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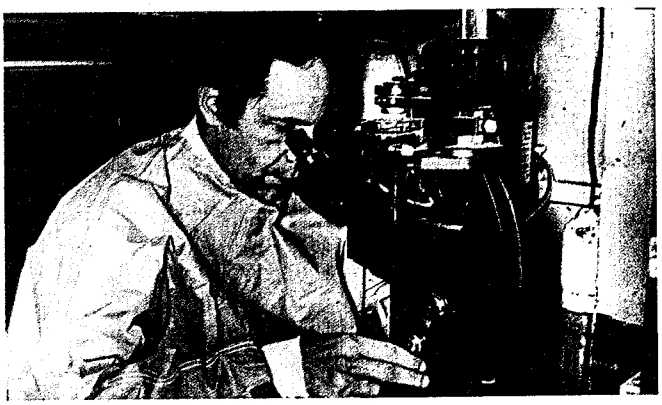
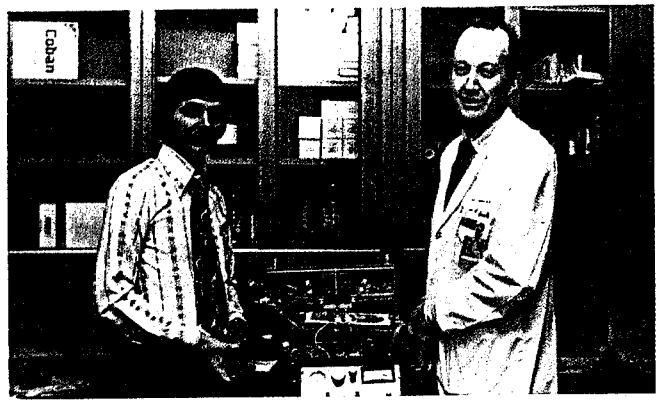
mrmp horizons

Maryland Regional Medical Program • March, 1974 • volume 8 number 1 • promoting cooperation to improve the quality and distribution of health care services • health manpower development • encouraging the regionalization of health facilities manpower and other resources

Maryland Regional Organ Procurement and Transplantation Program Receives Approval



G. Melville Williams, M.D., Co-Program Director, Professor of Surgery, Chief, Division of Transplantation, The Johns Hopkins University School of Medicine



Left, *Ron E. Purser, Physician Assistant, Coordinator of Technical Programs of Division of Nephrology, University of Maryland.* Right, *John H. Sadler, M.D., Project Director for MRMP Organ Procurement and preservation Program, Associate Professor of Medicine, Head Division of Nephrology, University of Maryland, School of Medicine.*

MRMP originally submitted this project proposal on October 31, 1972 to begin May 1, 1973. However, it was delayed by the "phase-out" telegram from RMPS on February 1, 1973. After receipt of the letter and memorandum of September 7, 1973 from Dr. Herbert J. Pahl, Acting Director of RMPS, it was resubmitted with the full endorsement of the Regional Advisory Group, the Maryland Comprehensive Health Planning Agency, the Maryland Commission on Renal Disease and the Chronic Illness and Aging Administration of the Maryland State Department of Health and Mental Hygiene. The grant became effective October 1, 1973 for $35,960 and was extended January 1, 1974 through June 30, 1974 for an additional $29,038. It is expected that the program will be self-supporting following July 1, 1974 from third party payments from Medicare (Section 2291, Title II of the Social Security Amendments of 1972). John H. Sadler, M.D., Head of the Nephrology Division at the University of Maryland School of Medicine, is the program director. G. Melville Williams, M.D., Professor of Surgery and Head of Transplantation Surgery at Johns Hopkins University is co-director.

The program represents an outstanding example of full partnership between the Region's two university medical centers and other cooperating institutions in furtherance of the goal of a comprehensive regional program of care for all chronic renal disease patients. It supplies the major missing link in the Maryland renal program in making transplantation the top priority in management of chronic renal disease whenever possible. MRMP is proud of the way in which the several key health institutions involved have worked out really effective cooperative arrangements to make the most effective use of the resources available.

For most patients with chronic renal failure, kidney transplant offers the best treatment. For some of them a family member is able to give a kidney. If this kidney is well matched, the likelihood of success is better than 80 percent. Most people are not so fortunate. Their kidney must come from someone dying without renal disease. This source of kidneys provides over half the kidneys transplanted in America each year, but this is only a small fraction of the need for transplants. It is an even smaller fraction of the kidneys which might potentially be made available for transplant, some estimate 100,000 potential donors per year. Half of these would be enough. Last year, there were less than 2,000 donors.

