must discharge.

Mr. ROGERS. Thank you, Dr. Chapman, for an excellent statement.

I might say, too, that I recall that many of your suggestions were accepted by this committee in the writing of the original law. You were most helpful to the committee.

Before questioning, if we could have a statement from Dr. Lloyd Elam.

Dr. ELAM. Mr. Chairman, my name is Lloyd Elam. I am president of Meharry Medical College in Nashville, Tenn. Before assuming that position, I was chairman of the Department of Psychiatry at Meharry and for a brief time, dean of the School of Medicine.

I speak today as an official representative of the Association of American Medical Colleges and wish to comment specifically on relationships between regional medical programs and medical schools.

I come before you today as one who has had direct experience with a regional medical program, a program which is already entering the operational phase after having made remarkable progress in bringing together various health resources in the Midsouth area during its planning phase. I have a deep concern about the availability and quality of health care among the poor, especially in our cities; I am particularly

interested in what regional medical programs can do in this critical area.

The regrettable fact that my institution, Meharry Medical College, has limited personnel and resources allows me to emphasize the point that the responsibilities we assume under regional medical programs must not become a drain on our finances or our manpower. Thus, as we enter into cooperative arrangements with other health resources of our region, to improve diagnosis and treatment of heart disease, cancer, and stroke, we must do so without jeopardizing our primary educational obligation.

Within these constraints, Meharry and the other medical schools of the Nation wish to express a strong sense of responsibility for the health problems of the communities that surround us. Regional medical programs offer an opportunity for such involvement. Indeed, we see in them the possibility for strengthening our colleges to carry out their unique obligation in community health, especially in the development of better ways to apply new and advanced procedures and improved ways of educating health personnel for this task.

Let me describe briefly how the Tennessee Midsouth regional medical program came into being and what we expect to accomplish in the next few years. The program was initially established through the cooperative endeavors of a wide variety of interested groups in Tennessee and southern Kentucky.

The discussions involved Meharry Medical College, Vanderbilt University School of Medicine, Hospital and Health Planning Council of Metropolitan Nashville, private hospitals, medical societies, public health agencies, and voluntary health organizations. A regional advisory group was established and planning funds were received in August 1966.

In our area, as in many regions across the country, the bringing together of these interests for planning purposes has resulted in an entirely new perception of health problems of the region and of new ways to solve them. I can indicate the extent of our progress by telling you that in June 1967, a little more than 10 months later, a request was made for operational funds for 34 projects to be carried out in the region. The projects varied widely in content and in scope, but each was concerned with solving a particular health care problem in heart disease, cancer, or stroke which had been identified during the planning process.

One project which typifies the region's activities, and allows me to speak to a particular problem that we at Meharry are addressing, is the regional medical program project concerned with long-term evaluation of the health status of 30,000 underprivileged persons in an urban poverty area known as north Nashville.

Our department of family and community health, in conjunction with the Office of Economic Opportunity, is establishing a neighborhood health center for this group of needy people. This is, as you can imagine, a large undertaking and one which requires a great deal of medical skill and effort. One of the major problems is to determine exactly what type of health care is actually required by these persons. Another, of course, is to measure the quality of care and to find out if it is actually achieving what it sets out to do. The regional medical

program is supplying the means by which Meharry, with the cooperation of Vanderbilt University, can establish a multiphasic screening laboratory as an adjunct to the neighborhood health center. The cooperation with Vanderbilt involves consultation and computer services needed for the automated laboratory procedures and recordkeeping. Regional medical program support will help us uncover heart disease, cancer, and stroke in this population in the earliest stages, provide documentation of the incidence and type of these disorders, assist in the initiation of necessary treatment, and aid in evaluating the treatment these patients receive at the neighborhood health center.

The potential of a cooperative arrangement between a multiphasic screening laboratory for the identification of need for medical care through early diagnosis and of a neighborhood health center for meeting that need is very great. This activity would have been difficult, if not impossible, to undertake without the help of regional medical programs. Many of the essential and important elements of regional medical programs are present in this one project: The bringing together of previously disparate elements of the medical care system—providing of manpower and funds to get things done—and the coming to grips with the really significant health issues of our region.

The involvement in regional medical programs of Meharry and Vanderbilt medical schools and of many other medical schools in this country, is far from superficial. Indeed, in many areas the medical school was instrumental in the establishment of the regional medical program and these institutions have lent their expert assistance in launching this major new program. They are accepting responsibilities beyond the traditional ones of teaching medical students and conducting research. They have begun new programs to translate more promptly the fruits of medical research into improved care for the people within the regions that they serve.

I shall like to close simply by giving my earnest and enthusiastic support to the legislation extending this program. I sincerely hope that you will agree with my estimation of its great importance.

Thank you for the privilege of speaking before you today.

Mr. ROGERS. Thank you, Dr. Elam.

Are there any questions?

Mr. KYROS. I have only a few questions.

Dr. Chapman and Dr. Elam, I want to welcome you here and thank you for your statements.

Dr. Chapman, on page 2 of your statement you include in your remarks that occasionally one hears the view that the medical schools are attempting to use the regional medical program for the purpose of gaining control of the Nation's health care system.

Would you kindly expand on that a little bit? What is the problem there? I didn't know such a problem existed.

Dr. CHAPMAN. This is something that has largely begun to disappear, I think. We heard this a good deal when the law was first passed. In addition, we have heard fears expressed that the medical schools might simply take funds that were available under this law and use them for standard, ongoing medical school purchases.

Of course, this is not possible under the law, and I think I can state with assurance that no medical school is doing that. Most of us have

attained small amounts, relatively small amounts of funds in order to find the personnel, provided the personnel that we needed to enable us to be involved effectively in this program, but I don't think, Mr. Kyros, that these criticisms are at the moment very serious.

Mr. KYROS. In the State of Maine, I have been told by doctors that one of the valuable benefits of this program is that in a State where you don't have a medical school, as in Maine—and I imagine there are other States in the United States that don't have a medical school—you serve an educational function by disseminating vital and current information to doctors who normally would not have that kind of information.

Dr. CHAPMAN. Yes, sir; and many of us who are deans regard many of the most important aspects of this activity to be the continuation education feature for physicians, and in our own northern tier of States, Mr. Kyros—of course, we represent three regions there, Maine and Vermont are separate regions, and Maine is tied in with New Hampshire.

We are meeting regularly with the Maine and the Vermont regional medical program officials, and one of the main things is this: the continuation of medical education.

Mr. KYROS. On page 4, you talk about the desire, perhaps, in the act to obtain a more definitive organizational guideline and to reconsider critically the geographic structure of the various regions. What specifically are you suggesting?

Dr. CHAPMAN. New England is a good case in point. As you well know, sir, New England for a long time was been working itself as a region with the northern tier of States focusing for many purposes on Boston, and to some extent on Montreal and Albany as well.

Our present regional structure will undoubtedly have to undergo modification. In fact, I would say it already is in a functional sense. The northern tier of States is a similar region in terms of population, climate, geography, and medical health problems.

Mr. KYROS. On page 4 again, you say cooperation between lay and professional groups in designing such methods—that is, of getting the latest advances in diagnosis and treatment translated into action for the patient have been most impressive, but the balance has not been invariably ideal. What does that mean?

Dr. CHAPMAN. I think it is a matter of groups that have never really worked together before are now having to do so, and as I said earlier, I think, in the State, some such difficulty was inevitable and indeed predictable.

In our own area, the balance is coming around very nicely, as I see the operating in the advisory group, which has brought together people who had certainly never approached any serious proposals together jointly.

Mr. KYROS. Do I understand your testimony this morning to be entirely in favor of the program that is set forth in the act before us today?

Dr. CHAPMAN. Yes, sir. We would consider it very distressing indeed if it were not continued. It is at the point now where we will begin to obtain the critical information we need in order to bring forth a program that will really do the job, and will really carry out the intent of the original act.

Mr. KYROS. Are you satisfied with the $65 million provided for fiscal 1969?

Dr. CHAPMAN. I am really in no position to speak to that. I believe under the circumstances it will take us the next step.

Mr. KYROS. Dr. Elam, I understand your multiphasic screening turned up uterine cancer in patients that would not otherwise have been found. Will that be continued?

Dr. ELAM. Yes, sir; and the results of the screening will be sent to a doctor in the anticipation of turning up such things.

Mr. KYROS. Thank you.

Mr. ROGERS. Dr. Carter?

Dr. CARTER. No questions.

Mr. ROGERS. It has been helpful to have your testimony, and we appreciate your sharing your knowledge with the committee. I hope that you will let us have your suggestion for any improvement that you think the program should undertake. Particularly I am concerned about bringing in more hospital people. I think maybe this balance that you are talking about the people in the program, along with the medical people—I think it has got to involve more people, and I would like to get more details if you could submit that to us, on your examination program. I think this could be most helpful to the committee.

Dr. CHAPMAN. Thank you, Mr. Chairman.

Mr. ROGERS. Thank you.

The committee stands adjourned.

(Whereupon, at 12:30 p.m., the committee adjourned, to reconvene at 10 a.m., Wednesday, March 27, 1968.)

REGIONAL MEDICAL PROGRAMS; ALCOHOLICS AND NARCOTICS ADDICTS FACILITIES; HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRATORY WORKERS

WEDNESDAY, MARCH 27, 1968

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2322, Rayburn House Office Building, Hon. Paul G. Rogers presiding (Hon. John Jarman, chairman).

Mr. ROGERS. The committee will be in order, please.

We will continue hearings on H.R. 15758, introduced by the chairman, Congressman Staggers of West Virginia, and our first witness today is the Honorable Richard Daley, mayor of Chicago, who cannot be with us, but whose statement will be read by Miss Phyllis Snyder, who is the executive director of Chicago's Alcoholic Treatment Center.

We are delighted to have you with us Miss Snyder, and we will be pleased to have you read the mayor's statement.

STATEMENT OF HON. RICHARD J. DALEY, MAYOR, CHICAGO, ILL., PRESENTED BY PHYLLIS K. SNYDER, EXECUTIVE DIRECTOR, MAYOR'S COMMISSION FOR THE REHABILITATION OF PERSONS AND CHICAGO'S ALCOHOLIC TREATMENT CENTER

Miss SNYDER. "Mr. Chairman, members of the committee, I welcome this opportunity to add my support, on behalf of the city of Chicago, for passage of title III, part A, of H.R. 15758, known as the Alcoholic Rehabilitation Act of 1968.

"We in Chicago have long recognized the need for an adequate program of alcoholism care and control. We are very proud of the fine work being done at Chicago's Alcoholic Treatment Center, a municipally supported facility providing inpatent care for 72 males and outpatient services to men and women. This facility has been operating since 1957.

"My commission on rehabilitation, comprised of 22 very able, dedicated, and knowledgeable citizens, has been studying the city's alcoholic problems and the needs to combat these problems since 1955. Our treatment center is a direct result of their recommendations.

"The studies of this commission have confirmed that it is not within our fiscal power to implement the kind of comprehensive program which is so necessary. Inasmuch as Chicago and Cook County have an estimated 250,000 alcoholics, more than one-half of the total alcoholics

in the State of Illinois, passage of title III, part A, of H.R. 15758 will be of significant help to us in Chicago.

"Enactment of legislation in this area is long overdue. The disease of alcoholism ranks among the foremost health problems of our society. Under present conditions, the primary burden of dealing with the more severe stages of alcoholism on the community level lies with law enforcement, rather than public health authorities.

"This situation is as unrealistic as it is ineffective. Law-enforcement authorities, already burdened with increased responsibility in the area of crime control, are no better equipped to handle incidents of alcoholism than medical doctors to handle crime problems in the community. Several Federal, State, and local courts have already transferred responsibility for handling chronic alcoholic repeaters from law enforcement to public health agencies.

"The President's National and District of Columbia Crime Commission both recommended such a transfer in communities throughout the Nation, not only for sound humanitarian reasons, but to relieve law-enforcement authorities of an onerous, unproductive responsibility—a responsibility, I might add, which drains law-enforcement resources away from the real fight against crime and criminals taking place in the country today.

"The legislation being considered by the committee would therefore be extremely helpful to U.S. communities, especially major urban centers, which need assistance in the development and improvement of alcoholism care and treatment facilities and services.

"This is particularly true in light of the possible court decisions which would prohibit the criminal detention of chronic alcoholics on charges of public drunkenness. Action must be taken, and soon, to prepare communities for the task of effecting an orderly transfer of community responsibility for chronic alcoholism from law enforcement to public health hands.

"The Alcoholic Rehabilitation Act of 1968 is therefore a vitally needed step toward alleviating one of the most serious urban health problems of our time. It will help the communities to help themselves in developing local programs to curb the incidence and prevalence of alcoholism in our society. And let us not forget that in addition to the humanitarian and administrative aspects of this legislation, it will also be a step toward reducing the economic impact of a disease costing American industry an estimated $2 billion annually in lost man-hours and work efficiency.

"In conclusion, then, our country urgently needs a comprehensive national program to deal with the health problem of chronic alcoholism. The Alcoholic Rehabilitation Act of 1968 represents the beginning of such a program. The administration is to be commended for proposing it, and Chairman Staggers for sponsoring it.

"On behalf of the city of Chicago, I sincerely hope that your committee will approve, the 90th Congress will pass, and the President will sign to law, this bill that will aid our States and communities in providing services for the care and control of a disease afflicting millions of American citizens.

"I thank you."

Mr. ROGERS. Thank you very much, Miss Snyder, for this statement from Mayor Daley. We appreciate his testimony, and I think it might

be helpful for the committee if you could submit for the record a run-down on your alcoholic treatment center. I would be very interested to see the staffing, the number of people, and the types of treatment that are given.

(The information requested was not available at time of printing.)

Mr. ROGERS. I notice you have in-patient as well as out-patient care, Miss Snyder.

Miss SNYDER. Yes, we do.

Mr. ROGERS. Thank you.

Our next witness is an old friend of this committee, Dr. Michael De Bakey, chairman of the Department of Surgery, Baylor University College of Medicine, Houston, Tex.

I might say that Dr. De Bakey was on the President's Commission for Heart, Cancer, and Stroke, which was really the guiding force for the formation of the regional medical program.

It is a pleasure to have you with us, and we are pleased to receive your testimony at this time.

STATEMENT OF DR. MICHAEL De BAKEY, CHAIRMAN, DEPARTMENT OF SURGERY, BAYLOR UNIVERSITY COLLEGE OF MEDICINE, HOUSTON, TEX.

Dr. DE BAKEY. Thank you. I am grateful for the opportunity to again appear before this committee, as I did on July 7, 1965, in support of the regional medical programs and to report on their progress. I would like to tender my thanks for what this subcommittee and the entire Committee on Interstate and Foreign Commerce have done to develop this program, a program which is already setting a pattern for enhanced medical care within the Nation.

I come before you in strong support of title I of H.R. 15758, introduced by the chairman of your full committee, Mr. Staggers.

I have been a member of the National Advisory Council on Regional Medical Programs since its creation, and I, therefore, have had the opportunity to see this program in its planning phases, and see it develop throughout the country as we hoped it would.

There have been times when I have been guilty of impatience, but the fact is that this program has developed, I think, at a normal pace and in a very sound way.

Now we are at a point where I think we will begin to see the first fruits of this program in terms of its original objective, which was to provide the best possible care for the patient at all levels of our society, and to extend this kind of care to every citizen. This was a need we have recognized but were not able fully to achieve in the past.

I believe this program will achieve its main objectives; certainly in the fields of heart disease, cancer, and stroke, and hopefully in all the related areas.

At this time there are certain aspects of the legislation I would like to discuss in more specific terms. You will recall, Mr. Chairman, in the original testimony, and in the original bill, there was much discussion of construction authority.

I think the committee was wise in pointing out that without this type of authorization for new construction—there was authorization

for renovation—that the program would not be jeopardized in the planning phase.

Now, however, we are in the area of actual operation, and already there are 11 programs functioning. I would say by the next several months, perhaps 40 or 50 percent of the programs will be in some phase of operation. So we are moving, you see, quite rapidly.

As we move into this area, construction needs will become increasingly more apparent, and already we have evidence of this need.

This construction is fairly specific in nature and fairly limited in scope. It is not on the same scale as already existing construction needs within the medical centers—construction for which the centers already have the authorization if not the money.

Now, the construction authority we need for the regional medical programs applies primarily to the community hospitals and to the more peripheral units, where the past construction has not anticipated this type of program.

In the Surgeon General's report there is documentation and outlining of the various types of construction needed.

What I should like to do, Mr. Chairman, rather than take your time now, is to submit a formal statement for the record within the next few days. I had hoped to have this ready for you today, but I got involved in a series of emergencies over the weekend.

Mr. ROGERS. We understand, and without objection, your formal statement will be made a part of the record, following your testimony.

Dr. DEBAKEY. This is the limited but well-defined need for new construction. I leave to the committee's judgment as to how this best should be met.

Allow me to point out that it is essential for the future of the program to find means of meeting these needs of the community hospitals. These needs include construction space for classrooms; particular types of diagnostic facilities, laboratory space of special types; and treatment units relating to heart disease, cancer, and stroke. The outlying hospitals simply do not have this type of space available, and frequently have no means of finding the funds to provide this kind of construction.

Finally, Mr. Chairman, I would emphasize that we have reached the stage in this program where we must look to the funding levels over the next 3 to 5 years. As we move more and more into operation, I think the cost of these programs will reach the figures we visualized in our original concepts and the original proposals in the President's Commission's report.

You will recall that we expect this to reach authorization levels of well over $450 million by the end of 5 years. Now we are beyond that point in our thinking, and we now have better evidence of what the needs are going to be. I would say they will approximate $5 or $10 million in each region within the next 5 years. Therefore, I would hope the committee will contemplate authorization levels of some $500 million within the 5-year period.

This level will not be reached soon, of course. However, I would think by 1971 we would be close to the $300 million level.

I would hope by that time the opportunities to provide funding at this level would be more readily available than at this moment.

Mr. Chairman, I will be glad to answer any questions you have.

Mr. ROGERS. Thank you very much, Dr. DeBakey, for giving us your viewpoints on this program and its importance.

Could you give us an example of one region that you may be aware of, or maybe you would want to do this in your statement.

Dr. DE BAKEY. Well, rather than take your time about it, let my statement provide this information. I would like to discuss an area where they have not only accepted the total concept of the program but are utilizing the program in a most efficient way to provide the particular three elements that I think are essential: research, education, and patient care. These three elements must be combined at the level at which the physician meets the patient.

Mr. ROGERS. This has been my concern with the program, and I realize it is still very young. But I am beginning to get feedbacks that the program is not reaching the practicing physician yet. It is not down to the hospital. It has stopped at a little higher level, at the dean's office.

Dr. DE BAKEY. This is understandable at the planning stage. Only at the operating stage will they begin to feel the program.

The most important thing to me is the fact that the program is becoming better understood by the practicing physician, and there is developing an enthusiasm for the program at the grassroots level that really is in striking contrast to some of the earlier experiences.

Mr. ROGERS. That is right. I remember very vividly.

I think it might be helpful to point out some of these areas where you feel the program is being effective in getting to the community hospital, and where the people in the community are really beginning to receive the benefits. This would be helpful to the committee, and also to spread it upon the record so that other areas can see what is being done in the most successful programs.

Dr. DE BAKEY. I will be very pleased to do this and include it in the statement I will file with you.

Mr. ROGERS. Thank you.

Mr. Kyros?

Mr. KYROS. We are happy to have you here, sir.

These programs of construction that you are talking about would still have to be initiated at the local level and passed on by the Advisory Council.

Dr. DE BAKEY. Yes; and they would also have to show justification as being within certain guidelines, as being essential to the efficacy of this program.

There are all kinds of construction needs, but we have various types of construction authorities, and I would think the important thing is that we limit the construction to the needs of this program; that is, where it can be demonstrated unequivocally that without the construction space the program couldn't be effective, couldn't be implemented.

Mr. KYROS. I don't know how familiar you are, sir, with the money requirements of the program; but the figures yesterday were that it would be about $30 million carryover from the last fiscal year, and the bill this year carries $65 million.

Do you think $95 million will be enough for this kind of planning this coming year?

Dr. DE BAKEY. Well, if I read the situation within the next year correctly, I would say we would come close to that, certainly; and I don't think it is going to jeopardize the program.

What I am concerned about is when we get into the operational phase within the next—well, say by 1971. I would say within this 2- to 3-year period we are going to see a real escalation in activity and, therefore, in funding needs.

Mr. KYROS. I understand, thank you very much.

Mr. ROGERS. Mr. Nelsen?

Mr. NELSEN. I have no questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. It is an honor, Dr. De Bakey, to have you here. You are so well known to many of us as being absolutely dedicated to the service of humanity. We are honored to have you here.

I would like to ask about how the funds that you want—are they to be for something similar to intensive care units in different hospitals?

Dr. DE BAKEY. Yes. Well, some of them would be used in that way. For example, let us take the community hospital that is in a program. They need and can use, and in a sense can support, an intensive care unit; but the hospital is built in such a way that they can't even renovate space.

You are familiar from your own experience, I am sure, in your own area of Kentucky, where hospitals, even those built with Hill-Burton funds, are now so jammed that it would be denying the use of the space for some very essential purpose.

So they need additional space. To build this, they have to have money. It may be a relatively small sum. It may amount to a hundred thousand dollars, but it is still money that is hard to find for this purpose.

An intensive care unit would be one wing. Another would be—I hope my colleague will point this out in his testimony to you—in terms of acute stroke units. There will be diagnostic facilities of certain specific character.

We point out in the Surgeon General's report, which the Council had the opportunity to review, the types of space needed. They will need classroom facilities. This is the kind of space that is essential to carrying out the program.

Mr. CARTER. Certainly we have seen that many of our hospitals in the smaller areas, and I am sure it is true in cities, that in the past few years building has taken place, but still it is inadequate.

Dr. DE BAKEY. Completely inadequate, and also it doesn't take into consideration these kinds of needs. They didn't even visualize these needs in the early plans. Their concern was with immediate needs that they had to meet.