A major public and professional educational program is carried on by many agencies to stimulate a broader willingness to donate organs. Progress is slow. A major problem was obtaining kidneys at a time when the transplant could be done, maintaining them in a viable state until the recipient, the kid-

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New Projects Approved for Fiscal Year 1974

The Regional Advisory Group, acting on instructions from RMPS dated September 7, 1973, approved a first request application for $160,740 for the months of October, November and December, 1973. A second request for $226,878 for the new budget period January 1, 1974 through June 30, 1974 was also approved.

In addition to maintaining the reduced program staff and providing a modest fund for "mini-contracts," the first request initiated the Maryland Regional Organ Procurement and Preservation Program and the contract with the Greater Ocean City Health Care Corporation to start implementing recommendations of the CHP Ocean City Health Care Study for solving problems of accessibility to health services. Both of these projects, which are briefly described below, had been included previously in MRMP's Anniversary Review and Application submitted on November 1, 1972, but were stalled by the RMPS "phase out" telegram of February 1, 1973.

The second request continued these two programs and added five additional projects. MRMP has also been assigned $178,620 (from FY 1973 fund), but "expenditure of these funds cannot be made until instructed by RMPS." In the most recent award notice dated December 27, 1973, which approved the application for January 1, 1974 through June 30, 1974, this instruction was continued.

Since the extended budget year ended on December 31, 1973, carryover of $52,617 in estimated unexpended funds has also been approved.

Greater Ocean City Health Care Corporation—$17,742

(January 1, 1974—June 30, 1974)
This is an example of health planning to promote geographic equity of access to health services in a rural (but changing) area of Maryland's Eastern Shore where the summer (four-month) population soars from approximately 3,500 in non-vacation months to nearly 200,000 at peak periods. This phenomenon has been accompanied by a decrease in available physicians services.

Several years ago the State and Areawide CHP agencies anticipated the problem and the former commissioned a "Study and Plan to Meet Health Needs in Ocean City" by consultants from the Operations Research Division of the Johns Hopkins University School of Hygiene and Public Health.

One of the recommendations was to form a Greater Ocean City Health Care Corporation which was accomplished in part by previous MRMP support. The objective of the Corporation is to bring together all those elements in the community responsible for the health of the area and to serve as the focal point for planning, development, implementation and evaluation of present and future health care services within its area of responsibility. At present a principal activity is the creation of a new Medical and Diagnostic Center, which would be related in the future to an existing community hospital for secondary care and specialized diagnosis and to a university center for tertiary care and continuing professional education programs.

Maryland Regional Procurement and Preservation Program—$29,038

(January 1, 1974—June 30, 1974)
This program, which is a key component of Maryland's comprehensive program for the care of chronic renal disease, is sponsored jointly by the University of Maryland and Johns Hopkins Medical Schools. This is described on page one.

Pediatric Nurse Practitioner Program—$9,075

(January 1, 1974—June 30, 1974)
This project is the only one which represents an extension of an existing MRMP program. It deals effectively with the maldistribution-access problem which the Administration has repeatedly emphasized in recent policy statements, namely the high priority which will be placed on increased use

Pediatric nurse practitioner, Mrs. Marcia Katz, demonstrates her skills in gaining confidence of the child and his mother.

of nurse clinical practitioners, pediatric nurse practitioners, nurse-midwives and physician assistants. The RAG assigned a no. 1 priority to this project.

The program located at the School of Nursing, University of Maryland, has already prepared 16 registered nurses from rural and urban areas of Maryland to practice in this expanded role. All 16 graduates are employed in community based programs or private physicians' offices and have assumed full responsibility for a case load to provide primary care for infants and children in their respective agencies. Activities include initial new born assessments at local hospitals (in two of the rural counties); routine well baby health supervision; diagnosis and treatment of minor childhood illnesses; collaboration with pediatricians; providing continuity of care between the Health Department and the private sector; and providing health guidance and counseling to parents.

The objective of the present extension is to prepare another group of 8 registered nurses to function in a primary capacity in ambulatory health care for children through collaboration with physicians and other health professionals. Some aspects of the curriculum will be revised as a result of the evaluation of the performance of the 16 graduates now practicing, i.e. increased emphasis upon defining, interpreting and implementing role change for the nurse practitioner. After

termination of MRMP support in July it is expected that the program will continue from other sources of support available to the School of Nursing and the activity will be coordinated with a similar program at the Johns Hopkins School of Health Services to achieve maximum benefit from teaching resources and to avoid duplication of effort.