Mr. CARTER. I see the need of these things.

Dr. DE BAKEY. May I say to you, Dr. Carter, that it was part of your understanding that helped produce this program, and I want to thank you again for your insight into this whole program.

Mr. CARTER. Thank you, sir.

Dr. DE BAKEY. It was a tremendous help to us.

Mr. ROGERS. Mr. Skubitz?

Mr. SKUBITZ. Thank you, Mr. Chairman.

I have no questions, Dr. De Bakey, but I want to join my colleagues in welcoming you here today. I am looking forward to receiving your recommendations.

Dr. DE BAKEY. I want to express my appreciation to the committee for the wisdom and kindness and generosity they have shown, and it is good to know there are public servants like yourselves.

Mr. ROGERS. Thank you.

(Dr. De Bakey's prepared statement follows:)

STATEMENT OF MICHAEL E. DE BAKEY, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF SURGERY, BAYLOR UNIVERSITY COLLEGE OF MEDICINE, HOUSTON, TEX.

Mr. Chairman and members of the subcommittee, I am Michael E. De Bakey, Professor and Chairman of the Department of Surgery, Baylor University College of Medicine, in Houston, Texas. I had the honor of being named by President Johnson as the Chairman of the Commission on Heart Disease, Cancer, and Stroke, whose report led to the initial recommendation of the Regional Medical Programs legislation which this committee developed and passed in 1965. Since its creation, I have been a member of the National Advisory Council on Regional Medical Programs and am also a member of the Regional Advisory Group of the Texas Regional Medical Program.

I testify today in strong support of Title I of H.R. 15758 introduced by the distinguished Chairman of your full committee, Mr. Staggers. If enacted, Title I would extend the authorizing legislation for Regional Medical Programs for an additional five years as well as clarify certain technical aspects of P.L. 89-239.

I would like briefly to reiterate the basic concept of the Regional Medical Programs, the future of which this subcommittee is presently considering.

The Regional Medical Programs comprise a group of units added—wherever possible—to already existing medical centers in regions throughout the country. The units are part of the overall research, teaching, and medical care going on within the medical centers in regard to heart disease, cancer, and stroke.

These units together make up a national network for research, for teaching new developments to doctors and nurses, and for care of patients under investigation. Thus each physician served by this network has, readily accessible to him for his patients, the full range of up-to-date knowledge and skills developed through nation-wide research. At the same time the doctor contributes to research, for his observations add to the total knowledge.

Each of these units we are discussing has its own facilities and staff, though they function as part of the existing medical work force, to pull together and strengthen the medical resources now in existence.

The Regional Medical Programs as initially authorized, placed principal emphasis on regional voluntarism, as the means by which their goal might be achieved. Today I can report that your confidence in this approach has been well placed. Within the last three years 54 Regional Medical Programs have been brought into being. By this summer approximately one-half of these will have entered the operational phase. The remaining regional programs will shortly thereafter begin operation.

With its emphasis on voluntary cooperation the Regional Medical Program mechanism has managed to harness the creative energies of practicing physicians, hospitals, medical schools, voluntary, state and local health agencies. All too frequently in the past these creative energies have been isolated from one another or, even worse, in competition. Regional Medical Programs make it possible for all providers of health services to combine their strengths to improve the care of patients with heart disease, cancer, or stroke. Thus our aspirations of 1965 today are working entities.

One of the most important developments is the large and increasing involvement of the medical profession. In a recent speech the President-elect of the American Medical Association said, "As a whole, the medical profession at the beginning of the year 1968 is probably more deeply involved in the planning process to determine the nature of the Regional Medical Programs than it has been in the planning of any previous Federal program."

Now in considering the future of these Programs, Mr. Chairman, I would like to discuss the legislation before your committee. I was disappointed to

find that Title I of the bill does not propose to broaden the construction authority for Regional Medical Programs. During the initial hearings before the Interstate and Foreign Commerce Committee on Regional Medical Programs in 1965, there was much testimony that construction authority would be necessary if the requirements of the legislation were fully to be met. The committee in modifying the bill deleted the authority for new construction. In its report on the bill the committee reasoned that the program would not be jeopardized by the lack of such authority in its initial planning phases. Furthermore, the committee felt in those instances in which new construction might be required for Regional Medical Programs, other Federal sources of funding should be sought. Finally the committee in its report indicated its intention to review this question at the time of the legislation's extension.

Mr. Chairman, I would like to commend the committee's wisdom on this matter. In fact, the Regional Medical Programs have not been jeopardized during these past three years, during which they have organized themselves, planned their programs and begun to enter the operational phase.

However, this situation is rapidly changing. Already 12 of the 54 Regional Programs are operational and within the next year or so all of them will have begun operations. Accordingly, their needs for additional facilities will rapidly increase.

The Surgeon General's Report to the President and The Congress on Regional Medical Programs documents the case for limited Regional Medical Program construction authority. It is extremely important to understand that these facilities would principally be located in community hospitals, not our medical schools.

Examples of needed community hospital construction described in the report include class and conference rooms for regional continuing education programs, space for special demonstrations of community patient care, and expanded diagnostic laboratory facilities.

These needs are not now being met under existing Federal construction programs. There are two interrelated reasons for this:

(1) The competition for Federal funds for the construction of health facilities has grown enormously as a result of an overwhelming demand for such facilities.

(2) By definition, the nature of Regional Medical Program construction needs goes beyond the needs of a single institution to the needs of the region. Accordingly, it is unreasonable to assume that any *single* institution would be willing to divert its scarce funds for matching purposes when the benefits of the facility are intended for *many* institutions.

Since it is essential that there be no substantial distortion of the concept of Regional Medical Programs, I concur that rather strict limitations should be placed on this vitally needed construction authority. The kinds of limitations one finds in the Surgeon General's report, having to do with the amount of funds available for construction purposes, seem entirely reasonable to me.

Having considered the limitations, what kind of Regional Program projects are we working to generate? How does such a project work? An example of the effective implementation of the program involving community hospitals is provided by the Rochester (New York) Regional Medical Program which has inaugurated an initial five-part operational program in the area of cardiovascular disease. Each part is specifically designed to meet observed or expressed needs in the delivery of specialized medical care to the heart patient. One project will provide postgraduate training in cardiology for general practitioners and internists who practice medicine in the ten counties which make up this region. Several different training programs will be offered so as to best meet the individual needs of the physicians who will participate. This program is being persented in direct response to the requests of physicians for this type of assistance. One phase of this program includes visitations to peripheral hospitals by the cardiologists who will provide this instruction. Certain audio-visual equipment will be placed in these peripheral hospitals for continued use by the local physician.

A parallel program will present intensive month long courses to prepare professional nurses in the management of coronary care units. The growth in the number of coronary care units which provide essential medical care during the acute phases of cardiac illness, has created an urgent need for an increased number of well trained nurses; the latest advances in nursing techniques and modern life-saving equipment demands specialized instruction in the nursing skills re-

quired. Hospitals in the region have already expressed their intent to have nurses participate in this program as soon as it is activated. The objectives of this program go beyond that of supplying specially trained nurses for coronary care units in general hospitals; every effort will be made to train coronary care unit nurses from the smaller community hospitals as well, even though they may not as yet have such a unit.

Three additional activities will also be pursued under this initial operational program. A regional laboratory will be established for education and training of medical personnel in the care of patients with thrombotic and hemorrhagic disorders. This is the first such facility in the region and will be based in one of the general hospitals participating in the Rochester Regional Medical Program. A region-wide registry of patients with myocardial infarction will be implemented which will gather uniform information from the coronary care units of participating hospitals and provide immediate as well as longitudinal data for analysis. A relatively small amount of funds has been made available to the region to develop the first learning center in the region where some of the educational programs in heart disease, cancer, and stroke may be presented to physicians and nurses.

The first year award for this multifaceted program in cardiology is $343,749.

Having described an example of what we are building, Mr. Chairman, I should like finally to say a word or two about the level of funding I believe essential if Regional Medical Programs are to have a fair chance to achieve their goal.

We all realize that the maintenance of health is assuming an increasingly important role in our socio-economic area of concern and activities. The health industry today accounts for an expenditure of $50 billion but it is scheduled soon to increase to an expenditure of $75 billion.

If the Regional Medical Program is to fulfill its function as the interface between the moving parts of this health care mechanism, it must continue to be able to influence that increasingly expensive device.

We would be short-sighted engineers, indeed, to derive authorization ceilings for the next five years of this program by looking backward at the cost of these programs at the time they were being planned. The cautious development of those programs has unleased a chain reaction of operational activity which will necessitate substantially increased funding levels. It is already clear that on the average these programs will be operating at a level of between $5 million and $10 million each within the next five years. It is, therefore, necessary that an authorization level of roughly $500 million be used as the yardstick with which one measures the funding levels of the program contemplated by this extension.

Mr. Chairman, I am indeed privileged to again have the opportunity to present my views to the committee which has done so much to shape health legislation in general and the Regional Medical Programs in particular.

Mr. ROGERS. Our next witness is Sidney Farber, director of research, Children's Cancer Research Foundation, Boston, Mass.

Dr. Farber is also an old friend of the committee, and he was helpful in the formulation of the original legislation, having served as chairman of the Cancer Panel of the President's Commission.

Welcome back, Dr. Farber.

STATEMENT OF DR. SIDNEY FARBER, DIRECTOR OF RESEARCH, CHILDREN'S CANCER RESEARCH FOUNDATION, BOSTON, MASS.

Dr. FARBER. Thank you. It is a great honor to be once more before this committee, where my memories are as heartwarming as any memories I have in my entire professional career. I join Dr. DeBakey and all our colleagues in expressing gratitude to this committee and Congress for starting what I regard as the most important program in the field of medicine in the history of our country that is applied directly to the care of the patient.

I speak strongly in favor of H.R. 15758, the purpose of which is, among other things, to amend the Public Health Service Act so as

to extend and approve the provisions relating to regional medical health programs.

I join my colleague, Dr. DeBakey, in strong recommendation for construction funds, and I will give one example of this later, which will illustrate the great need for construction funds in this program.

What we are asking today is authorization for the next 5 years for these funds, with the hope that funds will be available, released from other sources, which will make the support of this program and so many other worthy programs before the Congress possible.

I would like to say just a few words about these programs.

There has been a magnificent beginning already. I want to give evidence that the administration is excellent under Dr. Marston in the division of regional medical programs, and that the Council and advisory boards are composed of wise and courageous men who are not afraid to say no, nor are they not afraid to say yes, in the approval of programs that deserve approval.

I have the privilege as a member of the National Advisory Council to represent that council to the Regional Medical Programs Council; this is my second year of watching and listening with great appreciation and helping, when I am asked for help, in the deliberations of these advisory boards.

The regional medical program represents the first time in the history of American medicine where all segments of society concerned with the health of our people have come together to achieve a common goal of better health, preservation of lives, and the prolongation of good life for people who suffer from these dread diseases. This is a great triumph in itself, and would be worthy of the entire cost of this program if this were the only spin-off of what has been done.

The regional medical programs, quite simply, are concerned with bringing to every man, woman and child suffering from these dread diseases, and eventually, I hope, from all diseases, all that is known today that might save lives or prolong good life. This is accomplished in the simplest terms in two ways.

We begin with the community hospital and the doctor in practice. We give added strength first in manpower in trained personnel in those community hospitals, and, second, technical facilities for what is lacking. And we link these community hospitals with so-called "centers."

These centers are not buildings in one place. They are not in one building, but they represent a portion of a given region where there is a concentration of expertise in medical schools, teaching hospitals and research institutions, where there are facilities and manpower and expertise that cannot be duplicated endlessly.

The country just can't afford that.

If we can bring these two segments of the medical community together, the community hospitals and these medical complexes, and with good means of communication in the modern idiom for rendering diagnostic assistance and therapeutic advice, we will achieve something that in the field of cancer, and other fields, will bring great rewards.

I want to mention figures that I had the privilege of mentioning once before before this committee.

In cancer, if we could bring to every man, woman and child everything that is known in diagnosis and therapy today, there would be a saving of 100,000 to 300,000 who are destined to die of cancer this year.

In the field of heart disease and the field of stroke, this can be multiplied as evidences of what this program can accomplish.

For the remaining 200,000 of the 300,000 for whom we have nothing available today and who will die of cancer, we require research. The great research programs of the National Cancer Institute and the American Cancer Society, and the many private institutions of the country will provide the research in the course of time which will bring answers to the problems which cannot be answered today.

But if we can focus our attention on those who can be saved with knowledge presently available, this goal is worthy enough.

I want to point out one example in regard to construction. You are familiar with the great returns from the privtae sector to the Hill-Burton Act and to the Health Facilities Construction Act, and so on. In those there has been an outpouring of private money. That will happen here, too, in those parts of the country where the private sector can aid. In those where the private sector is unable, this program should shoulder the entire burden, because human life is precious wherever it is.

There is one example that I learned about just before coming here.

The community of Anchorage, Alaska, in response to the needs identified by the Washington-Alaska regional medical program, for high-energy radiation facilities closer than Seattle, Wash., is now conducting a campaign to build the facility. Solicited private funds will be used to construct the housing for the equipment, which is very expensive.

The equipment will be purchased by the regional medical program.

The treatment center will be operated as a regional resource by the Providence hospital, as planned and approved by the local and and regional advisory groups.

The decision to support the activity involves cooperative arrangements at another level also, and of this I am very proud. The National Cancer Institute conducted the site visit, which gave assurance of the sound scientific and professional basis of this project. Here is a beautiful example of two segments of the National Institutes of Health cooperating.

I have just heard that the Anchorage Construction Trades Council, comprising 14 unions, have taken on the construction of the building, contributing more than one-half of the total cost from this one source alone. This is heart-warming, indeed, to see a community as a whole joining with a Federal program in aiding people suffering from cancer by providing a form of treatment that had been lacking in that part of the country.

The time has come now to recommend greater support for this program on the basis of the fine progress which has been made.

You have already heard from Dr. DeBakey in response to questions for the amount which is recommended for this year. May I mention two other figures?

By 1971 this program should be supported by an amount no less than $300 million, not counting construction. And we should reach

the figure of $500 million within 5 years' time if we are to utilize to the full the strength of what has been mobilized in the various regions of the country in behalf of the health of our own people.

I close these remarks, Mr. Chairman and gentlemen, confident in the belief that the leadership to the Congress offered by your committee will permit these regional medical programs to make a truly great contribution to the health of all of us.

Thank you.

(Dr. Farber's prepared statement follows:)

STATEMENT OF DR. SIDNEY FARBER, DIRECTOR OF RESEARCH, CHILDREN'S CANCER RESEARCH FOUNDATION, BOSTON, MASS.

Mr. Chairman and members of the Subcommittee on Public Health and Welfare, it is with gratitude that I acknowledge this opportunity to appear before you in strong support of H.R. 15758, the purpose of which is, among other things, "to amend the public health service act so as to extend and approve the provisions relating to Regional Medical Programs."

My name is Sidney Farber. I am founder and Director of the Children's Cancer Research Foundation in Boston, and Chairman of the Staff of the affiliated Children's Hospital Medical Center. For almost 44 years I have been associated with Harvard Medical School as a student and member of the Faculty, where I am now the S. Burt Wolbach Professor of Pathology. My medical, research, and teaching activities have been devoted to children and to the field of cancer. At the present time I am President-elect of the American Cancer Society which derives its great strength in its struggle to control cancer, from more than 2 million volunteers in all parts of the country. Presently I am a member of the National Advisory Cancer Council of the National Institutes of Health, and represent that Council to the National Advisory Council on Regional Medical Programs. It was my privilege to serve as a Member of the President's Commission on Heart Disease, Cancer and Stroke, as Chairman of the Panel on Cancer. It was this Commission which produced the renowned DeBakey Report which culminated in the enactment of P.L. 89-239, the Heart Disease, Cancer and Stroke Amendment of 1965. It was my privilege, too, to testify before this Committee in support of the original enabling legislation.

Today I come before you in support of the extension of this program which represents one of the greatest opportunities in the history of medicine to prevent death from these dread diseases, and to prolong good and useful life for our people. May I summarize briefly a few points concerning the program as a whole, and that portion dealing with cancer in particular:

(1) A magnificent beginning in planning, and to a smaller extent in operations has already been made in this very short period of time. The Regional Medical Programs already show convincing evidence that for the first time in American history the various components of a given region of the country concerned with the health of our people can and will work together toward the achievement of a goal which has never been so broadly defined.

(2) The goal of the Regional Medical Programs, in a few words, is the provision for every man, woman and child suffering from any of these dread and related diseases, of all that is known as well as all sophisticated technical procedures for the prevention of death and the prolongation of good life. Fundamental to the achievement of these goals are developments in data collection and the perfection of better methods of delivery of medical care, as well as improvements in continuing education for the physician and education of the public. Making use of these invaluable tools, then, the Regional Medical Programs, in the case of cancer, are beginning to create meaningful relationships between community hospitals and those parts of the region where are located the medical schools, teaching hospitals, and research institutions concerned with cancer. The community hospitals must be strengthened by increasing the number of members of their staffs, specially trained in the various aspects of diagnosis and treatment of the many different diseases we call cancer, and the addition to their technical armamentarium of such special technical devices as radiotherapy units, and other diagnostic and therapeutic equipment.

In the medical school complex there will be concentrations of specialists in the many phases of cancer research, diagnosis and treatment to give expert assistance

to any doctor in the region in behalf of his patient. In such complexes where a critical mass of expertise is to be found, primary responsibilities will include continuing education with the help of technical equipment in the modern idiom, demonstrations of new techniques for diagnosis of treatment, and consultation services to the community hospitals and all doctors in the region, in addition to the conduct of research designed to provide solutions for problems in cancer which can not be satisfactorily handled on the basis of present knowledge.

(3) It has been estimated by experts that if we could make available to every patient with cancer in the country today all that is known concerning diagnosis and treatment, we could save 100,000 of the more than 300,000 who will die of cancer this year. This is without new knowledge emanating from research laboratories. It is a goal that can be achieved by the full development of these Regional Medical Programs in the field of cancer alone.

(4) As was the case with the Hill-Burton program, and also the Health Facilities Research Construction Program of the National Institutes of Health, investment of Federal money will be sure to call forth investment from the private sector. You will be interested I am sure in one experience in a part of our Country which has serious need for improvements in the field of cancer.

The commodity of Anchorage, Alaska, in response to the needs identified by the Washington-Alaska Regional Medical Program for high energy radiation treatment facility closer than Seattle, Washington, is now conducting a fund raising campaign. Solicited private funds will be used to construct housing for the equipment, which will be purchased by the Regional Medical Program. The treatment center will be operated as a regional resource by the Providence Hospital, as planned and approved by local and regional advisory groups. The decision to support the activity involves cooperative arrangements at another level also, for the National Cancer Institute conducted a site visit which gave assurance of the sound scientific and professional basis of this project. I heard just before coming here that the Anchorage Building and Construction Trades Council, comprising some 14 unions have taken on the construction of the building as a project, contributing more than one half of the total cost from this one source alone.

RECOMMENDATION

The time for increasing the support for these Regional Programs in Heart Disease, Cancer and Stroke has come on the basis of the truly splendid start that has been made. The upward trend of needs—almost double each year—is apparent as more programs reach the stage of actual operation. In fiscal 1967 only 4 programs were operating; in 1968, 20 more will reach that stage. Even to make possible the universal application of such a simple and established technique for detection of cancer of the uterus at the Papanicolaou smear, is an expensive procedure, but one that will be followed by the saving of thousands of lives of women each year. We should emphasize, too, that many segments of our system—in ghettos, rural areas, or old-age homes among others, have little or no access to modern scientific health technologies.

We are aware that particularly at this time priorities must be established and that choices must be made. It is our purpose today merely to point out the great good that will come if there is support of programs which have already demonstrated their ability to achieve the goals defined by the President's Commission on Heart Disease, Cancer and Stroke and put into law by the Congress of our Country on the recommendation of this Committee. From the time of the identification of these goals in P.L. 89-239, the Regional Medical Programs have captured the imagination and raised the expectations of the general public and the health provisions alike. Those who have studied the needs of this program most carefully recommend that the ceiling for the national program as a whole should reach the level of more than 500 million dollars within 5 years, and should certainly not be lower than 300 million dollars for 1971 if we are to utilize to the full the strength which has been mobilized in the varous regions of the country in behalf of the health of our own people.

I close these remarks confident in the belief that the leadership to the Congress offered by your Committee will permit these Regional Medical Programs to make a truly great contribution to the health of all of us.

Mr. ROGERS. Thank you very much, Dr. Farber. We are indebted to you for being here and giving us your opinion on this program.

Let me ask you, for instance, with the Children's Cancer Research Foundation, can you give us any example where a new treatment, perhaps, has been disseminated through a regional medical program?

Dr. FARBER. Yes, Mr. Chairman. The Children's Cancer Research Foundation, if I may speak of something with which I have been concerned for the last 21 years, is really a prototype of the Regional Medical Center program. It is a private foundation, assisted from the private sector and receives research funds from the National Cancer Institute and help from the American Cancer Society. It is supported by the entire New England community.

It provides expert care and diagnosis and treatment for children with leukemia and all forms of cancer, for any child sent by a doctor in the entire region. The doctor takes care of the patient at home and gives the tremendous moral and medical support required by a family which has a seriously ill child at home.

The foundation provides the techniques and equipment which are much too expensive to be in a doctor's office. It carries out all these expensive services without professional charge to the patient; at home the patient is the private patient of his private doctor.

In 21 years, Mr. Chairman, I have never had a complaint from a single doctor in this region. We have had remarkable cooperation, and the community as a whole has cooperated to support something which they considered absolutely necessary for the comfort, the well-being, and the mental peace of the family, as well as for the health of the child.

Mr. ROGERS. Have we had any real breakthroughs in this area, in the treatment of leukemia in children?