Demonstration of a Model Hospital Quality Assurance Information System—$31,280

(January 1, 1974—June 30, 1974)

The primary leadership for this demonstration comes from the Maryland Hospital Association in cooperation with five hospitals — 3 urban and 2 rural. The Maryland Foundation for Health Care is also participating and discussions are underway with other groups with a view to ultimate development of a commonly held corporation to manage a statewide health services information service.

The project will demonstrate the feasibility and effectiveness of performing the following quality assessment/claims review activities, consistent with Joint Commission on Accreditation of Hospitals (JCAH) and Professional Services Review Organization (PSRO) requirements, through the use of a centrally managed, single, uniform, reporting and review process for:

- utilization review and certification of medical necessity acceptable by third party purchasers
- the collection of uniform discharge data abstract information
- interfacing with medical audit functions

Related objectives will be to demonstrate the value and feasibility of developing a single, uniform method of external third party claims surveillance and utilization review which could be applied to all hospitals in the State and to all patients regardless of source of payment, utilizing a process similar to that of the Maryland Admission Review Program (MARP) of the Maryland Foundation for Health Care.

Also the program will endeavor to establish a health services information system utilizing a single source document to provide reports to serve the following purposes:

- report patient care outcome as compared to pre-established norms and standards of care for use in a medical staff's medical audit function.
- management and evaluation of the utilization/claims review, preadmission certification, and discharge planning functions.
- report all hospital data for service area analysis; utilization analysis; patient profile analysis.

Development of Quality Assurance Norms, Criteria and Standards for Community Health Care—$30,000

(January 1, 1974—June 30, 1974)

The principal sponsor of this project is the West Baltimore Health Care Corporation located in an urban setting in close collaboration with the South County (Anne Arundel) Health Care Center which is located in a rural area. Technical consultation and direction is provided by Management Advisory Services, Inc., of Columbia, Maryland.

The activity is directed towards development of methods and procedures to assess the quality of personal health care delivered in two ambulatory settings, both administered by consumer citizen groups.

The program will utilize the data base of a *currently operating* computer based encounter system to derive norms, criteria, standards and techniques associated with current endeavors to assure quality of care in various Federally funded medical care programs. The encounter system has a data base which includes disease diagnosis, medical procedures and medication for every patient treated for *each encounter*. Subsequently, disease profiles and associated usage rates of health care services can be determined as a function of demographic and socioeconomic characteristics.

For example, the information content of the encounter form allows for the comparative evaluation of different medical procedures and medication and the outcome as indicated by the frequency and duration of acute and intensive care required by the patient. Of course, the "end result" will need to be adjusted for age and type and severity of the disease.

In conjunction with the Medical Staff of the participating community health centers, the Management Advisory Services, Inc. will develop the key parameters for which norms and criteria will need to be established in the future for ambulatory services in community health centers, health maintenance organizations and other organized health care delivery models which are evolving.

Comparative evaluation of the patient's health profile will be performed on the basis of disease category, as well as use rate of health care by disease type.

In brief, the expected results are the development of methods and procedures for establishment of norms and criteria for quality assurance of ambulatory care on the basis of "outcome" and "end results" as indicated by:

- The frequency and use pattern of the patient's ambulatory care, adjusted for age, type and degree of disease. For selected diseases this will result in the establishment of numerical percentile tables.
- An analysis of potential differences between urban and rural patient populations pertaining to their use frequency and pattern of ambulatory care.

Supplementary Studies to Augment State Comprehensive Health Plan—$7,299

(January 1, 1974—June 30, 1974)

This is a supplementary grant adding to the State Health Plan Study currently being undertaken by the Johns Hopkins University Multidisciplinary Health Planning Group. The source of funding for the Maryland Health Plan Study is the Maryland Comprehensive Health Planning Agency.

The supplementary activity has two main objectives of great interest to MRMP:

- To describe and determine the various health services in 72 Maryland hospitals and surrounding hospitals in West Virginia, Virginia, District of Columbia, Pennsylvania and Delaware. Through the use of questionnaires

and personal interviews, these specific services and procedures available in each hospital will be determined using levels of care methodology approach.

• To attempt to determine patient flow for Maryland to West Virginia, Virginia, District of Columbia, Pennsylvania and Delaware in order to determine overall regional patient-flow patterns and the effects of hospitals located in the five surrounding areas on the Maryland health care delivery system.