Dr. FARBER. Mr. Chairman, there has been very great progress. It was 20 years ago last November when the first chemical that could control leukemia, at least temporarily, was administered to a child for acute leukemia.

There is no cure for acute leukemia, but patients live good lives for several years, instead of a few weeks or a few months. And there are alive a few hundred patients, adults and children, about 1 percent, I estimate, of all the patients with leukemia treated, who have lived good lives for 10 to 15 years without evidence of the disease.

This is not a cure, in my opinion, but this is very heartwarming evidence that we are in the right direction in the use of chemicals, and many supportive programs, such as platelet transfusions and so forth.

If we can keep good life going, the next forward step in research may come in time for that child.

We have other tumors in adults as well as children, which have responded to surgery, radio therapy, and chemotherapy. In one case of cancer of the kidney in children, we are now above 80 percent in long-term survivals because of the addition of chemical, in this case an antibiotic, to modalities of surgery, and radio therapy. We have accomplished what seemed impossible 20 years ago. Once spread to the lungs had occurred in this kind of tumor, there was a matter of 3 to 6 months of life ahead. We are now able, in about 60 percent of the children who have had spread of this cancer to the lungs, we are able to have complete destruction of the tumor using small amounts of radio therapy and an antibiotic. Life has continued in the longest patient for 13 years with no evidence of the return of the tumor.

There are many examples that could be given from the splendid institutions in the country and in other parts of the world where greatest advances have been made. The word "cancer" does not apply to a single disease. It includes many different diseases, which may be unrelated, all of which are called cancer, so we may have to answer your question instance by instance as we record success.

Mr. ROGERS. I think that is encouraging, and I think it is well for us to spread on the record some of these examples, so where you have a technique that is successful, this can be spread quickly through a regional medical program—at least that is the theory—that it can get to the local doctors and hospitals. And although we may not have the necessary treatment there, it can be arranged for and the treatment prescribed.

Dr. FARBER. We hope these regional programs will provide for the community hospital the expertise and the equipment which will take care of the vast majority of patients with cancer, leaving for the centers the new problems which require far greater outlay in equipment and manpower.

Mr. ROGERS. Thank you.

Are there any questions?

Mr. KYROS. I want to join with you in welcoming Dr. Farber here.

Mr. NELSEN. I was interested in your statement that many patients have gone as long as 13 years with no evidence of recurrence.

Is there any specific number of years that the medical profession assumes to be past the danger point in radiation treatment of a tumor?

Dr. FARBER. This varies from tumor to tumor.

In the case of the kidney tumor I mentioned, I have experience for more than 40 years with this kind of tumor. If there is no recurrence or evidence of tumor 2 years after initiation of therapy, we may assume with a high degree of certainty that the patient will remain in good health. In the case of other tumors, cancer of the breast, for example, although most patients will remain well if they have been well for 10 years, all of us—Dr. Carter, too, I am sure—have seen patients who have had recurrences 18 to 20 years later.

So we must give a different answer for each kind of tumor.

Mr. NELSEN. I had in mind a case that I am well aware of, that happens to be my son who had a brain tumor. It is now 5 years since the radiation treatment was given, and he has been in very good health since this operation was performed.

I am always watching, of course. This was 5 years ago, and it would seem he is in very good health at this time.

Dr. FARBER. I am sorry to learn you have this personal experience, Mr. Nelsen. I would say the story you give is encouraging. If there is no evidence of tumor after 5 years, this looks very hopeful.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I want to say thank you for an interesting and informative—and I started to say "persuasive" presentation, but instead of that, I am going to say that so far as I am concerned, I am a believer and am fully persuaded in what you say.

Thank you.

Dr. FARBER. Thank you very much, Dr. Carter.

Mr. SKUBITZ. Doctor, I have one statement.

You made the statement, I believe, that if we could make available to every man, woman and child the evidence that we have on cancer, 100,000 lives would be saved this year or any year. Is this correct?

Dr. FARBER. That is correct.

Mr. SKUBITZ. Of course, I recognize the task we have in trying to get to every individual, but don't we have a central clearing agency of some sort where information is collected?

Dr. FARBER. Yes, we do, through the National Cancer Institute and the American Cancer Society, but the problem is complex. May I mention a few of the complexities?

First, we must have the patient come to his doctor early. This is No. 1. The American Cancer Society particularly has had a great educational program for many years in the attempt to have patients come much earlier than is now the case. If we could apply the cytologic diagnostic test, for example, to every woman today, we could save thousands of lives, literally thousands, because here is a form of cancer of the uterus which can be cured by surgery, or radiotherapy.

But if we can't get the patient examined properly and regularly, we cannot save lives.

There is a further point that should be made. It is that there is a lack of facilities in many of the community hospitals of the country where there are good men and well trained men and devoted doctors, but without expensive facilities and without all of the supportive therapy that is extremely costly, one cannot do as much for the patient as we hope to do when these regional medical programs bring support to every community hospital that is connected with every center, and every center connected with every other center.

There are many reasons of this kind, but if this country decided today that it was worthwhile saving these 100,000 lives by bringing the financial support and the administrative relationships that would be required, these lives could be saved.

Mr. SKUBITZ. Maybe I misunderstood you. I thought you were saying that one of our first problems is trying to bring about an awareness in the individual of what the danger signals are, and if they could recognize them, and then get to the proper place for proper medical attention, they would be saved. Am I right?

Dr. FARBER. That is point No. 1. Part of it is what the individual patient will do, and part of it is what the doctor will do. But if these patients come to hospitals which do not have facilities, the doctor, who is already tremendously overburdened with the tremendous amount of good that he is doing in general practice, will be unable to give the optimal treatment, because the facilities are lacking, because of the expense of supportive therapy, because of the number of experts in many fields of medicine, surgery, and laboratory science, are not available for the patient.

But if a patient should receive everything that is known today, he will stand a far, far better chance in such a place than he can otherwise.

Mr. SKUBITZ. Thank you, Doctor.

Mr. ROGERS. Thank you very much, Dr. Farber, for your excellent testimony.

Our distinguished colleague, Congressman Kuykendall, will introduce the next witness. We are pleased to have our colleague with us at the committee here and are delighted that you will introduce our next witness.

STATEMENT OF HON. DAN KUYKENDALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mr. KUYKENDALL. Thank you, Mr. Chairman. It is a real privilege to be with the subcommittee for a few moments, and a particular privilege to introduce a man who for several reasons, I think, is peculiarly qualified to testify on this particular bit of legislation.

I think he is qualified for several different reasons.

First, if not foremost, is the fact that our city and area of Memphis is very much a regional city, probably more so than any major city outside of the crowded area of the eastern seaboard, where within 125 miles of our city we have five States. And we have run into problems of Hill-Burton, because of implications of not getting benefits from a regional concept.

We proudly announce that Memphis is a major medical center around our fine university. And Dr. Cannon himself is one of the outstanding surgeons and, maybe more particularly pertinent to this hearing, one of the major contributors to medical education in the whole Nation, having been one of the leaders in the field of medical education for quite some years.

So it is a privilege to introduce my fellow Memphian, a good friend and a leading educator, Dr. Bland Cannon, of Memphis.

Reluctantly, I have to leave now, and go to my committee.

Mr. ROGERS. We understand.

Dr. Cannon, we are pleased to have you and welcome you to the committee.

I understand you have an associate, Dr. Henry Brill.

Dr. CANNON. Yes. I would like to ask Dr. Ruhe, Dr. Brill, and Mr. Harrison to accompany me to the witness table.

Mr. ROGERS. We welcome all of you to the committee and will be pleased to receive your testimony. It is my understanding, Dr. Cannon, that you are representing the American Medical Association in giving your testimony.

STATEMENTS OF DR. BLAND W. CANNON, MEMBER OF COUNCIL ON MEDICAL EDUCATION, AND DR. HENRY BRILL, MEMBER OF COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE, AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY BERNARD HARRISON, DIRECTOR, LEGISLATIVE DEPARTMENT, AND DR. WILLIAM RUHE, DIRECTOR, DIVISION OF MEDICAL EDUCATION

Dr. CANNON. That is correct, Mr. Chairman.

I am a practicing neurological surgeon and a member of the American Medical Association's Council on Medical Education.

With me to present the views of the American Medical Association on H.R. 15758 is Dr. Henry Brill, of Brentwood, N.Y. Dr. Brill is chairman of the AMA's Committee on Alcoholism and Drug Dependence.

Mr. Bernard Harrison is director of AMA's Legislative Department, and Dr. William Ruhe is director of AMA's Division of Medical Education.

The three parts of H.R. 15758 affect three programs of special interest to the American Medical Association. I will comment on the first part which relates to the extension of the regional medical program. The second part proposes an extension of the program for grants for health services for migratory workers. The third part proposes a new program for alcoholic and narcotic addict rehabilitation. Dr. Brill will provide the subcommittee with the association's views on the latter two subjects.

STATEMENT OF DR. BLAND W. CANNON

Dr. CANNON. One hundred and twenty-one years ago, as a result of the concern of the profession with problems relating to the quality of medical education and health care, the AMA was founded. Since that day in 1847, organized medicine has encouraged methodologies of health care which it believes will best provide improved health care for all patients.

The increased longevity which the American people enjoy today is a tribute to medical advances and their application to the health care of the American people. The American physician today is prepared to render the best medical care in the world because he is a product of a constantly improving pattern of the finest medical education and research; because his opportunities for postgraduate education are unexcelled anywhere; and because he has been armed with matchless and ever-advancing diagnostic and therapeutic techniques.

I have made the previous statement, Mr. Chairman, because it should be clear that while we constantly strive for improvement so that what we have today will be better than yesterday, and what we obtain tomorrow will still be better than today, we must not lose sight of the remarkable accomplishments that have been made in health care by our medical educators, medical researchers, and practicing physicians.

In July 1965, when Dr. James Z. Appel, who was then president of the association, appeared before the full Interstate and Foreign Commerce Committee to testify on the bill to establish the regional medical program concept, he voiced the association's concern with certain provisions of the bill then before the committee. Because of the amendments made by the committee, much of our concern was quieted. RMP began auspiciously and, since that time, continues to promise a hopeful future.

But there are still some who would like to see the regional medical program as an instrument by which the organization and delivery of health care to the American people could be changed in some revolutionary manner. Importantly, this does not appear to be the view of those in the administration charged with the implementation of Public Law 89–239.

Dr. Dwight L. Wilbur, president-elect of the AMA, in addressing the conference-workshop on regional medical programs on January 18, 1968, noted that on an earlier occasion Dr. R. Q. Marston, director of the regional medical programs, had said that RMP faces the challenge of influencing the quality of health services without exercising Federal

or State governmental control over current patterns of health activities. Dr. Wilbur then said:

> If the program in fact is clearly one designed to catalyze and to facilitate the development of better programs than now exist to serve patients and their physicians, it will undoubtedly receive enthusiastic cooperation from the medical profession and related groups.

Such support is evidenced by the participation in RMP by some of our outstanding physicians and by constituent medical societies of the AMA. In five of the 54 regions, a State medical society is the program grantee. These are Georgia, the District of Columbia, Nebraska, Minnesota and Pennsylvania. In many of the other regional programs, the state medical society is an active participant.

We view with favor the early progress of RMP, its ability to build on existing patterns of medical care (sometimes adding new features or changing old ones as local demands and resources make possible) and the local flexibility which allows the program to make a real contribution to the health care of our nation.

At the same time, we recognize that the concept of the regional medical program is still in its very early stage of existence and that it is difficult to appraise the program. We do not know, for example, how much this program adds to the stress on an already overtaxed supply of available medical manpower. There is some concern that the proliferation of Federal health programs substantially contributes to the rise in health care costs. For this reason, we are pleased that H.R. 15758 provides for an evaluation of the program. We would suggest, however, that the evaluation begin July 1, 1968, rather than July 1, 1970, since evaluation should be an integral part of the planning. We also suggest that the subcommittee consider further amending section 102 to provide that the evaluation shall be made by a nongovernment agency.

Sections 103, 104, and 106 contain provisions which we believe to be salutary. Section 103 provides for the inclusion of the territories under RMP; section 104 makes combination of regional medical program agencies eligible for planning and operational grants; and section 106 adds a new provision under which grants could be made to public or nonpofit private institutions for services needed by, or which will be of substantial use to, any two or more regional medical programs. We recommend the adoption of all three changes.

As to other amendments, we recommend that the subcommittee delete the open-end authorization for funds for the 4 fiscal years ending after June 30, 1969. In view of the fact that we are still dealing with a relatively untried program, we believe it would be wise to limit the authorization to such sums as this subcommittee may determine to be reasonable, rather than to provide for "such sums as may be necessary for the next 4 fiscal years." Further, with the same concern, we urge the subcommittee to extend the program for a total of 3 years rather than the 5-year extension provided in the bill. Both of the previous witnesses have mentioned 1971 as a landmark in the activation of the program.

Finally, we note that section 105 provides for an increase in the number of Advisory Council members from 13 to 17. As this change is made by the subcommittee, we would suggest the further amend-

ment to provide that four members of the council shall be practicing physicians. The current law requires that only two be practicing physicians. In view of medicine's involvement with RMP, we believe that having a minimum of four practicing physicians would be helpful to the Advisory Council and to the RMP program.

Mr. Chairman, in conclusion, let me say that RMP has stimulated favorable reaction from the medical profession. Some of our distinguished medical leaders are participating in the regional program and many State and county medical societies are cooperating in the planning of the activity. On the whole, we feel that the programs hold much hopeful promise.

With your permission, Mr. Chairman, I would now ask Dr. Brill to continue the association's statement with comments on the remaining provisions of H.R. 15758.

Mr. ROGERS. Thank you, Dr. Cannon. Dr. Brill, the committee will be pleased to hear your testimony.

STATEMENT OF DR. HENRY BRILL

Dr. BRILL. Mr. Chairman and members of the subcommitee: The Medical Association, on March 4, 1965, testifying before the full Interstate and Foreign Commerce Committee on a bill to extend the program for health services to migratory workers, said:

> We recognize that migrant families can and do present public health problems which are beyond the capacity of some small communities to handle efficiently. The Public Health Service has done excellent work in alleviating these problems, and we recommend that the Committee favorably consider the request to extend the program for five years.

Title II of H.R. 15758 would now provide an additional 2-year extension of this program. As we did before, we again recommend this subcommittee's favorable action. With our recommendation of support, however, we add this note.

In the past, there has been a clear, special need involved with the health care of migratory workers. While these people are commonly of the low-income group, their mobility has made it difficult for them to obtain medical aid from established welfare agencies. However, the implementation of the title XIX programs under the Social Security Act would help meet this problem, as it moves to the goal of covering all the medically needy in the State. We believe that limiting the extension of the migratory workers' program to 2 years is appropriate, at which time the program can be evaluated in the light of its proper "phasing out" into the title XIX medical assistance programs.

Now, Mr. Chairman, we would like to turn our attention to the one remaining part of H.R. 15758—title III, entitled "Alcoholic and Narcotic Addict Rehabilitation." Part A of the title refers to alcoholic rehabilitation, and part B to narcotic addiction. Both would amend the Community Mental Health Centers Act.

Part A would provide grants for construction, staffing, operation, and maintenance of facilities for the prevention and treatment of alcoholism under the community mental health centers program. It also provides grants to help communities develop facilities and serv-

ices for the homeless alcoholic, even where no community mental health center exists.

We are in full accord with the provisions of this section which relate to the funding for construction of facilities. The AMA has long stated that "alcoholism is a disease that merits the serious concern of all members of the health professions." At its clinical meeting in November 1967, the House of Delegates of the AMA resolved that the American Medical Association "identify alcoholism as a complex disease and as such recognize that the medical components of this are medicine's responsibility."

It may be of interest to the subcommittee to review briefly the AMA's increasingly active interest in the field of alcoholism over the past year:

We have issued a new manual on alcoholism for physicians, summarizing the essential considerations in the causes, diagnosis, and treatment of this illness;

We are planning an exhibit, based on this manual, for showing at professional meetings;

We issue new material for the public on alcoholism and problem drinking;

We have published a guide for industrial physicians concerning their role in alcoholism programs for employees;

We are encouraging more extensive and comprehensive instruction in medical schools in the nature and problems of alcoholism; and

We are urging that more and more general hospitals admit alcoholics as patients, recognizing that alcoholism is a disease that should not be treated in isolation but one that needs the concern of the total community.

H.R. 15758 gives strong encouragement to the integration of services for alcoholic patients with other mental health services in the community.

It underscores the complexity of the disease and correctly recognizes that it should not be treated as an isolated condition.

In addition, by making provision for the homeless alcoholic, irrespective of the existence of a community health center, it wisely attempts to cope with what promises to be a growing problem in the view of recent court decisions. These decisions have regarded the public drunkenness of an alcoholic as a symptom of his disease, rather than an offense punishable by jailing.

The preponderant number of persons arrested for this offense have had no adequate shelter, let alone medical attention. Very often, they look upon a jail cell as a welcome roof over their heads. Now, a substitute, and a more meaningful one, linked with adequate treatment programs must replace the cell.

We hope that these facilities will be forthcoming, not only directly through this legislation, but under private auspices, as well, encouraged by the expression of the national policy which this bill reflects. We recommend your support for the construction grant provision. However, we have long felt that funds for staffing and operation are properly the responsibility of the community, once the major burden of construction has been met with Federal assistance.

Part B would provide a similar program for narcotic addict rehabilitation. This section, in effect, supplants that portion of the Narcotic Addict Rehabilitation Act which seeks to assist States and communities in programs of aftercare. It amends the Community Mental Health Centers Act to provide grants for specialized prevention, treatment, and rehabilitation services. Again, we applaud the move to integrate treatment and aftercare for an identifiable group of sick persons in to the totality of community services. We note, however, that there is no provision for the homeless addict similar to the provision for homeless alcoholics. We believe that communities, irrespective of whether they have comprehensive mental health centers, should be encouraged to make adequate shelter facilities available for narcotic addicts and we recommend to this subcommittee that a provision for grants for this purpose be included.

As we have stated with respect to the provision for alcoholic rehabilitation, we support Federal assistance in grants for the construction of the necessary facilities, but would urge that funds for operation and staffing be the responsibility of the participating communities.

Finally, we suggest that the subcommittee specify the sums to be authorized under both programs, rather than the open-end authorization as stated in part C.

Mr. Chairman, with regard to both the alcoholic and narcotic addict rehabilitation amendments, we are hopeful that this legislation will reinforce the determined efforts of all of the health professions to prevent, to control and to treat all aspects of drug dependence, of which alcoholism and narcotic addiction are a part.

Mr. Chairman, both Dr. Cannon and I thank you and the members of your subcommittee on behalf of the American Medical Association for this opportunity to comment on this important legislation. We will be pleased to attempt to answer any questions the subcommittee may have.

Mr. ROGERS. Thank you very much, Dr. Brill, for your statement, too, and these statements that have been presented on behalf of the American Medical Association.

As I recall, too, Dr. Brill, didn't you help us on the Drug Abuse Control Act?

Dr. BRILL. Yes, sir. I remember well.

Mr. ROGERS. We appreciate your coming back to help us again.

Mr. Kyros?

Mr. KYROS. Thank you, Mr. Chairman.

Dr. Cannon, on page 3 of your statement, sir, you say that any evaluation that will be made of the effects of the regional medical program you prefer should be made by a nongovernmental agency.

Whom are you suggesting?

Dr. CANNON. There are agencies that do evaluations of programs. There is the Stanford Institute. I think that the administrators of the program would want to select a nongovernment agency anyway for its evaluation.

I think objectivity of such an evaluation would be of more benefit to them. I think they realize that.

Mr. KYROS. What is there so far in the operation of this act, especially the section on evaluation, that concerns you at all about this

objectivity? Is there any question that they wouldn't be looking for the full effects of how to make the program effective, and couldn't they have the feedback effect of learning something while they are evaluating?

Dr. CANNON. No doubt, but I think they could improve it by having someone from the outside look at their house.

Mr. KYROS. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I want to congratulate the distinguished gentlemen on their presentations here today. There is in the planning stage now, within this committee, on the advice of our chairman, a plan to evaluate some of these programs.

We do have a very efficient organization in the General Accounting Office which evaluates these things for us, and it is responsible only to the Congress, and not to the executive department, which does do excellent audits for us, and has done them in the past.

This is a very good agency which is responsible to us and does work for us. I don't think it is biased, do you, Mr. Chairman?

Mr. ROGERS. We hope not.

Mr. CARTER. It hasn't been in some work they have done for me. But certainly we would consider, or I would consider, a nongovernmental agency. However, we do have confidence in the General Accounting Office, because they usually——

Dr. CANNON. Dr. Carter, I did not mean that there was bias in evaluation of the program. I think that there are institutions available that can give expert analysis that may be of great value to this program.

Mr. CARTER. Yes, sir.

Dr. CANNON. And knowing those who are administering this program, I have the utmost confidence that they will seek such advice. This doesn't mean that you should not have someone else evaluating it, too.

Mr. CARTER. I believe in evaluation to see where we are and to see if we are spending our money wisely.

Dr. CANNON. My statement about objectivity didn't imply bias.

Mr. CARTER. Thank you, sir. We appreciate that.

Now, so far as open-end authorizations are concerned, as a usual thing they just don't happen in this committee. Usually it is limited to 3 years. Am I not correct in that, Mr. Chairman?

Mr. ROGERS. Yes.

Mr. CARTER. In a general rule that has been followed in the committee, it is usually limited to 3 years in authorizations. So I think that it is in agreement with your paper.

Our bill, I believe, is in agreement with Dr. Brill, also, in that the program concerning migratory workers is for 2 years, as he suggested, and we do have a great many problems with alcoholism, and we do recognize it as a disease.

It is regrettable that some of our governmental agencies haven't taken to this idea, however, because it is very, very difficult for us to obtain admission to a veterans hospital for an alcoholic—very difficult. In fact, it is almost impossible at times.

I should like to see this changed somewhat.