Hypertension Materials Development Project for Lower Socio-Economic Levels—$10,000

(January 1, 1974—June 30, 1974)
This is a modest cooperative project between the Central Maryland Heart Association, the Educational Films Foundation (a non-profit organization) and the MRMP. Financing is cooperative as well, e.g. total budget $25,400, plus one-half time of staff coordinator: Educational Films Foundation $15,400, MRMP $10,000 and Central Maryland Heart Association one-half time staff salary.

Objective is the production of audio visual materials suitable for use in educating and motivating known hypertension patients in the lower socio-economic level, with the object of making the patient a member of the therapeutic team.

NARMP WINS SUIT

A U.S. District Court in Washington, D.C. on February 7, 1974 has ruled in favor of the National Association of RMPs in a suit calling for release of impounded 1973 and 1974 funds.

Judge Flannery enjoined any interference with the actual spending of the money, denied a stay pending appeal, and ordered the government to pay costs of the plaintiff, The National Association of RMPs, Inc. A non-profit corporation, NARMP receives no program funds, but is supported entirely by private individual contributions

Development of an HMO Information System

Background — By December 31, 1973, the terminal date of the grant to the Office of Health Care Programs and the Health Services Research and Development Center of the Johns Hopkins Medical Institutions, the major objectives of MRMP Project #36, "Development of an HMO Information System," had been met. Briefly, these objectives were directed at the development of a data collection and information system which would serve management, clinical, and evaluation functions that are particularly useful to HMOs in their quality assurance and related utilization review programs.

Before considering the details of progress made, it is worth noting that national events since the start of the project have increased the significance of the program. The Health Maintenance Organization Act of 1973 (S.14) emphasizes evaluation and there is little question but that the development of data information systems in HMOs will accelerate as a result. Contributing to this movement is the recent appearance of recommendations that define the structure and content of such systems and provide a minimum set of items and tabulations for adoption by HMOs.* The basic elements of the information system developed under the MRMP grant and implemented at the Columbia Medical Plan and the East Baltimore Medical Plan are consistent with these recommendations and, in fact, the experience with this system contributed to the formulation of the recommendations.

Accompanying the interest in information systems is the recognition that realization of their full potential for addressing management and clinical issues related to economics and quality of care in HMOs requires new reseach efforts. A major activity of the Health Services Research and Development Center, The Johns Hopkins Medical Institutions, with grant support from the Bureau of Health Services Research and Evaluation (DHEW) and Foundations, is being directed at the issue. The groundwork laid by the MRMP grant is making possible this study of the strengths and constraints of information systems in addressing specific planning and evaluation questions.

The Information System — Major components of the information system operating in the Columbia Medical Plan and the East Baltimore Medical Plan follow (the system has also been introduced in the Broadway-Orleans Housing Project clinic, a non-HMO facility):

• Routine reports of face-to-face encounters between enrollees and providers (physicians, nurse practitioners, health associates, and other mid-level health personnel).

• Computer stored information about the encounter including identification of patient and provider seen, diagnosis (or problem), procedures performed, disposition, referrals, laboratory tests, and X-ray procedures ordered, prescriptions filled, unit cost assigned to each service, and other descriptive data about the visit.

• Reports of hospitalizations and computer storage of data on where patient was admitted, dates of admission and discharge, discharge diagnosis, surgical procedures performed, admitting physician; computer files on ambulatory and in-patient care are being merged.

• Computer based enrollment file that identifies families and each member of the family enrolled in the HMO; the file also contains information on personal characteristics (data of birth, sex, marital status, relationship of individual to primary subscriber, contractor group through which family enrolled).

• Computer programs to retrieve information for currently defined management, clinical, and evaluative purposes (with aid of other grants these programs are to be expanded during 1974 and 1975).

*Murnaghan, J. H. (Editor): Ambulatory Care Data, Report of the Conference on Ambulatory Care Records, Philadelphia, Pa., J. B. Lippincott Co., 1973

Costs for operating the above system is being met by the HMOs where they were developed under the MRMP grant. *Manuals and programs are available to facilitate the introduction of the information system by other HMOs in the region, in consultation with the developmental staff.*

Management Applications — A monthly series of reports to monitor the volume and types of medical services rendered by the physician and non-physician practitioners in the HMO is in effect. This series routinely covers many of the items of information on the encounter form and reports of hospital stays and is designed to provide management with a means for determining (1) trends in utilization of different specialties and non-physician manpower, laboratory tests, X-ray procedures, drugs prescribed and hospital care; (2) the influence of changes in subscriber composition on these trends; and (3) the need to consider modifications in manpower allocations.