I notice the agreement in the construction of facilities for care of alcoholics and addicts. Certainly, I am in agreement with that. Here is the hard part, the difficult part, for some parts of our country. If we come from a wealthy area, it is easy for the area to provide funds for operation. But if you happen to come from an impoverished area, as it happens I do, it is very, very difficult, down in Appalachia, to get the funds for running such an institution.

At the same time, we have the same problems there which they have in wealthier communities, and I would hope that we would be a little bit charitable to our less fortunate brothers.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you, Dr. Carter.

Mr. CARTER. I want to compliment you, again, gentlemen, on your excellent presentation.

Mr. ROGERS. Mr. Skubitz?

Mr. SKUBITZ. Dr. Carter raised a question that I had intended to ask.

I am wondering whether we shouldn't limit these authorizations to 1 year. When we authorize for 3 and 4 years, the departments do not have to appear before us and justify their program, or tell us what they have done. They are through with us. Would you oppose 1-year authorizations?

Dr. CANNON. I think that 1-year commitments could create difficulties.

Mr. SKUBITZ. This doesn't stop the agencies from planning for 4 or 5 years. It means they are to come back and report to us and tell us what they are doing.

Dr. CANNON. There may be difficulties in effecting the program, in hiring personnel, and many other things, but we wouldn't be opposed to your annual evaluations and appropriations. I mean, that is a decision for your committee.

Mr. SKUBITZ. I don't think the committee wants to abandon the program. But this is the committee that listens to the testimony.

I think it is important for the agencies to come back and tell us what they have done and justify the money they need for the next year. Otherwise, the departments are on their own. We have no control.

Dr. CANNON. We are tremendously pleased and have commended this committee for its perceptivity in organizing this program into a meaningful piece of legislation. We still have that confidence in your judgment.

Mr. SKUBITZ. I notice, for example, in this particular bill there was an authorization for $100 million in 1967. This makes it appear that the program is starting to level off at this time. It doesn't make sense to me.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you very much.

Dr. Cannon, I notice you still express some concern that this program might be used to bring about some change in a revolutionary manner in health care of the American people.

Is this widely felt in the medical community?

Dr. CANNON. I think that there still exists an aura of concern, because some might interpret the legislation to mean that it can effect the standardization of health care.

Mr. ROGERS. I thought we had dispelled that in writing the bill. We made every attempt to in this committee. I recall the concern when the bill came out of the Senate. It would have put up medical complexes where patients could be referred, and so forth. But we changed the concept of the program in this committee, as you may recall, and, I hope, dispelled this idea. And I would hope the American Medical Association could dispel that viewpoint.

Dr. CANNON. I think the amendments have been very gratifying, but the shock wave initially was rather great. And, as you know, this is something that we have had to gradually overcome.

Mr. HARRISON. May I comment, Mr. Chairman, that as indicated by Dr. Cannon in his statement, that because of the amendments made by this committee at the time it passed on this bill, the fears and concern of the association were somewhat quieted. And while there still remains some concern, we have seen much hopeful promise.

We have been very much appreciative of the work done by this committee in the adoption of the initial program.

Mr. ROGERS. Thank you.

I notice you express concern on page 3—you don't know yet how much this program may add to the stress of an already overtaxed supply of available medical manpower.

It was my concept in the original legislation, and from hearing testimoney, that rather than add a burden to manpower, this would perhaps serve as an easing of manpower, because the theory was that you could quickly get to the doctor in his own locality the latest treatments, the information of the latest treatments, and so forth. And teams could be brought in from the university centers to work with them in a cooperative spirit, where it didn't take the time of the local man to have to go someplace for 2 weeks in the summer to do the continuing education that we carry on now. Communications would be improved, and this was, I thought, a hopeful way of helping to ease the manpower problem rather than put a burden on it.

What is your feeling on that?

Dr. CANNON. I think your point is well taken. The average practicing physician is somewhat in a box for time. He bounces around and can't really break away from an educational experience.

However, many men, as you know—I would say most of them—are dedicated to continuing self-education.

What I had reference to here was the number of personnel, the demands on an already scarce commodity has been increased, and the utilization of those people who are trained in medical care to administer programs, to particitape in them, to teach, to set up units. We don't have any specific figures, but we are concerned.

Mr. ROGERS. I am interested in having information along this line, because I would see it operating just the opposite, and I would hope it would.

Dr. CANNON. May I ask Dr. Ruhe, who is director of our Division on Medical Education, to comment?

Mr. ROGERS. Yes.

Dr. RUHE. I believe what you said will ultimately be the case. In the planning and early operational stages, however, it has been necessary for all of the regions to accumulate rather large staffs of professional people to administer the program and to direct it.

As I recall, and I am not certain this is the exact number, but I recall one of the larger regions estimated that it would need approximately 90 professional people.

Mr. ROGERS. All doctors?

Dr. RUHE. Not necessarily M.D.'s, but persons at that comparable degree level, in order to carry on the administrative work and the direction of the program. Thus, one of the immediate effects has been a rather considerable increase in the competition for—that isn't perhaps the right word—but in the available opportunities for employment of professional people at the administrative level.

We have noticed this already. I think it has been noticed in the medical schools which have been actively involved in the regional activities. It has been necessary for them to add additional faculty and administrative personnel in order to discharge their responsibilities under the program.

These people have to come from somewhere. They were not in great supply before. A number of them have come out of practice, and while we feel ultimately this may result in more efficient utilization of health care services, we think there is an immediate effect here in providing some competition for manpower in the health field.

This is, I think, the basis for this statement.

Mr. ROGERS. Well, now, what I wondered was this: For instance, I envisioned the fact that you would carry on a continuing education program, perhaps through television, where you have an expert in a medical center giving instruction to your local hospitals in a certain treatment that may have just come out; so that you don't have to send instructors out to each hospital, or have each doctor come in and take that time to come to the medical center. But the communication is one of the means that you are going to cut down on the use of manpower, I would hope.

Is this envisioned?

Dr. RUHE. Yes; it is.

Mr. ROGERS. So there are so many things where I think you would be saving the time of the local doctor; so you don't have to have five doctors where one doctor may do the work of two doctors—for instance, where he performs his exam and wants a reading on an X-ray, and he sees something that is wrong, but he can get it in the medical center where it comes back immediately with a communication on the diagnosis.

Isn't that going to save him time and enable him to see more patients?

Dr. RUHE. I think in time it will.

Mr. ROGERS. Right; and this is what we are concerned with, getting the health to the people, and this is the reason this program was envisioned and adopted, I think.

Mr. CARTER. Mr. Chairman, will the gentleman yield?

Mr. ROGERS. Yes.

Mr. CARTER. I want to say something in behalf of the general practitioner in this case, if you plase. I don't think we should sell him too short. He is a man who is known by the fruits of his labor. If he doesn't produce, certainly his practice is going to fall off, and he does take part in schools. He goes as a member of the Academy of General Practice. He is required regularly to go to school.

Our universities, too, in cooperation with the medical associations, do provide aid and visiting physicians who come to our hospitals throughout rural America to teach us, and we are glad for this.

The general practitioner in most cases, if he is efficient and effective, he has developed channels of communication with universities, and surgeons and dignosticians who can be of help to him.

Most of our community hospitals, I would say, have a qualified radiologist who read their films from time to time. So we have most of these programs already. They have already been developed by private initiative, forced by the necessity of doing the best type of work.

And I should say that most general practitioners do these things.

This program, as I see it, is to complement the program which is already existing.

Mr. ROGERS. I am not trying to run down the general practitioner. I think he has done a grand job. We want to help him to do a better job for the American people.

I agree with you. I think he has done a great job. We want to help him do a better job with this program. This is a program, really, for the doctors, so I would understand why the American Medical Association would support it. It is really basically for the doctors, to be helpful to them in giving good treatment.

Dr. CANNON. Mr. Chairman, may I comment on your statement?

Mr. ROGERS. Yes.

Dr. CANNON. This is, in essence, why we believe in the expansion of the Advisory Council. We believe it is wise to take two new members from the practicing profession.

Mr. ROGERS. I think it is a good suggestion. I think we should have practicing people, and I don't think we are getting enough hospital people in there, either, Dr. Cannon. I think we are getting too many educators. This is natural at first, and we need them.

But we have overlooked in this program, to date, I think, bringing in a more active participation by practicing physicians and by hospital administrators, and some of the people who are actually involved with providing some of these services and where the critical units should be.

We need a more practical approach in the implementation of what is a good program in theory, and I think your suggestion is good.

I might state that I think the only group that requires continuing education is your group of general practitioners; does it not? Your specialties don't require continuing education. Perhaps they will. This will be good.

Dr. CANNON. By our negative reward system, they require it.

Mr. ROGERS. I am sure all the doctors try to keep up as best they can. It is not easy.

I can assure you this committee is not going to go for open-ended funding. We have made it a practice, as has been expressed by my colleagues here. We will set a certain sum to be authorized, and our normal procedure has been a 3-year program.

Let me just ask a couple of questions quickly, since our time is running out.

Doctor, I wonder if, on the alcholic and the narcotic provisions of this legislation, you endorsed building these residential areas, the quarters for homeless alcoholics and homeless narcotic addicts.

Dr. BRILL. Yes, sir.

Mr. ROGERS. Do you envision this as part of the community mental health center, or a separate facility?

Dr. BRILL. It can be a separate facility. Where it is feasible, it can be part of the center, but it can also be associated with the mental health facility or it can be separate.

Mr. ROGERS. How can we keep them in it?

Dr. BRILL. There are a considerable number of persons of this type who will stay voluntarily if shelter is offered. They need this as reentry into society. If they come from a treatment facility into a community, they tend to go back——

Mr. ROGERS. This would be a sort of a halfway house?

Dr. BRILL. Yes.

Mr. ROGERS. They would still have to go to a treatment center or to the mental health center in the community?

Dr. BRILL. This can be used in a flexible way. It can be used for those who can't find their way but need sheltered care for a period of time.

Mr. ROGERS. Are there any estimates on how many need this type of shelter? I would appreciate it if you could provide that for the committee.

(The following letter was received by the committee:)

AMERICAN MEDICAL ASSOCIATION,
Chicago, Ill., April 3, 1968.

Hon. JOHN JARMAN,
Chairman, Subcommittee on Public Health and Welfare, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. JARMAN: During testimony on H.R. 15758 on March 27, 1968, representatives of the American Medical Association were requested by Representative Paul Rogers to supply information as to the need for half-way houses for alcoholics and narcotic addicts under Title III of the bill.

The present estimate of the number of alcoholics who would benefit from the availability of half-way houses ranges between 150,000 and 200,000. Their distribution is generally throughout the United States, with the greatest need being in centers of population.

The estimate of narcotic addicts who would benefit from the availability of half-way houses is 3,000. Approximately one-half of these individuals are located in New York City, with the remainder being distributed throughout the centers of population.

In sincerely hope that the above information will prove useful to your Subcommittee in its deliberations on Title III of H.R. 15758.

Sincerely,

F. J. L. BLASINGAME,
Executive Vice President.

Mr. ROGERS. What about narcotics users? Are there about 60,000?

Dr. BRILL. 60,000 known ones.

Mr. ROGERS. Would you envision this being done by a grant program?

Dr. BRILL. The narcotics problem is in half a dozen big cities.

Mr. ROGERS. You don't envision doing this in every community health center in the country?

Dr. BRILL. No; I don't think that is necessary.

Mr. ROGERS. How about alcoholics?

Dr. BRILL. That is diffused.

Mr. SKUBITZ. In Chicago, they have 250,000 alcoholics.

Dr. BRILL. May I say that the total number of alcoholics, of course, includes a great number of people who wouldn't need this sort of shelter. This refers to the Skid Row alcoholic, who is really a minority.

Mr. ROGERS. I understand it is estimated in the country that there are 200,000 to 300,000.

We have a distinguished colleague from Illinois, who may know about the Chicago problem. Congressman Springer is here, our distinguished minority leader on the committee, and he may have some questions.

Mr. SPRINGER. Just one or two, Mr. Chairman.

Doctor, were you any part of the AMA structure at the time we passed the heart, stroke, cancer bill?

Dr. CANNON. If "structure" is an all-inclusive term, I certainly was. But I was not one of the spokesmen at that time. I am aware of the statements that were made.

Mr. SPRINGER. Well, never will I accept the testimony of anyone who comes before this committee as an expert on a program until I am more than satisfied.

The gentleman from Florida and I kept this thing within what we thought were reasonable boundaries at that time. It came over here from the Senate with one and a half days of hearing at $970 million, almost a billion dollars to start a program, and I have never seen such an array lined up for that bill, and I almost swallowed it, until I went home and thought about it. Then I just began to make some investigations to find out what should be done.

And despite all the mean things that were said about the distinguished gentleman from Florida, and me, too, during that time, that we were keeping that bill from coming to the floor, we finally got it out at $320 million. We didn't let it out until they agreed in the other body that they would pass our bill.

If my figures are correct, we are almost at the end of 3 years, and out of what they called a piddly little $320 million, they have been able to spend $85,200,000 to date.

I am coming back to this for one reason only, and that is that you are now asking for $65 million for the fiscal year 1969, and nothing has been said, I take it, Mr. Chairman, with reference to any possible remaining 2 years.

Mr. ROGERS. It has been said, and they are submitting the figures.

Mr. SPRINGER. I am glad to see that.

I come back again to my colleague in saying that at the time you were speaking on this before, your people doubted that this program could be undertaken. They went on and pointed out why, in terms of personnel available and so on.

I am glad that what you said and what I said and Mr. Rogers said, and a few others on this committee, has come true. Only it has come even more true than we anticipated. This is about the only time we have overevaluated a program.

This was a program that I supported energetically, once I thought it was within some reasonable means. But I merely point this out, that I am extremely skeptical of anyone who comes before us with figures unless they can be justified.

This was, may I say, what I considered to be the best testimony in the country. But you ought to go back and see that testimony, from Dr. DeBakey on down. It was presented before this committee, to justify a program for a billion dollars, which turned out 3 years later to have spent $85 million.

I just want to put that on the record, because I think it ought to be brought out here that what we get in the way of landslide testimony here is a selling job and snow job claiming that something can be done immediately.

Mr. SKUBITZ. Mr. Chairman, will my colleague yield?

Mr. SPRINGER. Yes.

Mr. SKUBITZ. Was $320 million authorized and $320 million appropriated?

Mr. SPRINGER. Fifty-nine and 200.

Mr. SKUBITZ. But how much money was appropriated?

Mr. SPRINGER. $85,200,000.

Mr. SKUBITZ. That is all they spent. How could they spend any more if more wasn't authorized?

Mr. SPRINGER. The fact is they didn't spend all that was appropriated. They appropriated more than $85 million.

Thank you, Mr. Chairman.

Mr. ROGERS. Thank you.

I do think it might be brought out at this point that I would commend the administration of the program in the fact that they haven't just gone out and spent money. So I think this is rather commendable, that they have held up some 8 million on last year because they felt they were not at a stage to spend it.

So this is commendable, and I would want to put that on the record, too, that we don't want them, just because we may authorize something on it may be appropriated, that expect them to go out and spend it unless they are at that point where it could be done effectively.

So I think whether we reach goals that we may have set is not necessarily the determination on the spending of the money. We want to make sure that it is appropriately spent and even though the goals may have been set above that.

So I think the administration of it has not been in error in that regard.

Dr. RUHE. May I comment on that?

I think we would support this fact. We have been reassured and encouraged by the way this program has been administered. I think in defense of the program, one thing can be said, that in the early stages, very careful attention has been given to the planning and the preparation for the operational stage of the program. This has been one of the things which has kept the expenditures down at the present time.

But as the program gets moving into the operational phases, I think it is reasonable to expect that the costs would increase greatly.

We feel that the program has been administered very well, and with restraint and good judgment.

Mr. ROGERS. Thank you.

Mr. SKUBITZ. That brings me back to the question I raised a few moments ago, the necessity of limiting these authorizations and having the agencies come back and present their case and prove their point.

If we authorize for 3 years, they don't have to come back. From that moment on they go before the Appropriations Committee——

Mr. ROGERS. This is right.

Dr. RUHE. There is one problem in that, if I may. That is, from the standpoint of the region which is attempting to recruit personnel, if

there is any question whether the program is going to be continued for the indefinite future, it would be extremely difficult to get good people to change their careers and come into this program.

Mr. SKUBITZ. Doctor, you sound like a Government bureaucrat. We hear the same statement time and again we must have a 3- or 4-year program, or we can't get the people. But for some reason, the Government has no trouble hiring people.

Mr. ROGERS. It may be the doctor is looking at what happened to the Congress on only a 2-year contract, and he is disappointed.

[Laughter.]

Mr. HARRISON. I would like to comment on Mr. Skubitz' question, The association would generally support, if it was the committee's good judgment, an authorization for a single year which would require the program people to come back and give the committee an opportuntiy to examine the program again. If that was your judgement, and we would support that movement.

Mr. SKUBITZ. You had better stay with the chairman. I am the low man on the totem pole.

[Laughter.]

Mr. ROGERS. As a matter of fact, Mr. Skubitz, you might be interested to know that we did a special study on HEW and recommended yearly authorizations.

Mr. SKUBITZ. I am glad to hear that.

Mr. ROGERS. We haven't been able to move it in committee yet.

Thank you very much. Your testimony has been most helpful.

Dr. CANNON. Thank you, Mr. Chairman.

Mr. ROGERS. Our next witness is Dr. William Likoff, immediate past president, American College of Cardiology, from Bethesda, Md.

We are very pleased to have you with us, Dr. Likoff.

STATEMENT OF WILLIAM LIKOFF, M.D., IMMEDIATE PAST PRESIDENT, AMERICAN COLLEGE OF CARDIOLOGY; ACCOMPANIED BY WILLIAM D. NELLIGAN, EXECUTIVE DIRECTOR

Dr. LIKOFF. I am pleased to introduce William Nelligan, executive director of the college.

I appreciate the privilege of appearing before this committee to present the views of the American College of Cardiology regarding bill H.R. 15758.

The goals and philosophy of Public Law 89–239, the progress recorded by the regional medical program during its short life and the future promises embodied in this endeavor are pertinent to your current considerations and, therefore, prompt this testimony.

Medical science in this country is favored by superb talent, competence, and abundant resources. This committee, however, is particularly aware that the distribution of these assets, specifically in terms of patient care, is shamefully uneven. The basic goal of Public Law 89–239, the authority for the regional medical program, is to bridge this unequal gap between science and service and to provide an efficient health care system which will assure the transmission of the best in scientific knowledge to all people of this country suffering from heart disease, cancer, and stroke, or struggling to avoid these catastrophies.

The concept regulating the regional medical program is remarkably simple and in the best tradition of this country's genius for effective action. It holds that modern medical advances can be made available to all people when needs are identified at a regional level by individuals involved in regional affairs and when available resources and manpower are properly exploited through cooperative arrangements linking discovery with learning and application.

Critical analysis of the activities of the regional medical program uncovers an unusual record of accomplishment toward that goal over a relatively short period of time. Federal funds have stimulated the planning for a health care system in approximately 50 regions encompassing about 90 percent of this country's population. Operational programs have been activated in 11 additional regions.

Solicitations for planning and operational grants for areas not yet involved are being constantly prepared and reviewed. The speed with which Public Law 89–239 has exercised its impact and the wide area of its maturing influence is most impressive almost denying the complexities of establishing a new administering organization and staff within the Public Health Service and the difficulties in assembling for planning and action representatives of diverse scientific and consumer groups in a myriad of local communities.

The first dynamic engagements with the problems of organization, defining regional needs in health care and interrelating local resources for their correction have revealed a number of specific facts. Those who have worked in the field developing a program for a specific region, almost without exception sense that institutions and men representing medical, paramedical, and consumer interests welcome the challenge and opportunity to serve. They are applying themselves unstintingly to the search for sound administrative structures and for effective voluntary cooperative arrangements which will assure the success of the program. They share a positive view about the likelihood of obliterating the void now separating the conversion of knowledge to service. They appreciate local needs and they are creative in their plans to meet them. From early experience it also appears that the funding provisions of the act are adequate and that the Public Health Service is awarding these funds judiciously and in keeping with the needs and sophistication of the applications from the petitioning regions.

However, and in contrast to some of the statements made to this point, the community is extremely sensitive to the limitations imposed by the fact that the program has not been established on a continuing basis. The paradox of contesting with long-term needs and long-range objectives under the umbrella of a short-term act is uncomprehensible. It impairs the harnessing of manpower; it constricts programs to the immediate; dedication is diminished; promise is aborted; potential threatened. In a frank acknowledgement of clear fact, Public Law 89–239 has evoked the type of robust response that deserves the assurance of continuing support and inclusion of logical areas of involvement not heretofore embraced. At least a portion of these are recognized in H.R. 15758. Certainly the provisions to involve areas outside of the 50 States is consistent with our traditional obligations; those improving implementation through interregional cooperative, those seeking involvement of Federal hospitals and providing for construction funds are necessary logistically and functionally.

The American College of Cardiology enthusiastically endorses the objectives and philosophy of the regional medical program because they embrace an unchallenged need and seek to use forces which require only release and coordination. We support the planning and operation of every regional program where we possess manpower and resources.

The college is certain the program will elevate the health of the Nation. It pleads for a favorable action on bill H.R. 15758. This amendment to the Public Health Service Act extends and expands the medical regional program to a new and amplified potential and hopefully to the status of the most distinguished medical program conceived in our time.

I am grateful for the opportunity of expressing these views.

Mr. ROGERS. Thank you very much, Doctor. We appreciate your testimony.

Did your associate have any statement?

Mr. NELLIGAN. No, sir.

Mr. ROGERS. Doctor Carter.

Mr. CARTER. No questions.

Mr. ROGERS. Mr. Skubitz?

Mr. SKUBITZ. No questions.

Mr. ROGERS. I might say that the committee, in adopting a 3-year program rather than a 5- or 10-year program, feels that this is one way for this committee to carry out its responsibilities to the Congress and the American people, because otherwise we have no review of the program.

Dr. LIKOFF. I understand that philosophy, Mr. Chairman, but I do wish to tell the committee, and particularly Mr. Skubitz, that we in the field have found it difficult to construct long-range, vital organizational programs and planning in view of the uncertainty from time to time of the funding required to support these ventures.

Something we plan for a decade ahead cannot be accomplished on 2-year appropriations. How you get Government workers under these conditions, I don't know. We are having difficulty.

Mr. ROGERS. I am sure it would be desirable to set programs for as much time as we wanted with as much money as was wanted, but we have to equate the economy of the Nation. But this is the committee's function, and that is what we will do.

We are grateful for your testimony in support of this legislation. It will be helpful to us in our consideration.

Our next witness is Dr. Clark Millikan, of the Mayo Clinic, who will appear and give testimony for the American Heart Association, Inc.

Dr. Millikan, we are delighted to have you here, and will be pleased to have your testimony.

If you would like to put your statement in the record and just sum up for us, it would be acceptable, or if you prefer, read it.

STATEMENT OF DR. CLARK MILLIKAN, CHAIRMAN, COUNCIL ON CEREBROVASCULAR DISEASE, AMERICAN HEART ASSOCIATION

Dr. MILLIKAN. Mr. Rogers and members of the subcommittee, it is not only an honor, but a responsibility, to take part in the construc-

tion of the continuing legislation. I would prefer, actually, to just make some comments.

Mr. ROGERS. That will be done. Without objection, Dr. Millikan's statement will be placed as part of the record following his remarks.

Dr. MILLIKAN. I represent the American Heart Association, being chairman of the association's council on cerebrovascular disease.

This program has turned out to be a unique opportunity and a practical, recognizable entity for cooperative and collaborative arrangements, not only between the university centers and practicing physicians but between government and nongovernment agencies and personnel.

The Heart Association, for instance, has taken an extraordinarily active part all over the Nation, not only at the level of regional advisory committees but in smaller community affairs. Last week there was a meeting in New York at which over 400 volunteers were present, and one of the firm decisions arrived at at that meeting was to encourage further the participation of Heart Association personnel, which can bring a great deal to the implementation and the purposes of the past bill and the new bill.

This exemplifies the kind of feeling and the loyalty, for instance, that is being generated by the very wise provisions of this act, and we heartily endorse the continuation of these basic principles, including the business of originating ideas at the local level and having administration remain at the local level.

Commenting about the matter of the finances, $65 million is a suggestion for fiscal 1969, and as is brought out, there is to be some holdover.

You are aware that there are now actually about 11 operational programs, and within the next few months there will be a total of 30 to 35 operational programs. It is extraordinarily important to consider that we are thinking in terms of a graph of continuity here. And as this program develops effectively, gaining momentum, it is mandatory that we not put a fence in front of it at any point in time with the attendant loss, in possible instances, of personnel.

This whole program relates to people, whether at the administrative end or the practicing physician end, or at the patient end. And if we do something which cuts back the momentum in the year 1968 to 1969, we have lost more than 1 year of progress, and so I would emphasize the need for the continuity of fiscal support for this whole business.

Now, on the matter of construction money, that has come up in reference to the new bill.

It would seem highly important that there be authorization for this. As Dr. DeBakey mentioned and Dr. Farber added, there are areas of activity for which new construction funds will undoubtedly be necessary at the level of 2, 3, or 4 years from now, which should be evaluated at that point in time. It does not need to be done now in terms of assigning an amount of money. But it should be looked at precisely later on.

But the cardiac intensive care unit, or a stroke unit, or a matrix which requires space—that is not the issue at the moment. But for adequate planning in the future there should be the authorization

for the potential of including new construction somewhere in the course of time.

Now, a comment in the area of stroke, because this is the area of my particular interest.

The American Heart Association has been much interested in stroke and has formed a council on cerebrovascular disease and has been active in promoting teaching and spreading the word in communities.

I believe that RMP offers us an opportunity to produce a greater matrix where we are really going to do something about stroke.

You are aware of the need for treatment in terms of acute facilities for rehabilitation, reentry of the patient into the community, but we are now beginning to accumulate data which, if we can get the information to the population and to the physicians, will significantly affect stroke prevention. And this is the kind of thing that RMP is designed to do, among other things.

One of the most interesting items that is coming on the agenda now is the word "hypertension," or high blood pressure, and we now have definite epidemiological evidence through programs which have been supported and originated by you people that hypertension is as important in stroke as it is in heart disease, certain categories of heart disease in particular, and that via the detection and treatment of hypertension, we may cut significantly down on the incidence of stroke.

The Heart Association is designing programs to interrelate to RMP and provide screening and detection mechanisms to find these people. Some 20 percent of hypertensives are not even detected at this point in time.

In relationship to the very important subject of hypertension, the regional medical programs offer an excellent matrix for the evaluation of antihypertensive drugs. As programs for screening, detection, and diagnosis of high blood pressure are constructed, funds should be available for evaluation and comparative trials of drug agents; including drugs already known and those which will come out of developmental laboratories.

These are simply summaries of some of the comments that are in the formal record. I don't want to belabor these issues, but to me, we are dealing with the national resource, the health of our people, and we couldn't be discussing a more important subject.

I congratulate and commend you on all of the things that you have done, and in this particular frame of reference your wisdom in guiding RMP has been unique.

(Dr. Millikan's prepared statement follows:)

STATEMENT OF DR. CLARK MILLIKAN, CHAIRMAN, COUNCIL ON CEREBROVASCULAR DISEASE, AMERICAN HEART ASSOCIATION

I am Dr. Clark Millikan, Chairman of the American Heart Association's Council on Cerebrovascular Disease. Representing the Association I welcome the opportunity of testifying in support of H.R. 15758, the five-year extension of the Regional Medical Program (P. L. 89-239). As one of the organizations instrumental in promoting the original Regional Medical Program in 1965, we are pleased with the significant contribution it has made to the application of new medical knowledge to the diagnosis and treatment of heart disease and stroke. We are particularly pleased that the Regional Medical Program has provided, as intended, an effective vehicle for governmental and non-governmental cooperation in combatting the three diseases taking the greatest toll of life in

American society. Maximum responsibility has been on local leadership and regional cooperative arrangements.

Heart Associations across the country have been active on almost all Regional Advisory Committees planning programs, gathering data on health manpower requirements and analyzing available health facilities and services. We expect continued participation during the five years of the proposed renewal as the emphasis of the program shifts from the planning to the operational phase.

Last week in New York City 400 American Heart Association volunteers and staff from across the nation planned ways in which we can improve our program. One entire discussion group was devoted to the interrelationship of the Regional Medical Program and the American Heart Association. We discussed the ways in which the relationships between Heart Associations in the various states and the governmental agencies in their areas could be reinforced. It was decided at this national meeting that part of our future program would be to encourage our membership to take every available advantage of Regional Medical Programs, so that Heart Associations would be playing their maximum role to the maximum benefit of their communities.

The original law provided over a three-year period increasing grants of from $50,000,000 to $200,000,000 for the fiscal year ending June, 1968. We note that H. R. 15758 specifies $65,000,000 for fiscal 1969 and "such sums as may be necessary for the next four fiscal years." We are aware that nearly $35,000,000 of unobligated funds are available in addition to the $65,000,000 provided in this bill for the next fiscal year. However, we would prefer that specific funding for fiscal years 1970 through 1973 had been included in this bill to assure the maximum growth of this successful program.

If the $65,000,000 for fiscal 1969 is appropriated and authorized, we understand 30 of the 54 Regional Medical Programs will be receiving their initial operational grants and 14 will be in their second or third year of operational grant activity. It is to be expected that in the following four years operational requirements will increase; yet the legislation under consideration here today leaves the program to the unknown quantity of annual Congressional appropriations after fiscal 1969. We have some reservations as to the wisdom of this approach since long-range planning is essential to the success of this program. One final word as to funds, we stress the minimal necessity of the full $65,000,000 requested in H. R. 15758 for 1969.

Among the promising developments in the Regional Medical Program of particular interest to us has been the recent emphasis on extending the development of coronary care units and the necessary trained personnel to hospitals not now having these life-saving facilities. It is our understanding that the Regional Medical Program has many applications for funds for this purpose. We thoroughly applaud the establishment of these life-saving facilities in every hospital caring for coronary artery problems and hope that in the future even more funds will be available for coronary care units.

As the Chairman of the American Heart Association's Council on Cerebrovascular Disease, I can speak with particular knowledge of the constructive purposes the Regional Medical Program has and will continue to serve in mobilizing professional attention and funds for community-wide stroke detection programs and treatment. Teaching units in many medical schools have shied away from involvement with the stroke patient. As part of the planning and operational grants of the Regional Medical Program, new interest in this problem has been stimulated in a constructive way. This promising development must be encouraged in the next five years of the Regional Medical Program and adequate funds supplied for this purpose.

Section 103 of the bill extends the Regional Medical Program to areas outside the United States which should be the beneficiary of this program. We endorse the inclusion of Puerto Rico, the Virgin Islands, Guam, American Samoa and the Trust Territories of the Pacific Islands. Value to citizens of the states within the United States should not be hoarded but shared with areas not part of, but historically connected to the United States.

Additionally, the American Heart Association endorses the use of grants for two or more Regional Medical Programs, as proposed in Section 910. This provision will permit the economical development of teaching films, videotapes and other educational materials for use by several regions on a national basis. This provision also permits the kind of flexibility the American Heart Association has always envisioned for this program.

The inclusion of referals to Regional Medical Program facilities by practicing dentists proposed in Section 107 is of particular importance. Dentists can play an important role in preventing the recurrence of rheumatic fever and bacterial endocarditis if aware of this opportunity. Their inclusion along with physicians in this program is therefore of significance to the alleviation of some forms of cardiovascular disease.

In relationship to the very important subject of hypertension, the Regional Medical Programs offer an excellent matrix for the evaluation of anti-hypertensive drugs. As programs for screening, detection and diagnosis of high blood pressure are constructed, funds should be available for evaluation and comparative trials of drug agents; including drugs already known and those which will come out of developmental laboratories.

Finally, the American Heart Association endorses the inclusion of federal hospitals (Section 107) in the total operation of the Regional Medical Program. The broadest possible range of community medical facilities enlarges the scope of health services to the public contemplated in the original purpose of the program.

Despite one reservation expressed at the beginning of this testimony, the American Heart Association strongly recommends the enactment of H.R. 15758.

Mr. ROGERS. Thank you very much, Dr. Millikan. We appreciate your testimony, and I would agree with you that stroke is an area where we need to do great work, and much needs to be done to improve the health of the people in this area. I think it has been overlooked a great deal from the testimony I have heard.

Dr. Carter?

Mr. CARTER. No questions.

Mr. ROGERS. Mr. Skubitz?

Mr. SKUBITZ. Doctor, the point I am trying to get across is, I have no objection to a continuing program. But I want the agency to come forth each year, justify what they have done and prove how much additional money is needed.

Maybe $65 million is sufficient for 1969, but who is to say how much we need in 1970 or 1971 without the Department coming before us and reviewing the program. Maybe we need $200 million next year, in 1970. And maybe the year following we may need $300 million instead of $100 million.

I don't know. What I want is for the Department to come in and justify its request from year to year. If it can't justify them, then I see no need of carrying the program forward.

Dr. MILLIKAN. May I ask a question? Are you addressing yourself to just filing the authorizations, or the amount?

Mr. SKUBITZ. The amount.

Dr. MILLIKAN. I believe these are different things, in essence. It seems to me that the record is now being written on the justification of this program, and that we are seeing significant changes in the interrelationships between the laboratory and teachers, on one hand, and the practicing physician community, on the other hand, which are going to accrue to the benefit of patients all over the Nation.

Mr. SKUBITZ. I don't think there is much doubt about that. I am sold on the program.

Dr. MILLIKAN. It seems to me that if the question is how much money is to be allocated per year, that is really in the province of the committee, as you deliberate how you establish mechanisms to find out about this.

Mr. SKUBITZ. My point is, though, that if we authorize $200 million for 1970 and $300 million for 1971, the Department does not have to

come before this committee anymore. It goes to the Appropriations Committee.

Mr. ROGERS. Mr. Kyros?

Mr. KYROS. Dr. Millikan, I found your testimony most interesting, not only in support of the program, but particularly what you say about money. And, again, as a man who has just come to Congress in the last year or so, it surprises me to see doctors come before this committee and ask for this money and for the continuation of programs.

I used to think that doctors in the American Medical Association took a different view.

I am in full agreement with your position as it is expressed here.

Dr. MILLIKAN. Thank you.

Mr. ROGERS. Thank you very much.

It is my understanding that one of our witnesses has a 3 o'clock plane to catch back to California, and if the committee would bear with us, if we could hear his testimony now, it would be helpful.

Dr. Lester Breslow, professor of health administration and chief of the division of health services, School of Public Health, University of California, Los Angeles.

Dr. Breslow, we appreciate your helping the committee, and we will be pleased to receive your testimony. If you would like to file your statement for the record and make appropriate comments, we would be pleased to follow that procedure.

STATEMENT OF DR. LESTER BRESLOW, PRESIDENT-ELECT, AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. BRESLOW. Thank you. I am appearing before you as president-elect of the American Public Health Association. I would like to make some remarks based on the written statement which has been submitted for the record.

Mr. ROGERS. Your statement will be made a part of the record following your remarks.

Dr. BRESLOW. The effective organization and utilization of the resources that we now have, and the unique contribution of the original cooperative arrangements, are made possible by this program.

The unique contributions are to extend the excellence of the medical centers out into the communities, and to accelerate the progress that is being made.

I think it is unfortunate that the American people still do not realize the advances that are being made against heart disease, cancer, and stroke, and the point of this program is to accelerate progress.

When we speak about regional cooperative arrangements, it is important to note that these are developing as a two-way street. The extension of expertise is not only from the medical centers out into the community but also from the point of view of the practicing doctor, from the community hospitals, back to the medical centers. They then begin to appreciate the real problems physicians are up against in the day-to-day handling of medical problems.

This is a truly cooperative arrangement and a two-way street, with motion in both directions.

I would like to say a few words about the progress that is being made in California. From the outset, the California program has

sought to effect cooperation between the hospital associations, the medical associations, the medical schools, and the State health department, Cancer Society, and Heart Association. There has been established a network of good communications, now, through area committees around every medical school and extending into every area of the State. Consequently, effective working bodies around many of the community hospitals and practically in all of the counties in the State are tied in with medical centers.

A couple of advances are being made. We are going to submit, on April 1 and 2, for consideration by our national site review, 14 proposals for operating grants in California. Among these will be a proposal to establish coronary care unit service in the coastal areas of California, a stretch of several hundred miles of small communities. If this program is approved these units will work with the university medical center in San Francisco, in order to extend this whole program out to the periphery of the State.

In the southern part of the State there is a proposal that would bring together the medical faculties of two of our universities there. This proposed program also would bring the medical faculties of these schools in contact with the practicing physicians in the Watts-Willowbrook area, in the center of Los Angeles—a scene of past violence and serious problems. The medical faculties of these schools would work along with the county and hospital administrators of the region who would then develop a postgraduate medical education program with concentration on heart disease, cancer, and stroke.

I mention these two projects merely to emphasize to the committee that this program is going to bring better care to persons not only in the medical centers but also into those parts of the State which have been relatively neglected in the past, such as the ghetto areas in the cities and the rural areas over the great stretches like in California.

Thank you, Mr. Chairman.

(Dr. Breslow's prepared statement follows:)

STATEMENT OF DR. LESTER BRESLOW, PROFESSOR OF HEALTH SERVICES ADMINISTRATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Mr. Chairman and members of the Committee, I am Lester Breslow, Professor of Health Services Administration in the School of Public Health at UCLA. I have previously been the State Health Officer for the State of California. I have come today to speak in support of H.R. 15758 and particularly that section of the bill which would extend the authority for the Regional Medical Programs.

In my professional career I have long been concerned with the need for a more effective organization of our vast health endeavor, and I view the Regional Medical Programs as having great potential for making a very important contribution to this objective. In recent years this Committee has heard a great deal of discussion about the current difficulties of our health-care system. For this Nation, these problems are not always the lack of health resources but rather the effective organization and utilization of the many resources with which we are blessed, including our resources of talent and knowledge as well as capital, equipment, and personnel.

In passing this legislation three years ago, the Congress expressed a public feeling that the benefits of medical science were not being applied uniformly enough to all segments of our population. This expression was part of a growing recognition within the health field that the present complexity and specialization of health care requires exploration of improved patterns of organization. The legislation carried through with this concern by placing emphasis on the development through the Regional Medical Programs of "regional cooperative arrangements"

among the health personnel and institutions on a regional basis as a necessary prerequisite to accomplish the objectives of reducing the unnecessary toll from these diseases.

The Regional Medical Programs become then an exciting new venture in the development of an improved health system—creating new relationships and capabilities while preserving and building upon the great strengths of our existing institutions, agencies, and personnel.

The history of past efforts at creating a regionalized approach to health services provides ample evidence that the task set for the Regional Medical Programs will be difficult and progress at times will seem slow. There have been previous beginning efforts at regionalized health activities in various parts of the country, some of which were described by this Committee in the report on the original legislation three years ago. Now the pressures of an increasingly complex health enterprise and the rapid advances of medical science and technology have added a considerable urgency to the need for regionalization in the health field if our people are to benefit fully from these advances. The pressures generated by the rapid rise of health-care costs and the increasing urbanization of our society add to this urgency.

The Regional Medical Programs are beginning to show some effectiveness in providing part of the answer to these problems. The activities of the Regional Medical Programs are helping to define the opportunities for improving the excellence of the health services within each region and the contributions that each element of the region's health resources can make to that excellence. The programs are establishing a permanent framework within the regions that becomes a two-way street whereby the expertise in the great medical centers becomes more readily available to the practitioner and institution at the community level, while at the same time the definition of community health needs and the involvement of community resources is made more relevant to the specialized capabilities of the large centers.

I have seen this process at work in California where we face a more complex task than most of the regions because of the great size of the region. This is the largest region with about 20 million people, and the development of the Regional Medical Program is following a somewhat different pattern than other regions, reflecting the commendable flexibility of the legislation in allowing each regional program to develop according to the particular pattern most suitable for that region. The amount of cooperation involving all of the medical schools, the medical profession, the hospitals, the public health agencies, and interested public in California has already made an invaluable contribution to the development of the essential basis for cooperative action. Even before the Californa Regional Medical Program has received any operational funds, the progress of the program during this planning phase and the establishment of much improved lines of communication among the many elements involved constitute substantial progress. In the interest of time, I would like to submit to the Committee a fuller statement of the accomplishments to date under the California Regional Medical Program. (See attachment A.) I think there is still a long way to go in developing the program in California when the progress is measured against the magnitude of the task. By that same measure, however, we in California are very pleased that the necessary initial steps in the development of the program are now well underway.

I believe that the Regional Medical Programs for heart disease, cancer, and stroke are a very important component of the development of health care on a regional basis in this country. With their emphasis on medical excellence, the involvement of medical centers, the practicing physicians, and the hospitals, the programs are a necessary part of the effort to bring the best in health care to the American people. Regional Medical Programs, however, can only make their full contribution in concert with the many other activities devoted to that goal. The scope of the challenge is too broad to be totally accomplished by any one program. The development of effective interrelationships among the Regional Medical Programs, Comprehensive Health Planning, and the wide variety of other health programs—Federal, State, and local—will be essential. I believe that the development of cooperative relationships among many diverse interests already underway through the Regional Medical Programs is a basis for hope that this cooperation can be extended to a broader level and that the effective interrelationships will be developed in ways appropriate to serve the diversities of the various areas of the country.

As an essential component of this broad effort, the authority for the Regional Medical Programs should be extended and support should be provided for their continued development.

Thank you very much for this opportunity to appear before you today.

[ATTACHMENT A]

STATEMENT OF LESTER BRESLOW, M.D., ON THE CALIFORNIA COMMITTEE ON REGIONAL MEDICAL PROGRAMS, MARCH 27, 1968

The California Regional Medical Program has been funded for only 15 months and although it would be premature to claim that lives had been saved, nevertheless, it can be said with confidence that the stage has been set for the provision of greatly improved health care services for heart disease, cancer, stroke, and the disorders related to them.

Just this week a study was launched by the California Health Data Corporation to gather information on the origin of every patient admitted during the entire week to every hospital in California. The study, never before undertaken on so large a scale, will show where each patient came from, what his diagnosis was when he was discharged from the hospital, and other information. While these may seem little more than a set of dry statistics, the results should reveal with great accuracy the kinds of medical services needed for Californians and others cared for in the State. Other data gathering studies, which are expected to lead very shortly to operational programs, will be described later.

From the very beginning, planning for the California Regional Medical Program embraced all the major medical and health interests in the State. The California Medical Association, spokesman for the State's 23,000 practicing physicians; the California Hospital Association, representing virtually all of the 600 short-term acute general hospitals in the region; the California State Department of Public Health; the California Heart Associations; the California Division of the American Cancer Society; the deans of all of the eight medical schools in California, and the deans of the two major schools of public health were joined by eight public representatives of the consumer. Together they constitute the legal advisory committee for the region and are known formally as the California Committee on Regional Medical Programs. The Committee has met many times, has gained strength, grown gratifyingly more confident of itself as an entity and has increasingly been able to resolve differences amicably.

As for operational programs, we are looking forward to a two-day site visit in California on April 1 and 2 by a review committee of the National Advisory Council for Regional Medical Programs. They will examine the merits of 14 operational proposals generated by local community interest in five of the State's eight planning areas, and by the California Heart Association. These first operational proposals are heavily weighted toward continuing education, and include some promising innovative experiments.

The greatest single topic of interest among these early operational proposals concerns coronary care units, reflecting a growing consensus throughout the Nation that such units, properly equipped and with highly-skilled doctors and nurses to run them, can bring about a dramatic reduction in deaths due to myocardial infractions and other cardiac emergencies. Four of the 14 proposals deal with the training of physicians and nurses and the equipping of coronary care units. One proposal would offer nurse training in several communities throughout Northwestern California, stretching from the Bay Area to the Oregon border along the Pacific Coast, and would include intensive training for physicians at the San Francisco General Hospital, under the tutelage of University of California cardiologists. Similar proposals would be offered through several hospitals in the highly concentrated Los Angeles basin and include the beefing up of the intensive coronary care unit at the Los Angeles County General Hospital.

A joint proposal by the University of Southern California and the University of California at Los Angeles would join with the Charles R. Drew Medical Society and others to establish a postgraduate medical school in the Watts-Willowbrook ghetto area of Los Angeles. Internship and residency programs would be generated along with inservice and postgraduate training for doctors, nurses and allied health professionals, close relationships with the faculties at USC and UCLA and detailed planning to meet heart disease, cancer and stroke needs in the area.

At Roseville, a community of 20,000 citizens 18 miles northeast of Sacramento, the University of California Davis Medical School has encouraged local physi-

cians to establish a "living laboratory" involving the whole community. Continuing education, training for licensed vocational nurses and other paramedical personnel, stroke treatment, handling of central nervous system malignancies, establishment of a tumor board, selected multiphasic screening and community education programs are involved.

The California Heart Association proposes a substantial expansion of its successful student research projects, bringing highly qualified science students into cardiovascular research laboratories.

In Los Angeles, special training in angiography—the visualization of the blood vessel system with the aid of radioactive dyes—would be presented for practicing and qualified radiologists.

Two proposals—one for the Sacramento Valley, the other for the lower San Joaquin—would make use of videotape recording units which would be moved from one hospital to the next, covering several score hospitals. The units would be accompanied by medical television tapes, for instruction of each hospital's staff members, and each local staff could record its own grand rounds, lectures and demonstrations, then, by playing the lesson back, improve its own teaching skills.

The California Heart Association proposes a substantial expansion of its sucpitals in the State, would be expanded to other regions.

The development of simple learning languages in a computer program available for undergraduate, graduate and postgraduate instruction to several regional medical program areas would be encouraged in another proposal.

The Loma Linda University School of Medicine has a highly intriguing pilot project based on a third-generation computer, and proposes to expand its library services to practicing physicians throughout its vast service area. The computer demonstration would test the feasibility of using a remote display, very much like a television set, on which a physician in a community hundreds of miles from the school could, by picking up the telephone, hook into the computer and ask it to analyze the electrocardiograph readings being taken on the patient lying by the physician's side. The computer analysis would be done in real-time, and the answer would return in 2 or 3 minutes. Such a project might provide needed services to small, remotely located hospitals and communities now lacking medical specialists.

These 14 operational proposals are under immediate consideration. Several others, submitted in the March, 1968 quarter, will be briefly detailed in a moment. All have been developed following planning activity which began in January, 1967. The first year's planning activity involved, among other things, the laying down of a data base from which operational proposals are being projected. Construction of the data base has gone through two phases.

In the first phase simple, readily available data were arranged in forms most useful for planning in each of the eight areas of California. *Demographic* data were acquired from the State Department of Finance. *Mortality* data were gathered from the State Department of Public Health. Also from the State Health Department, with added information from the California Hospital Association, came material for a *complete hospital roster* for each of the California Regional Medical Program areas. Finally, the first phase of data acquisition entailed analysis of less readily available types of information involving, for example, transportation and the many varieties of morbidity data.

During the second half of the first planning year, six planning studies were undertaken on a region-wide scale. All were approved by a data needs subcommitee on which each of the California Regional Medical Program areas was represented. Each study aimed at relatively deeper penetration into some aspect of the data base needed for planning. At the same time each pointed clearly to the shape of operational proposals in the making.

Patient origin study.—This study, rescribed briefly in the opening paragraphs of this statement, will include important material for morbidity analysis, particulary if the survey can be repeated at intervale. At the same time, the survey in is first round is expected to yield information needed for transportation and facilities planning in conjunction with the rendering of optimal care for heart disease, cancer and stroke patients.

Training facilities inventory.—Many of the ideas for operational projects, which began to take shape in the first planning period, concerned manpower needs and the possibilities of training programs for key health services, in addition to physician services. It was found, though, that little information had been gathered on the simple question of what training facilities now exist.

The California Regional Medical Program, therefore, contracted with the Survey Research Center at UCLA to make an analytic region-wide survey of existing training facilities for health service manpower of all sorts. The survey, besides being an inventory of facilities, includes analytic details as to capacities, present enrollments, expansion possibilities, curricula and new programs. It will serve as a basis for second-generation studies and operational proposals in the manpower field.

Physician referral patterns.—The Stanford Research Institute, in cooperation with the California Medical Association, is completing interviews with a random sample of physicians throughout the State on the subject of referral patterns for patients with heart disease, cancer and stroke. Here, too, material never gathered before is being acquired. Questionnaires already completed contain valuable material of two kinds. As a basis for improved delivery of medical service in cases of heart disease, cancer and stroke, referral patterns, both as to physicians and facilities, are being discussed. And, the needs seen by family physicians, and other physicians of first reference, are being recorded and analyzed for the first time in this context.

Registries.—A cooperative undertaking involving the System Development Corp. of Santa Monica and the UCLA School of Public Health is doing feasibility testing for possible registries in stroke and heart disease. California has already had rich experience in the development of a tumor registry, covering roughly a third of the hospital beds in the State and providing cancer incidence data of unique significance. The System Development Corp. study is, therefore, moving on to a preliminary examination of registry construction in stroke and heart disease. At the same time, the Director of the California Tumor Registry is cooperating with the California Regional Medical Program in connection with cancer registration and follow-up.

Use of medical scoiety review mechanisms.—On a trial basis, local medical organizations in three California counties are cooperating with the Regional Medical Program to determine the value of local medical review mechanisms—generally associated with claims review in health insurance programs—for case identification heart disease, cancer and stroke, review of prevailing community standards and practices in management of such cases, and possible development of postgraduate medical education and other programs. In each case, the county medical group has agreed to cooperate with the appropriate university medical center in the review.

Specialized resources in hospitals.—The sixth and last of the first-generation California planning studies is based on questionnaires sent to all the acute, general hospitals in the State, through the cooperation of the California Hospital Association. The hospitals are reporting whether or not they have various items on a detailed roster of specialized resources or facilities needed for treatment and overall management of patients with heart disease, cancer and stroke. This material, too, has not been gathered before, and is expected to highlight material lacks, oversupplies or maldistributions. At the same time, the study will bring manpower training requirements to a sharper focus as California's Regional Medical Programs enter their operational phase.

All these data gathering studies have been integrated into the 14 operational proposals described earlier. They have also been incorporated into the five operational proposals and the two additional requests for funds especially earmarked by Congress, submitted by the California Committee on Regional Medical Programs during the March, 1968 quarter.

This second set of proposals includes the expansion of existing clinical cancer diagnosis and treatment, social service consultation, radiological physics, nuclear medicine and computer retrieval of pertinent data to 26 hospitals in northern California, a coordinated year-round general practice residency, intensive coronary care training for physicians in small hospitals, and the establishment of a medical library and information service network.

The first of the projects seeking earmarked funds involves a sixth area in California—Orange County, the planning for which has been assigned to the University of California at Irvine—proposing a pediatric pulmonary demonstration center. It would be only the fourth of its kind in the Nation. The second project would expand and improve an existing hypertension program of the UC San Francisco Medical Center.

Taken all together, these first operational proposals can be seen as the beginning broad outlines in the development of a region-wide comprehensive blueprint,

whose cohesion and effective potential for vastly improved health care services are emerging, almost on a day-by-day basis, ever more clearly.

Mr. ROGERS. Let me ask this. Is your program getting to the ghetto areas? Could you give us a quick rundown on that?

Dr. BRESLOW. One program that is being considered—I perhaps should not prejudge the issue—is the proposal which has been developed by USC and UCLA faculties. It would transfer the medical expertise developed by these two centers, in the field of heart disease, cancer, and stroke, to the Watts-Willowbrook area. It is in this area that the county plans to build a new hospital with the aid of Hill-Burton support.

The aim of this program is to build around that hospital, bringing in the practicing physicians in the community, a program of postgraduate education, emphasizing heart disease, cancer, and stroke.

We think this will have a remarkable effect in mobilizing the services of that portion of Los Angeles to provide better care.

Mr. ROGERS. Thank you, and I am delighted to see you have given us a statement on the California program, which we will go into in detail.

Mr. Kyros?

Mr. KYROS. No questions.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. I am delighted to know you are making all these services available for the Watts area. I wonder what you are doing for the areas around Watts.

Dr. BRESLOW. Our programs extend into the Watts area and also around the Watts area, not only throughout the metropolitan region of Los Angeles, but in the mountainous areas, and so forth. Other projects——

Mr. CARTER. I believe in those surrounding areas we are liable to have more heart attacks and strokes. [Laughter.]

Mr. ROGERS. Thank you very much, Dr. Breslow. We appreciate very much your coming here.

I understand that we will try to hear one more witness here.

Reverend Works, you and Dr. Price, I understood, were going to have to get away. Could you come forward, then? We will be pleased to hear your testimony.

Mr. Macdonald, your Congressman, wanted to come and introduce you, but the committee knows of your work, and we are delighted to have you here with us, and Dr. Price.

And if you would like, we will make your statements part of the record, without objection and they will appear following your remarks. And if you could then summarize for us the points that you think wolud be important, this would be helpful to the committee.

STATEMENTS OF REV. DAVID A. WORKS, EXECUTIVE VICE PRESIDENT, THE NORTH CONWAY INSTITUTE, BOSTON, MASS., AND REV. THOMAS E. PRICE, DIRECTOR OF THE DEPARTMENT OF ALCOHOL PROBLEMS AND DRUG ABUSE, GENERAL BOARD OF CHRISTIAN SOCIAL CONCERNS OF THE METHODIST CHURCH

Dr. WORKS. Thank you, Mr. Chairman.

My name is Rev. David Works, of Topsfield, Mass., and North Conway, N.H., an Episcopal clergyman. I am the executive vice

president of the North Conway Institute, an interfaith, totally ecumenical fellowship of lay people and clergymen.

We have been studying, praying, working, and waiting for a new or more effective way for the churches and synagogues of the United States to help all people prevent alcohol problems.

In addition to my responsibilities with the North Conway Institute, which is now permanently located in Boston, Mass., I am also a member of the newly created task force on alcohol problems of the National Council of Churches, which was created to do two things:

(A) Study the report of the federally financed cooperative commission on alcohol problems with special emphasis on Dr. Thomas Plaut's Book, "Alcohol Problems: A Report to the Nation," and

(B) To recommend to the National Council of Churches and through the National Council of Churches of Christ, United States of America, to its constituent members, a broad, comprehensive program to prevent problem drinking.

In addition to my role as a member of the Protestant Episcopal Church and a full-time professional worker in our Lords' vineyard, I am also a very grateful recovered alcoholic who, along with my wife and children and other members of my family—especially my mother and brothers and sisters—wish to express our deep gratitude to this distinguished committee and to you, Mr. Rogers, Mr. Kyros, and other members of this committee, and to the other Members of the 99th Congress and to the present administration for the privilege of adding my words of strong support for H.R. 15758.

Starting in 1951, in a small mountain village in the White Mountains of northern New Hampshire, an ever-increasing group of competent and dedicated church people have been planning out a church program. After 10 years in New Hampshire and the neighboring State of Maine, and in Congressman Peter Kyros' neighboring State of Maine, His Eminence Richard Cardinal Cushing of Boston asked the religious leaders of the Greater Boston area to help sponsor our North Conway Institute program. We plan to do four things:

I will quote from "Alcohol and the American Churches," published by the North Conway Institute in 1967.

We call upon the people of God to join efforts in an ecumenical spirit to attack this major social problem by action in four areas:

A. THE PASTORAL CARE OF ALCOHOLICS AND THEIR FAMILIES IN THE COMMUNITY WHERE THEY LIVE

Each congregation must bring to the alcoholic and his family a redemptive ministry based on compassionate understanding and loving concern which seeks to help them withstand the stress, tension and anxiety of modern life by providing hope, acceptance, and spiritual guidance to a reliance upon God.

B. ALCOHOL EDUCATION OF THE ECUMENICAL COMMUNITY'S OWN CONSTITUENT MEMBERS

We urge all religious bodies to place a new emphasis on the importance of educating their constituents with regard to the personal and social issues involved in drinking.

C. ALCOHOL EDUCATION FOR THE PUBLIC WITHIN THE COMMUNITY

The ecumenical community should take the initiative in seeking the cooperation of other community organizations in the sponsorship of educational activ-

ities designed to acquaint the total community with objective facts about the role of alcohol in the life of the community, the several problems that grow out of it, and the responsibility of the community to deal with these problems.

D. SOCIAL AND LEGAL CONTROLS

We urge the people of God to work constructively for the creation of attitudes which will constitute a social control over the drinking customs of the populace by establishing high values on the virtue of sobriety and strong sanctions against the irresponsible use of alcohol including drunkenness.

We urge the appropriate public agencies to enforce the present legal regulations on the distribution and consumption of alcoholic beverages and urge the general public to obey these regulations in the interest of public welfare. At the same time, we urge that new forms of legal control based on scientific understanding be developed.

In particular, we urge the courts to expand practices under which chronic offenders for drunkenness may elect to receive treatment in lieu of jail sentences. We note the special need for constructive controls over the increasing problem of alcohol-related traffic accidents.

The churches then, to sum up, are helping people to prevent alcohol problems through three major avenues of concern:

First, we have a department of research and development headed by David Barton.

Second, we have a department of pastoral services and training which is headed by a native son of Oklahoma, the Reverend William Sprague.

Third, we have a department of communications which is headed by Simons L. Roof, and which is responsible for issuing our various publications.

All of us work at therapy or helping folks and communities who are already afflicted with not only alcoholism but many other types of alcohol problems.

The average Episcopal minister spends 75 percent of his pastoral time with parishioners who have alcohol-related problems.

What we need are facilities such as will eventually grow out of the Alcoholic Rehabilitation Act of 1968.

The responsible churches of America will evidence our long-time continuing interest by giving members of this committee our strong support in your attempts to achieve a new enlightened concept.

The North Conway Institute is a product of the ecumenical movement, which is sweeping the religious community. It is both interfaith and interdisciplinary. The institute has serving on its board of trustees individuals representative of the three major faiths—Protestant, Catholic, Jewish—and the health, education, and welfare professions and volunteer service groups. A wide spectrum of religious opinion from liberal to conservative is represented by the membership of the board of trustees.

One of the notable achievements of the institute was the endorsement of a statement by prominent church leaders of Metropolitan Boston in 1966. The statement was drafted by the Ecumenical Council on Alcohol Programs and was endorsed by leaders from 16 different churches ranging from Roman Catholic to Salvation Army. The key paragraphs read as follows:

We believe that alcoholism and alcohol-related problems are a serious threat to the health, happiness, and welfare of many people and to the stability of families and communities.

Among other consequences of excessive drinking which call for remedial action are the breakup of family life, the stimulation of crime and juvenile delinquency, the mounting of welfare costs, and the loss to industry through absenteeism and inefficiency.

These problems are not new, but they are acute and are made more so by an attitude of complacency and irresponsibility on the part of the general public in whose hands the final determination of social policy lies. It is urgent that churchmen and others concerned with human needs and the moral foundations of our society endeavor to create a more responsible public attitude toward drinking.

We believe that we may all unite on the ground of the virtue of sobriety. This can be practiced in two ways. One is by total abstinence from beverage alcohol for religious motives. The other is by true moderation in the use of alcohol, also for religious motives. On this common ground the virtue of sobriety may be practiced both by abstainers as well as by those who drink moderately.

Although differences of conscientious conviction in relation to certain current drinking customs exist among us, the area of our agreement with regard to drunkenness and alcoholism is sufficiently large and significant as to enable us to unite our best efforts for the alleviation and ultimate solution of these alcohol-related problems.

As churches move closer to one another and understanding increases, Congress will find more and more support among their constituents for health measures to help communities help the alcoholic and his family. H.R. 15758 is a major step in that direction.

In conclusion, may I strongly urge you to recommend the passage of a comprehensive national program to deal with the health problems of families and communities dealing with chronic alcoholism.

The Alcoholic Rehabilitation Act of 1968 represents a real step forward in the beginning of such a program. Again, I commend the Democratic administration for proposing this legislation, for Congressman Staggers of West Virginia for sponsoring it. And I hope you, Congressman Jarman, will get your subcommittee to approve this bill so the Congress can pass it shortly so our President can sign it into law.

Thank you very much, Mr. Chairman, for your gracious courtesy in allowing me to testify.

(Dr. Works' prepared statement follows:)

STATEMENT OF REV. DAVID A. WORKS, EXECUTIVE VICE PRESIDENT, THE NORTH CONWAY INSTITUTE, BOSTON, MASS.

My name is The Reverend David A. Works of Topsfield, Massachusetts and North Conway, New Hampshire, and Episcopal clergyman, who is the Executive Vice President of the North Conway Institute, an inter-faith, totally ecumenical fellowship of lay people (men and women) and clergymen (Roman Catholic, Protestant and Jewish) who have been studying, praying, working, and waiting for a new or more effective way for the Churches and Synagogues of the United States to help all people prevent alcohol problems.

In addition to my responsibilities with the North Conway Institute, which is now permanently located in Boston, Massachusetts, I am also a member of the newly created Task Force on Alcohol Problems of the National Council of Churches which was created to do two things:

(*a*) Study the report of the Federally financed Cooperative Commission on Alcohol Problems with special emphasis on Dr. Thomas Plaut's book, *Alcohol Problems: A Report to the Nation.*

(*b*) To recommend to the National Council of Churches and through the National Council of Churches of Christ, United States of America, to its constituent members a broad, comprehensive program to prevent problem drinking.

In addition to my role as a member of the Protestant Episcopal Church and a full-time professional worker in our Lords' vineyard, I am also a very grateful recovered alcoholic who, along with my wife and children and other members

of my family—especially my mother and brothers and sisters—wish to express our deep gratitude to this distinguished committee and to the other members of the 90th Congress and to the present administration for the privilege of adding my words of strong support for H.R. 15758.

Starting in 1951, in a small mountain village in the White Mountains of Northern New Hampshire, an ever-increasing group of competent and dedicated Church people have been planning out a Church program. After ten years in New Hampshire and the neighboring State of Maine, His Eminence Richard Cardinal Cushing of Boston asked the religious leaders of the greater Boston area to help sponsor our North Conway Institute program. We plan to do four things:

I quote from *Alcohol and the American Churches* published by the North Conway Institute in 1967, pages 24–25:

"We call upon the people of God to join efforts in an ecumenical spirit to attack this major social problem by action in four areas:

(*a*) *The pastoral care of alcoholics and their families in the community where they live.*—Each congregation must bring to the alcoholic and his family a redemptive ministry based on compassionate understanding and loving concern which seeks to help them withstand the stress, tension and anxiety of modern life by providing hope, acceptance, and spiritual guidance to a reliance upon God. We urge our congregations to take the initiative in offering such a ministry by training some of its members to join with the professional clergy to constitute a fellowship of redeeming love within which the alcoholic and his family may find the help they need.

Included in such a ministry should be the effort to detect those who are beginning to rely on alcohol as a crutch and to help them find new spiritual resources for handling their problem. In addition, to their own direct ministries to the alcoholic and his family, the churches should help stimulate community action to provide adequate treatment facilities for the alcoholic and adequate social services for his family. Clergymen should work as part of a therapeutic team which includes members of the medical, psychiatric, social work, and vocational rehabilitation professions. They should help develop reciprocal referral services between the churches and the public and private welfare agencies of the community.

(*b*) *Alcohol education of the ecumenical community's own constituent members.*—We urge all religious bodies to place a new emphasis on the importance of educating their constituents with regard to the personal and social issues involved in drinking. With each communion establishing goals and methods in harmony with their own traditions relating to the use of alcohol, we recommend that the following be among the educational objectives to be attained:

To help the membership understand the role of alcohol in society and the gravity of the problems connected with its use.

To help persons understand their own motivations for drinking or abstaining so that an individual choice may be made free from the necessity to confirm.

To provide better understanding between those who practice the virtue of sobriety through moderation and those who practice it through abstinence.

(*c*) *Alcohol education for the public within the community.*—The ecumenical community should take the initiative in seeking the co-operation of other community organizations in the sponsorship of educational activities designed to acquaint the total community with objective facts about the role of alcohol in the life of the community, the several problems that grow out of it, and the responsibility of the community to deal with these problems.

We urge that the members of each of our communions engage in conversation with others in the community for the purpose of helping to form new attitudes of responsibility in which all forms of excessive drinking are morally and socially unacceptable.

When there is no satisfactory general alcohol education program in the community notably in the schools and the churches, the ecumenical leadership should initiate the development of one, giving inter-faith support to school officials and offering every possible assistance. Such a program should assist individuals to make mature and responsible decisions about use or non-use of alcohol in keeping with one's own beliefs and individual needs. It should also present scientifically accurate information about alcohol and the nature of the illness, alcoholism. It should foster understanding between persons who follow the abstinence and moderation traditions without seeking to impose either.

(d) *Social and legal controls.*—We urge the people of God to work constructively for the creation of attitudes which will constitute a social control over the drinking customs of the populace by establishing high values on the virtue of sobriety and strong sanctions against the irresponsible use of alcohol including drunkenness. This should include the enunciation of new norms of etiquette which hold it to be an act of impoliteness to urge anyone to drink against his will and which dictates that when alcoholic beverages are served, non-alcoholic alternatives also be provided as a matter of course.

We urge the appropriate public agencies to enforce the present legal regulations on the distribution and consumption of alcoholic beverages and urge the general public to obey these regulations in the interest of public welfare. At the same time, we urge that new forms of legal control based on scientific understanding be developed. In particular, we urge the courts to expand practices under which chronic offenders for drunkenness may elect to receive treatment in lieu of jail sentences. We note the special need for constructive controls over the increasing problem of alcohol-related traffic accidents."

The Churches, then, to sum up are helping people to prevent alcohol problems through three major avenues of concern:

First, we have a department of research and development headed by David Barton. This is our "learning" arm.

Second, we have a department of pastoral services and training which is headed by a native son of Oklahoma, The Reverend William Sprague. This is our "teaching" or sharing arm of our Institute.

Third, all of us work at therapy or helping folks and communities who are already afflicted with not only alcoholism but many other types of alcohol problems. This is our "caring" or healing arm.

In addition we publish a number of publications and other statements and newsletters.

Eventually, I beileve the major churches and synagogues will also handle problems of drug abuse—including alcohol when it is misused through this three-fold approach of learning, sharing, and caring (i.e. Research, training, and therapy).

In 1968 the churches are now beginning to tackle six major areas of concern:

(1) People and alcohol and alcoholism.

(2) People, alcohol and youth education—including in many places increasing emphasis on drugs along with the drug alcohol.

(3) People, alcohol and drunken driving.

(4) People, alcohol, and the liquor and beer control systems. For example, you will note in our paper, *The Churches and Alcohol* on page five: "In 1966, the Federal government collected approximately three billion, eight hundred million dollars ($3,800,000,000) in beverage alcohol taxes [with an expenditure of about seven million dollars ($7,000,000)]. To this amount should be added comparable tax revenue collected by the States. Obviously no estimates are available as to the losses of tax revenue chargeable to the illicit manufacture, sale, and use of alcoholic beverages."

The church people are increasingly wondering if this is a fair proportion for a National Federal Program of research, training, and therapy as well as education for prevention.

(5) People, alcohol and the police court problem. Already mention has been made in these hearings of the impending United States Supreme Court decision on "Powell *vs.* Texas." In The North Conway Institute along with the Methodist Board of Christian Social Concerns is one of the Amici Curiae.

Also, since the first of January 1968, a small Task Force of professional people have been meeting in Boston to plan a concerted attack on "police court alcoholic." We will, however, need funds to help implement this program which we are developing in New England as you in the United States States Congress and in the Lyndon Johnson—Secretary Wilbur Cohen Administration are developing here in Washington.

(6) People, alcohol and the indifference of the two hundred million (200,000,000) Americans.

After almost a quarter of a century of satisfied sobriety, I can state emphatically that people are not so much indifferent to problems connected with alcohol as we are frustrated. The average Episcopal clergyman spends 75% of his pastoral time (i.e. with peopel in trouble or in distress) with parishioners who have alcohol-related problems!

What we need are facilities such as will eventually grow out of the alcoholic rehabilitation Act of 1968.

The responsible Churches of America will evidence our long time continuing interest by giving members of this committee our strong support in your attempts to achieve a new enlightened concept.

The North Conway Institute is a product of the Ecumenical Movement which is sweeping the religious community. It is both inter-faith and interdisciplinary. The Institute has serving on its Board of Trustees individuals representative of the three major faiths—Protestant, Catholic, Jewish—and the health, education, and welfare professions and volunteer service groups. A wide spectrum of religious opinion from liberal to conservative is represented by the membership of the Board of Trustees.

One of the notable achievements of the Institute was the endorsement of a statement by prominent church leaders of metropolitan Boston in 1966. The statement was drafted by the Ecumencial Council on Alcohol Programs and was endorsed by leaders from 16 different churches ranging from Roman Catholic to Salvation Army. The key paragraphs read as follows:

We believe that alcoholism and alcohol-related problems are a serious threat to the health, happiness, and welfare of many people and to the stability of families and communities.

Among other consequences of excessive drinking which call for remedial action are the break-up of family life, the stimulation of crime and juvenile delinquency, the mounting of welfare costs, and the loss to industry through absenteeism and inefficiency.

These problems are not new but they are acute and are made more so by an attitude of complacency and irresponsibility on the part of the general public in whose hands the final determination of social policy lies. It is urgent that churchmen and others concerned with human needs and the moral foundations of our society endeavor to create a more responsible public attitude toward drinking.

We believe that we may all unite on the ground of the virtue of sobriety. This can be practiced in two ways. One is by total abstinence from beverage alcohol for religious motives. The other is by true moderation in the use of alcohol, also for religious motives. On this common ground the virtue of sobriety may be practiced both by abstainers as well as by those who drink moderately.

Although differences of conscientious conviction in relation to certain current drinking customs exist among us, the area of our agreement with regard to drunkenness and alcoholism is sufficiently large and significant as to enable us to unite our best efforts for the allviation and ultimate solution of these alcohol-related problems.

As Churches move closer to one another and understanding increases, Congress will find more and more support among their constituents for health measures to help communities help the alcoholic and his family; H.R. 15758 is a major step in that direction.

In conclusion, may I strongly urge you to recommend the passage of a comprehensive National Program to deal with the health problems of families and communities dealing with chronic alcoholism.

The Alcoholic Rehabilitation Act of 1968 represents a real step forward in the beginning of such a program. Again I commend the Democratic Administration for proposing this legislation, for Congressman Staggers of West Virginia for sponsoring it, and I hope you, Congressman Jarman, will get your sub-committee to approve this bill so the Congress can pass it shortly so our President can sign it into law.

Thank you very much, Mr. Chairman, for your gracious courtesy in allowing me to testify.

Dr. WORKS. I would like to introduce the Reverend Thomas E. Price, director of the department of alcohol problems and drug abuse, the General Board of Christian Social Concerns of the Methodist Church, who is also a member of the board of directors of the North Conway Institute. I will be glad to answer any questions you have.

Mr. ROGERS. Thank you very much, Reverend Works, and we are pleased to have you, Dr. Price.

STATEMENT OF REV. THOMAS E. PRICE

Dr. PRICE. I am director of the alcohol problems for the Methodist Board of Social Concerns. I am here to register the church's concern for the kind of programs called for in H.R. 15758.

Now I of course have the statements of the Methodist Church on alcoholism and the needs.

I would read the final paragraph, the concluding paragraph of my statement, which is to say that the Methodist Church, which has a long tradition of abstinence, and it is not prepared to surrender its conviction that abstinence is an answer for many problems associated with it, not the least of which is alcoholism, but it is prepared to enter the public realm to encourage, to support, to cooperate with community-wide efforts at the national, State, and local levels to treat and prevent drinking problems through the most effective means available.

We consider H.R. 15758 an effective means, because of its provisions to facilitate State and community developments of model programs.

(Dr. Price's prepared statement follows:)

STATEMENT OF REV. THOMAS E. PRICE, DIRECTOR, DEPARTMENT OF ALCOHOL PROBLEMS AND DRUG ABUSE, GENERAL BOARD OF CHRISTIAN SOCIAL CONCERNS, THE METHODIST CHURCH

My name is Thomas E. Price and I am testifying in my capacity as Director of the Department of Alcohol Problems and Drug Abuse, the General Board of Christian Social Concerns of The Methodist Church. I am an ordained Methodist clergyman with a Ph.D. from Boston University. As administrator of the Methodist Church's national program of alcohol education and rehabilitation I am here to register the Church's interest and concern in support of the program called for in H.R. 15758, Title III, "Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968."

POLICY STATEMENTS OF THE METHODIST CHURCH

I call your attention to the position of the Methodist Church on alcoholism and narcotic addiction as stated by the 1964 General Conference, the highest policy making body of the Church:

> Methodists are called by love not only to abstain but also to seek healing and justice for the neighbor who is victimized. Concern for the alcoholic and for all those in trouble because of beverage alcohol is the clear mandate of the Christian faith.
>
> Abstinence is not enough. We also urge our people to join with those engaged in positive and constructive programs seeking solutions to alcohol problems. These include education in church and school, rehabilitation for alcoholics, strongest attainable legal controls and the stimulation of sound empirical research. Christians who love God and their fellowmen can do no less. (Paragraph 1822, 1964 Methodist *Discipline.*)
>
> Alcoholics are sick persons. They can be helped. The church has a unique role to play in the healing process which must be physical, mental and spiritual.
>
> Methodists should take the lead in establishing community agencies for alcoholism education and rehabilitation which are inter-faith and inter-professional in nature. (Miscellaneous Resolution 1964 General Conference.)

And on narcotic addition:

> Society must provide through public and private facilities for the treatment, rehabilitation, and after-care of narcotic addicts and other victims of drug abuse.
>
> The church should support carefully designed plans to control the traffic in narcotics and to rehabilitate the addict. We urge the reform of existing legal barriers for successful rehabilitation of the drug offender. Experi-

mental programs of rehabilitation must be expanded including those involving the administration of controlled amounts of drugs under strict medical supervision.

Churches should assist in developing half-way houses and similar centers to provide a therapeutic and supportive community for addicts. (1964 Methodist *Discipline*, Paragraphs 1820 and 1822).

The provisions of H.R. 15758, Title III, for constructing, staffing, operating, and maintaining new facilities in the treatment of alcohol and narcotic addicts is a basic step toward providing the kind of comprehensive care needed, if society is going to take seriously its responsibility toward those afflicted by alcohol and drug problems. We are grateful for the steps already taken by the Congress and Executive branch of government, and believe that H.R. 15758 will make available much of the necessary funding to implement plans already envisioned.

THE NEED FOR H.R. 15758

Obviously the Congress was aware of the pressing need for facilities to prevent and treat alcoholism and narcotic addiction or this bill would neither have been drafted nor would these hearings have been held. Others will document this need with statistics, so just let me underline the urgency of this legislation by citing one image of the enormity of the problem of alcoholism. According to the report of the Cooperative Commission on the Study of Alcoholism if all the psychiatrists and all the social workers in the United States were transferred to California, they could give only minimum care of one individual interview per week and one home visit per month to the alcoholics and their families in that *one* state. (I would remind the committee that, even though narcotic addiction is a dramatic and urgent problem, narcotic addicts are numbered in the thousands while alcoholics are numbered in the millions.) This astounding fact calls for a massive effort on the part of the whole nation to provide comprehensive care for the sufferers of this disorder of mind, body, and spirit and an equally massive effort to prevent others from being afflicted. H.R. 15758 is a highly commendable beginning because it provides for both treatment and prevention and specialized facilities such as half-way houses.

We should not fail to see this legislation within the context of the President's Commission on Civil Disorders, as well as the President's Commission on Law Enforcement and Justice, because the Commission on Civil Disorders noted the well known fact of the high rate of alcoholism and narcotic addiction in our inner cities. Implementing some of the recommendations of the Commission regarding jobs, education, and housing will get at many of the root causes of these twin illnesses, but in the meantime our urban poor need services. H.R. 15758 is one way of dealing with the crisis in the nation.

THE ROLE OF THE CHURCHES

The sheer size of the problems of alcoholism and narcotic addiction has moved the churches to unite in inter-faith efforts to deal with the problems. No single denomination or religious tradition has all of the resources of insight and competence to provide all the answers, but jointly, in cooperative ways that complement one another, the religious community can provide a relevant ministry to the total community.

The National Council of the Churches of Christ said in 1958:

> The churches share a pastoral concern for alcoholics, problem drinkers and their families...
>
> Alcoholics are persons in need of diagnosis, understanding, guidance and treatment. They are especially in need of pastoral care and the divine love which the church can bring them. There need be no condoning of their behavior, but neither should a church permit its antagonism to alcohol to prevent its offering an effective ministry to alcoholics and their families. (The Churches and Alcohol, 1958.)

At the same time the churches have been moving together to form a united ministry, they have been joining with forces in the community, professional and volunteer, to support and take their place on the inter-disciplinary team we know as the care-giving systems of our society—health, law, education, welfare, volunteer service groups, and religion. Again I cite the 1958 statement of the National Council of Churches:

We look to the member churches of the National Council to encourage the establishment and maintenance of clinics and other appropriate therapeutic facilities when competently conducted, for the victims of alcoholism. We urge the churches to give any help possible especially to those organizations which seek to include the resources of the Christian faith in working toward the cure and rehabilitation of alcoholics.

Alcoholism and narcotic addiction does not exhaust the concern of the churches for alcohol and drug problems in our society. The churches are also aware of problems such as driving under the influence of alcohol and drugs, youthful drinking and drug taking, effective legal controls of the manufacture, sale and distribution of alcohol and drugs, and the abuse of alcohol and drugs such as stimulants, sedatives, and hallucinogens in every level of our society. The report of the Cooperative Commission on the study of Alcoholism has demonstrated how alcoholism is interlocked with these other alcohol problems, and I am sure the same thing is true of narcotic addiction and drug abuse problems. Therefore, the churches are beginning to develop a comprehensive program to deal with all alcohol and drug problems. The provisions of H.R. 15758 are vital ingredients in this comprehensive program.

The primary role of the church is in prevention, but the remedial task before us of providing comprehensive care services for the great number of alcoholics and narcotic addicts already afflicted is so urgent that passage of H.R. 15758 is an imperative priority.

RECOMMENDATIONS

We feel that H.R. 15758 could be strengthened by two additions:

1. "Part C—Alcoholism" would be strengthened by adding a section providing for the training of personnel to work with alcoholics and their families just as Section 252, "Part D—Narcotic Addict Rehabilitation" provides for training of workers with narcotic addicts. Training programs for alcoholism workers are needed simply because they are in such short supply and the need for professional and sub-professional workers so great. H.R. 15758 is an excellent vehicle for providing them and I urge the addition of such a section.

2. A premable to "Part C—Alcoholism," such as the one suggested by Mr. Dimas who testified on behalf of the North American Association of Alcoholism Programs, would strengthen H.R. 15758 by explicitly relating alcoholism to existing health and welfare legislation. Alcoholism is already generally covered in these other programs such as the Office of Economic Opportunity, the Veterans Administration, the Department of Housing and Urban Development, the Justice Department, and the operating agencies or the Department of Health, Education, and Welfare, but presently alcoholism seems to be a low priority item. Because of the complex nature of alcoholism and the implications of it for the work of these other programs, the addition of such a preamble would express strong congressional intent that they be involved in the treatment and prevention of alcoholism.

CONCLUSION

The Methodist Church is not prepared to surrender its conviction that abstinence is a desirable practice in view of the confusion and ambivalence surrounding alcohol use and the many problems associated with it, not the least of which is alcoholism, in this country; but it is prepared to enter the public realm to encourage, support, and cooperate with community wide efforts at the national, state and local levels to treat and to prevent drinking problems through the most effective means available. H.R. 15758 is considered an effective means because its provisions will facilitate state and community development of model programs such as the one incorporated in H.R. 14300 for the District of Columbia which the House of Representatives has already passed without objection.

Mr. ROGERS. Thank you very much, Dr. Price. I am sure the committee is interested in the participation of the churches in the Nation in helping to meet these health problems. It would be an important part of trying to bring about some cure to have the interest of the churches in the Nation join with the medical people to help do some-

thing about these very serious problems, and certainly with the families affected, here is an area where so much needs to be done in the community and with the church groups which the medical people can necessarily help in.

Thank you for being here.

Mr. Kyros.

Mr. KYROS. I want to join with you in your remarks, and in welcoming Reverend Works and Dr. Price here. I can think of no better institution in our society than the church for doing the things before us.

In rehabilitation from alcoholism and drugs, I think the church hasn't been active enough in the past, and I appreciate your being here today and being in favor of title III of the bill.

Dr. WORKS. I know the hour for adjournment for lunch is at hand, Mr. Chairman; however, I would like to make just one additional statement. About 6 months ago, the North Conway Institute undertook three major studies for the Presbyterian Church, U.S.A., which dealt with the middle-class suburban housewife and alcohol; the Negro ghetto and alcohol; and the "hippie" community and drugs.

We found that the problem of drugs—including alcohol, which we regard as a drug—to be almost overwhelming.

When we sought possible sources of funds for a national resource center on drugs and a research program which could develop into decent therapeutic and educational facilities, we were told that there were no funds available for either treatment or prevention.

Today the Washington Post carries the story on page 1 of the stabbing death of 24-year-old Linda Marshall of Cambridge, Mass., whose mother and father are dear and beloved personal and family friends.

The New York Daily News wonders on page 1 if a drug-insaned "hippie" killed Linda Marshall. Some of us wonder if the streets of Cambridge, Mass. are as safe as Saigon, South Vietnam; and we ask you in the U.S. Congress about what can be done for adequate funds to finance alcoholism as well as other drug-related programs.

From 1956 until January 20, 1961, I served as chairman of a Federal Government commission on alcoholism among the American Indians; the entire Federal budget just a decade ago was about $126,000.

Therefore, I do appreciate the increase to the figure proposed in this legislation of $7 million. The time is long past for such tiny and insignificant sums.

Sometime in the future, maybe we can do something effective in the area of alcohol education and the prevention of alcoholism as well as drug abuse and drug dependence—especially with LSD, "speed," and other mood-changing chemicals.

We have now a seminary student from the Harvard Divinity School working in a small home in the Cambridge-Somerville, Mass., area where runaways from all over New England—including, Mr. Kyros, the state of Maine—are congregating. Most of these youngsters are using illegal drugs, and they need help now.

I know you are a man of great conscience about drugs, Mr. Rogers. You also know how effective is the great Florida State program on alcoholism which is located in Avon Park. You know that I would

be remiss in my responsibility as a clergyman if I did not remind you of the Episcopal vestryman's prayer, "O Lord, You keep him humble and we'll keep him poor." The people back home need financial resources.

Mr. ROGERS. Thank you. I hope it will be encouraging to you to know this, that this is one approach we are considering now, but Mr. Kyros and I have joined in introducing legislation to do something about the LSD problem, the hallucinogens, the barbiturates, and we are trying to get initiated an effective educational program, and I think we are pushing in the right direction here, and I think this is going to come about as the result of the work of this committee.

It is going to take time, of course, but I think we are well along our pathway to really accomplishing something in constructive programs to meet those problems.

Dr. WORKS. May I add for the record here a brandnew drug pamphlet which the North Conway Institute has just published entitled, "What You Need To Know About Drugs * * * Stimulants, Depressants, Hallucinogens, Narcotics, Deliriants, Alcohol." I would like to add this pamphlet as part of my written statement for the record.

Mr. ROGERS. The committee would like to have that for its file.

(The document referred to has been placed in committee files.)

Mr. ROGERS. Thank you so much.

(Whereupon, at 12:45 p.m. the committee recessed, to reconvene at 2 p.m. the same day.)

AFTER RECESS

(The committee reconvened at 2 p.m., Hon. Paul G. Rogers presiding.)

Mr. ROGERS. The subcommittee will come to order, please.

We have some witnesses who have to catch planes. We will try to get to them in order as rapidly as possible.

I believe the one who has to catch the first plane is George Dimas, who is president of the North American Association of Alcoholism Programs and executive director of alcohol studies and rehabilitation section, State mental health division, Portland, Oreg.

Mr. Dimas, it is a pleasure to have you, and we are delighted to hear from you now. If you want, we will make your statement a part of the record, without objection, following your remarks. If you could give us your comments, this would be helpful.

STATEMENT OF GEORGE C. DIMAS, PRESIDENT, NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAMS; ACCOMPANIED BY GUS HEWLETT, EXECUTIVE SECRETARY; AND BERNARD LARSEN, FORMER MEMBER, BOARD OF DIRECTORS

Mr. DIMAS. Because of the limited time, we are going to suggest again that we would like to submit our entire testimony for the record, and attempt in a short period of time to give you a condensed form of our presentation.

We want to thank you for the chance to appear before you today. I have with me Gus Hewlett, to my right, who is executive secretary, and at this time I would like to extend to you and your committee

and your colleagues the services of Mr. Hewlett, who has his offices in Washington, D.C.

Mr. ROGERS. Yes; we know Mr. Hewlett, and the good work he does, and we appreciate that offer.

Mr. DIMAS. I have Mr. Bernard Larsen from North Dakota, a former State legislator from that State, and a former member of our board of directors, and a person well informed on the legislative effort.

Mr. ROGERS. It is a pleasure to see you today.

Mr. DIMAS. Our association is comprised of 42 or 43 governmental programs. The governmental programs are parts of other governmental health bodies such as mental health division, such as health departments, such as public welfare departments. I emphasize this point to you, because the alcoholism programs do have a wealth of strength to gather from, rather than working autonomously, as some people might imply at times.

We have an additional 72 agencies which are governmental programs involved in treatment and rehabilitation programs related to alcohol problems.

The association also is considered the professional organization in the field. By this I mean professional people do belong to this association.

The North American Association of Alcoholism Programs strongly supports the provisions of title III, part A of H.R. 15758. We commend Chairman Staggers for introducing this progressive legislation. We also commend this committee for taking early action on this significant legislation.

In prior testimony reference has been made to the President's Crime Commission reports. Many recommendations in these reports are embodied in the provisions of title III, part A of the bill.

I would like to make reference to a February 29 report of a special committee of leading traffic safety experts to the Secretary of Health, Education, and Welfare who recommended a massive Federal program to eradicate the disease of alcoholism.

Reference has also been made in prior testimony to the two district court decisions that held that a chronic offender could not be convicted for the offense of public intoxication. Reference has been made to the pending Supreme Court decision in the *Powell* v. *Texas* case.

You gentlemen are aware of the amicus briefs that have been prepared. There was a broad spectrum of interested groups supporting this brief, which included the American Medical Association, the North American Judges Association, and other similar organization. These court decisions certainly represent a humane, logical advance from the outmoded custom of punishing sick people.

We applaud these decisions, but we recognize they present major problems to localities. I believe communities are ready to accept the decisions, but they are not ready to develop health services rather than criminal services for these clientele.

We feel strongly that the Federal Government can not and must not assume the total responsibility for providing the necessary facilities and other resources to meet this pressing need. We believe that the

States and communities have an essential responsibility in this area. However, the Federal Government does have a clear duty to help other governmental jurisdictions to meet the needs of our society.

Enactment, implementation and funding of title III, part A of H.R. 15758 will be a significant step by the Federal Government in fulfilling that duty.

Passage of this act will provide much needed impetus for the States to expand their own existing alcoholism care and control programs and to the establishment of new facilities and resources to meet the impending need. This will be in the beginning.

At this point I would like to make three suggestions concerning the provisions of H.R. 15758. One relates to emergency care. It is felt by the association that emergency facilities should be specifically designated as one of the types of facilities eligible for Federal assistance in the construction, staffing, maintenance, and operation provisions of title III, part A, of H.R. 15758, with a specific provision authorizing emergency care facilities, the possibility of adequate care for intoxicated alcoholics will be substantially reduced.

Two, existing health, welfare, and rehabilitation legislation. Comprehensive Federal assistance to States and communities can also be generated through the whole spectrum of Federal health and welfare programs. Congress has passed much solid legislation relative to the activity of various Federal agencies under which alcoholism help is available.

Alcohol agencies are receiving almost no consideration by these agencies, and they have a low priority in others.

Evidence of this is seen by the fact that a total of only $11.2 million was spent by the Depatrment of Health, Education, and Welfare during the current fiscal year despite the fact that the former HEW Secretary has called alcoholism the most neglected health problem facing the Nation today.

For the same fiscal year, the amount appropriated to the National Cancer Institute was $183,356,000. Added to this figure were millions of dollars appropriated to the cancer control branch, the Veterans' Administration and the Atomic Energy Commission.

There are approximately 1 million people under treatment for cancer. Alcoholism, with approximately 5 million victims, is currently receiving less than 5 percent of the Federal attention which cancer receives.

Similar statistics can be given to heart disease, vocational rehabilitation, and mental retardation. These are all worthwhile endeavors, but alcoholism should be accorded far greater recognition than it is currently receiving.

We would therefore strongly urge the Congress to reassert its intent that existent social, health, welfare, and rehabilitation acts must and should be utilized to aid in programs of alcoholism control, and control where applicable, care and control.

The third recommendation is regarding training programs. Training professional personnel to staff alcoholism treatment facilities is a crucial need in the field. A very limited number of professionally qualified personnel are devoting time and energy to the problems of alcoholism. This, coupled with the new acute problems posed by the court decisions makes necessary a large number of workers in the field.

The above points, emergency care, existing health, welfare and rehabilitation legislation and training, we respectfully submit, could be in a preamble to title III, part A, of H.R. 15758.

On pages 6 and 7 of my formal testimony a recommended preamble is included. The inclusion of such a preamble would, in our judgment, greatly strengthen the bill without affecting the amount of funds necessary to be appropriated by Congress. We respectfully urge your consideration to include such a preamble.

The last two comments, significant existing Federal efforts: Two significant developments have taken place as a result of the President's Health Message to Congress on March 1, 1966.

One of these was the establishment of the National Advisory Commission on Alcoholism, the purpose of which is to advise the Secretary of Health, Education, and Welfare on appropriate alcoholism related activity of the Department.

The second was the establishment of the National Center for the Prevention and Control of Alcoholism within the National Institute of Mental Health. Both of these actions were administratively implemented. Our association believes that these important governmental activities should be made statutory by Congress and that the amount of the appropriations and the size of the staff of the National Center should be increased to a level permitting the degree of services and research commensurate with the magnitude of the problem.

Although the court decisions have pointed up the need to handle the large numbers of patients found to be alcoholics, it must be pointed out that the chronic alcoholic coming to the attention of the court makes up a small part of the alcoholic population. Enactment of this legislation will be of great help in the efforts to control the disease. This will stimulate professional people to become involved, and awareness of all sectors of society will insure that progress will be made on this most complex problem.

(Mr. Dimas' prepared statement follows:)

STATEMENT OF GEORGE C. DIMAS, PRESIDENT, NORTH AMERICAN ASSOCIATION OF ALCOHOLISM PROGRAMS

The North American Association of Alcoholism Programs strongly supports the provisions of Title III, Part A of HR–15758 to be known as the "Alcoholic Rehabilitation Act of 1968." We commend Chairman Staggers for introducing this progressive legislation so urgently needed to cope with what is now recognized to be a major medical-social problem by medical authorities, social scientists, members of the Bar and Bench and law enforcement authorities.

We also commend this committee for taking early action on this significant legislation. Alcoholism is a major problem—there being between 5 and 6 million Americans who have the disease. This illness knows no socio-economic or ethnic boundaries. It is a problem recognized by Congress to be in need of early federal action. That this recognition and interest is non-partisan is seen by the fact that of the 95 members of the 90th Congress who have sponsored alcoholism legislation both political parties are heavily represented. In two messages to Congress the President gave substantial attention to the needs in this field of interest. Further, the 1964 Republican Platform contained a significant statement concerning the need for the federal government to become actively engaged in combating alcoholism. This is a problem above partisan consideration and the Administration as well as Congress has clearly demonstrated this fact, which is deeply appreciated by those in the field.

The President's Commission on Law Enforcement and Administration of Justice and his Commission on Crime in the District of Columbia both found arrests for public drunkenness to be an unnecessary and unwarranted waste of

law enforcement resources. One of every three non-traffic-related arrests for the nation in 1965 was found to be for public intoxication. The arrests for this offense in several urban areas numbered up to one-half of all non-traffic arrests. Specific and similar recommendations were made independently by both Commissions concerning this problem. Many of these recommendations are embodied in the provisions of Title III, Part A of HR–15758.

A February 29 report of a special committee of leading traffic safety experts to the Secretary of Health, Education and Welfare recommended . . . "A massive federal program to eradicate 'the disease of alcoholism' . . ."

In 1961 the National Institute of Mental Health supported a 5-year comprehensive study in depth of the problems of alcohol in American society. The recently published report of this Commission reflects the vital need to make sweeping changes in the techniques of dealing with these problems. The provisions of Title III, Part A, of HR–15758 meet several of these needs at the federal level.

The January 22, 1966 ruling of the Fourth U.S. Circuit Court of Appeals in the case of *Driver* v. *Hinnant* declared it violative of the 8th amendment of the U.S. Constitution to hold alcoholics criminally liable for public intoxication. Such long-established practice, held the Court, constitutes "cruel and unusual punishment." The decision of *Easter* v. *District of Columbia*, similarly precluded convicting an alcoholic for his public intoxication. Municipal courts in Philadelphia and Atlanta have since made similar rulings. Thus, in five states an several municipalities it is now against the law to punish chronic alcoholics for public drunkenness charges. This ruling is likely to be extended across the land within the next two months when the U.S. Supreme Court is expected to render a decision in the case of *Powel* v. *Texas*, a case similar to the *Driver* and *Easter* cases. The high court heard oral arguments in the *Powell* case on March 7, 1968.

Amici Curiae representing a wide spectrum of interests have urged the Supreme Court to hold in the *Powell* case that a chronic alcoholic may not be punished for his public intoxication. In addition to NAAAP, Amici Curiae that took this position were: American Civil Liberties Union, American Medical Association, Correctional Association of New York, Methodist Board of Christian Social Concerns, North American Judges Association, North Conway Institute, Texas Commission on Alcoholism, Washington D.C. Area Council on Alcoholism. In their amicus brief, these organizations supported the recommendations of the President's Crime Commissions that public drunkenness statutes should be repealed and replaced with humane and effective public health measures. Thus, these organizations support legislation of the scope and thrust being considered here today. Another organization, the National Council on Alcoholism, filed a separate brief in support of Mr. Powell and that organization also supports Title III, Part A, of HR–15758.

These court decisions represents a humane, logical and progressive departure from the outmoded and primitive custom of punishing sick people for displaying symptoms of their illness. While NAAAP applauds these decisions, we recognize that they present major problems for state and community health, welfare and alcoholism treatment facilities which must transfer responsibility for the chronic homeless alcoholic from the criminal system to a public health, welfare and rehabilitation system.

The implications of the expected Supreme Court decision can best be seen from a description of what took place in Washington, D.C. following the *Easter* decision. The nation's Capital was, as is the entire country today, totally unprepared to handle the many patients found by the courts to be chronic alcoholics. In the first six months following the *Easter* decision, more than 2,000 chronic alcoholics were referred by the court to the D.C. Health Department. The number today is in excess of 5,000. Chaos resulted because of the completely inadequate resources available in Washington to treat alcoholics. It has now been two years since the *Easter* decision, during which time a 425-bed inpatient diagnostic and tratment unit has been established, along with a 50-bed detoxification unit (an emergency care facility where patients suffering acute intoxication are cared for on a temporary basis). Further, a Community Mental Health Treatment Center has been established with a 50-bed unit for alcoholics. A halfway house for alcoholics has recently been established. The D.C. General Hospital and St. Elizabeths Hospital both have had to expand their services for the treatment of alcoholism. Still, the District Health Department's outpatient treatment center for alcoholics,

which existed many years before the *Easter* decision, remains inundated with court-referred alcoholic patients. Prior to the *Easter* decision this facility, though very inadequate to serve the needs of the community, did provide helpful therapy to alcoholics who were not homeless, who still maintained families and jobs and were still productive members of society, but who were, in fact, problem drinkers. Now, these patients have no public facility from which they can receive the kind of help which they so desperately need. They have been displaced by the thousands of cases referred by the courts. The District of Columbia, despite the tremendous increase in the number of beds and facilities available to help the city's alcoholic population, still has inadequate programs and facilities to meet the need.

The House of Representatives on December 13, 1967, unanimously passed HR-14330, a bill introduced by Congressman G. Elliott Hagan of Georgia, to provide adequate services for the treatment of alcoholics in the District of Columbia to meet the needs resulting from the *Easter* decision and to implement the recommendations of the President's Commission on Crime. This bill will also serve as model legislation for rates and communities in coping with similar problems throughout the nation. For indeed, no state or community in the land is yet prepared to meet these needs. Of the forty-four state-level programs on alcoholism and the many municipal alocholism programs in the nation, not one state or community is adequately equipped to handle the problems, and not one will be able to establish the very minimal facilities and resources necessary without signficant aid from the federal government.

Additional model legislation is being developed by a joint committee of the American Bar Association and the American Medical Association which will also serve as a much-needed instrument in guiding legislators on the needs at the state and community levels.

NAAAP feels strongly that the federal government cannot and must not assume the total responsibility for providing the necessary facilities and other resources to meet this pressing need. We believe that the states and communities have an essential responsibility in this area. However, the federal government does have a clear duty to help other governmental jurisdictions to meet the needs of our society. Enactment, implementation and funding of Title III, Part A, of HR-15758 will be a significant step by the federal government in fulfilling that duty. Passage of this Act, along with the excellent model legislation introduced by Mr. Hagan and that being prepared by the AMA and ABA, will provide much needed impetus for the states to expand their own existing alcoholism care and control programs and to the establish of new facilities and resources to meet the impending need.

EMERGENCY CARE: SUGGESTIONS CONCERNING PROVISIONS OF HR–15758

Because of the major emphasis placed on the need for detoxification services by the Crime Commissions, which was graphically demonstrated in the District of Columbia following the *Easter* decision, it is felt that such emergency care facilities should be specifically designated as one of the types of facilities eligible for federal assistance in the construction, staffing, maintenance and operation provisions of Title III, Part A, of HR–15758. We, therefore, strongly urge that Congress specify this eligibility within the appropriate section of the Act. We would point out in this regard that the ideal location for such emergency care facilities would be in existing general medical facilities, such as general hospitals and comprehensive health clinics, or at least closely affiliated with them. Without a specific provision authorizing construction of emergency care facilities, the possibility of adequate care for intoxicated alcoholics will be substantially reduced.

EXISTING HEALTH, WELFARE AND REHABILITATION LEGISLATION

Comprehensive federal assistance to the states and communities can also be generated through the whole spectrum of federal health and welfare programs. These include the Justice Dpartment, the Veterans' Administration, the Department of Housing and Urban Development, the Social Security Administration, the Office of Education, the Office of Economic Opportunity, and the Social Rehabilitation Administration, as well as the Public Health Service and National Institute of Mental Health. Congress has passed much sound legislation relative to the activity of these agencies under the provisions of which alcoholism programming assistance is ostensibly available. In practice, however,

alcoholism related project applications for assistance are receiving almost no consideration by many of these agencies and they enjoy only a very low priority in a majority of the others. Evidence of this is seen by the fact that a total of only 11.2 million dollars was spent by the Department of Health, Education and Welfare during the current fiscal year, despite the fact that the former HEW Secretary has called alcoholism the most neglected health problem facing the nation. For the same fiscal year the amount of appropriations to the activity of the National Cancer Institute was $183,356,000. Added to this figure were millions of dollars appropriated to the Cancer Control Branch, PHS, the Veterans' Administration and the Atomic Energy Commission. There are currently approximately one million citizens under medical care for cancer with an expected additional half million new cases for the coming year. Alcoholism with an estimated 5 million victims—3 times the incidence of cancer—is currently receiving less than five percent of the federal attention which cancer receives. Similar statistics can be given for heart disease, vocational rehabilitation and mental retardation. These are all worthwhile endeavors for which more federal activity is indicated. But alcoholism should be accorded far greater recognition than it currently receives. We would, therefore, strongly urge the Congress to reassert in HR–15758 its intent that existing social, health, welfare and rehabilitation Acts must and shall be utilized to aid in programs of alcoholism care and control where applicable.

TRAINING PROGRAMS

Training of professional personnel to staff alcoholism treatment facilities is a special and crucial need in the field. Because of the historically low governmental agency priority for alcoholism projects, only the most highly dedicated and motivated people have been able to withstand the frustrations heaped on the professional worker in this field. Consequently, a very limited number of professionally qualified personnel are now devoting time and energy to the problems of alcoholism. This, coupled with the now acute problems posed by the court decisions, makes mandatory the training of large numbers of professional workers in the field.

Suggested Preamble:

The above points, we respectfully submit, could be covered in a preamble to Title III, Part A, of HR–15758 such as follows:

The Congress hereby finds that—

(*a*) Alcoholism is a major health and social problem afflicting a significant proportion of the public, and is not receiving the attention required from federal, state and local governments.

(*b*) Alcoholism treatment and control programs should: 1) be community based whenever possible, 2) provide a comprehensive range of services, including emergency treatment under proper medical auspices on a coordinated basis in existing and new facilities, and 3) be integrated with and involve the active participation of a wide range of public and non-governmental agencies.

(*c*) The handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the problem. A public health approach permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public.

The Congress further declares that—

(*a*) Major federal action and federal assistance to state, regional and local programs are required 1) to conduct and foster research relating to the cause, prevention, diagnosis and treatment of alcoholism, 2) to develop and demonstrate new methods and techniques for the prevention of alcoholism and the treatment and rehabilitation of alcoholics, 3) to improve and coordinate services for the prevention of alcoholism and the treatment and rehabilitation of alcoholics, 4) to support programs for the training of persons to carry out the purpose of this Act, and 5) to promote full and equal access to humane care, effective treatment, and eventual rehabilitation for all alcoholics regardless of their circumstances.

(*b*) In addition to the funds provided for under this Act, other federal legislation providing for federal or federally-assisted state research, prevention, treatment or rehabilitation programs in the fields of health and disease

must and shall be utilized to help eradicate alcoholism as a major health problem.

The inclusion of such a preamble would, in our judgment, greatly strengthen the bill without affecting the amount of funds necessary to be appropriated by Congress. We respectfully urge your consideration to include such a preamble.

SIGNIFICANT EXISTING FEDERAL EFFORTS

Two significant developments took place as a result of the President's Health Message to Congress of March 1, 1966. One was the establishment of the National Advisory Committee on Alcoholism, the purpose of which is to advise the Secretary of Health, Education, and Welfare on appropriate alcoholism related activity of the Department.

The second was the establishment of the National Center for the Prevention and Control of Alcoholism within the National Institute of Mental Health.

Both of these actions were administratively implemented. NAAAP believes that these important governmental activities should be made statutory by Congress and that the amount of appropriations and size of the staff of the National Center for the Prevention and Control of Alcoholism should be substantially increased to a level permitting the degree of services and research commensurate with the magnitude of the problem.

CONCLUSION

Although the court decisions have pointed up the immediate need to establish adequate facilities and staff to handle large numbers of patients found to be alcoholics, it must be pointed out that the chronic alcoholics repeatedly coming to the attention of the courts make up only a small, though very visible, part of the entire alcoholic population.

Enactment of this legislation will be of great help in the nationwide efforts to control this disease and care for its victims. This action will stimulate professional people to become involved, and the resulting awareness and concern from all sectors of society will insure that progress will be made on this most complex problem.

Mr. ROGERS. Thank you very much for an excellent statement, Mr. Dimas. Some of your suggestions are well taken and they will be helpful.

In your projection of how this problem should be met, do these treatment centers effect a cure?

Mr. DIMAS. Are you referring to the detoxification centers, or the compressive centers, sir?

Mr. ROGERS. Either.

Mr. DIMAS. We feel the terms altering behavior or controlling behavior are much better used. If services commensurate to other services in the community with people with illnesses and problems, the rate of success in helping people is just as effective.

Mr. ROGERS. I was wondering how many times we have to run a man through this——.

Mr. DIMAS. In dealing with the chronic offender, I think we have to take into consideration the term "chronic," as we do have the chronic heart patient, the chronic diabetic and the chronic in many other kinds of illnesses, which means there is going to be some kind of a repetitive factor.

I think one of the philosophies of treatment is how you control the problem over a longer period of time. I would say in some cases some of these chronic offenders can be rehabilitated and never return to this chronic kind of problem. I would say other kinds of individuals, the period probably will be prolonged, from 1 week to 6 months to a year.

Mr. ROGERS. Should we have a provision in the law that if these facilities are used, it must be at the request of the person?

Mr. DIMAS. Well, I would say that we do have present laws for involuntary basis, or a basis in which the crisis could be created so the person could be referred to the service. We do have our present commitment laws which allow us now to take a chronic alcoholic and commit him for his own protection.

Mr. ROGERS. What I was thinking of was if a person agreed to begin a treatment that he must have, and in that voluntary commitment agreed to the conclusion——

Mr. DIMAS. I would say if he does not agree to stay to its conclusion. If he does not, some other measures might be taken.

Mr. ROGERS. Would you give us your thinking on how that might be incorporated in what we are trying to do?

Mr. DIMAS. I think the St. Louis experience shows that nearly 91 percent of these clients accept the treatment and complete the detoxification treatment.

Mr. ROGERS. I would be interested in seeing how many repeats there are.

Mr. DIMAS. I think this afternon or tomorrow you will be hearing from Dr. Pittman, who is the founder of the United States first detoxification center.

Mr. ROGERS Dr. Carter?

Mr. CARTER. No questions.

Mr. ROGERS. Thank you very much.

The next witness, Mr. Nathan J. Stark, group vice president for operations, Hallmark Cards, Inc., Kansas City, Mo.

STATEMENT OF NATHAN J. STARK, CHAIRMAN, MISSOURI REGIONAL MEDICAL PROGRAM

Mr. STARK. My operations have nothing to do with medicine.

Mr. ROGERS. I am not so sure. Don't you give get-well cards or something?

Mr. STARK. I have been accused of that.

I am pleased to have this opportunity to be at this hearing on regional medical programs. I am, as you note from the title, a nonexpert in the health field.

A businessman interested in health programs is my category. As I listen to all these experts, many of whom I have heard of, and several of whom I have known, I asked myself the question, "What am I doing here?" But perhaps this is the new look in the nonprofessional's view of the health field.

I think that the need for citizen participation has been rather unfamiliar to most of those in many parts of the health field, but I believe it is fast becoming consumer oriented.

My credentials in the health field are as president of the Kansas City General Hospital and Medical Center, and as chairman of the Missouri regional medical program, and it is to this latter role that I wish to address my remarks.

My statement will be restricted to the Missouri program, since this is the one I am most familiar with, and it may be typical, or may be typical of what other programs are.

The final focus of our program is on the cooperative delivery and planning of the best possible health care to patients suffering from heart disease, cancer, stroke, and other related diseases, regardless of economic, educational, or geographical status.

The program utilizes maximum local planning and initiative with regional emphasis upon coordinaion of efforts and review of the quality of endeavors. Policy is set by a council representative of the public and professional leadership with advice from all groups in the region who have a bona fide interest in the delivery of health care.

Because of the stated intent of the program which was to improve care by increasing the effectiveness of present systems, attention in the Missouri program was directed to early detection of disease, methodology for systems to provide maximum economy and effectiveness, and initially a small number of models of delivery systems, planning for a service to a specific population of people without regard to the exact place in which that service might be rendered, but with emphasis on delivering the care as close to the patient's home as is consistent with economy and quality. In other words, we are people oriented.

Primary emphasis has been placed on the development of supportive services which utilize the newest in scientific technology. This includes a variety of services which can be furnished both to the physician and to the patient quickly and economically at any time anywhere in the region.

The present testing of computerized interpretation of EKG's for physicians in rural areas is a precise example. For screening purposes, and for the first time in history, the private practitioner participating in the model system has consultation for heart disease immediately available to him at every hour, 168 hours a week, at an estimated cost of less than $3 per interpretation.

Each interpretation can be backed up by a dial-a-phone lecture reference source, recorded on tape and also automatically available at all hours at the cost of a phone call.

These backup lectures will develop on a demand basis in accord with experience. A model of delivery systems is found in the Smithville project. Here building upon an existing rural system, maximum effort has been placed by the local advisory group and the State university medical school upon a sophisticated consultation and referral program.

In Smithville, the system extends into home care utilizing all available ancillary and auxiliary personnel. Faculty members of the university teach and consult with the local staff.

Financial assistance was given with a specific terminal date, at which time the system of care is projected to be self-supporting. The program provides for careful change of quality of care as a result of intensified support.

It is the plan of the Missouri program to establish and terminate final support for all demonstration projects in this manner in order to provide the opportunity for cooperative programs with a maximum of communities in the region.

Supporting services and later innovations will continue to be made available on a financially self-supporting basis to these cooperating communities so long as these are found to be mutually helpful.

A final facet of the program is the interdisciplinary research group in the university who are studying intensively the delivery system