Utilization data are in the form of numbers and rates per person per year and are aggregated on a "year to date" basis to supplement the summary of monthly experience. Two additional sets of data that give insight to the functioning of the HMO are the distributions of patients by number of encounters during specified periods of time and the relationship between duration of enrollment and utilization.

The above data are related to copayment revenues and capitation costs to provide a basis for judging the effect of demand for services on the current economics of the HMO and to estimate future utilization and revenue in the program. Information on utilization and enrollment that is computer stored includes the identity of the membership group which makes it possible to generate utilization, revenue, and cost data for different groups. In addition, the data will provide a starting point in determining whether some groups require educational efforts to improve utilization practices (under or over utilization) with implications for both the economics of the plan and quality of care.

The ability to assess utilization levels and costs would be enhanced by the availability of comparative data in other prepayment medical plans. This has become apparent from the comparisons made between the experience in the East Baltimore Medical Plan and the Columbia Medical Plan and between the experiences of these two HMOs with those of other HMOs which are producing similar types of data. Although this is still highly limited, it is expected that as a result of the HMO legislation and the recommendations for establishing information systems in organized health delivery programs, many additional sets of utilization data will become available. The information system implemented through the MRMP grant can be used to parallel almost all types of data that might conceivably be produced by both well established and newly emerging HMOs.

Clinical Applications — A relatively costly but essential item of information for clinical application in quality assurance programs is the statement of diagnosis (or medical problem). The HMO Information System has routinely included this item in the computer data bank and significant steps were taken during 1973 to develop profiles of medical care received by patients with specified diagnoses. With the participation of clinicians, several conditions have been selected to test the capability of the system to provide information that would be useful in understanding the patterns of care received and variability in these patterns associated with patient and provider characteristics.

Conditions that are being examined from this standpoint include hypertension, bronchial asthma, urinary tract infection and headache. In the care of hypertension, profiles of care have been generated for patients who had this diagnosis during the period September-December, 1972. Intervals between initial diagnosis and first follow-up visit, between first and second follow-up visit, etc. have been determined, medications prescribed are being determined, and cases that require further studying to assess quality of care are being identified. In the case of headache, a sample of patients presenting this problem has been identified through the information system. Of interest here is how often a more definitive diagnosis is made, whether these patients are especially high utilizers, and in what situations referrals are made for psychiatric consultation.

To extend these applications to a wider range of conditions, a major investment has been made to develop an automated procedure for coding the diagnostic information being stored in text format. By February 1974, a dictionary of terms and corresponding codes that are consistent with the ICDA (and a compatible symptom list) will be programmed for this purpose. All but a small proportion of the terms that appear on the encounter form will be codable. This will facilitate the conduct of many clinical and epidemiologic studies.

Evaluation Applications — The implementation of the HMO Information System has opened the door to complex evaluation studies of approaches to increase the efficiency and quality of care in HMOs. Examples of the types of studies planned or underway that are dependent on the information system follow (all of the projects are supported by other grants):

- Utility of the information system for quality of care assessment. Central to the review of outcome of care under the Experimental Medical Care Review program (EMCRO) in the Columbia Medical Plan is the derivation of a problem status index during each of a repetitive series of inquires, followed by evaluation and modification of the questionnaires. An objective of the EMCRO study is to measure change in problem status over time and its relationship to accessibility and the expenditure of health care resources. In coordination with the EMCRO study, the relationship between process of care determinable from data stored in the information system and changes in problem status will be examined.
- Impact of drug utilization review on prescribing practices. This project is designed to measure the change in prescribing patterns over time as appropriate criteria for drug use is implemented in the clinic and to document cost savings as non-essential or

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HMO Legislation: Maryland Health Maintenance Plan Continues Local Involvement

The long-awaited Health Maintenance Organization Act (of 1973) was signed by President Nixon on December 30, after some three years of legislative deliberation. According to the American Medical Association News of January 21, 1974, President Nixon is enthusiastically endorsing the Health Maintenance Organization program effort. The government is "going all out" to implement the new law "as rapidly as possible", according to Charles Edwards, M.D., Assistant HEW Secretary for Health. Proposed regulations to carry out the HMO program are expected to be issued by the end of March.

The $375 million bill provides for a program of grants, loans and contracts to encourage the expansion and development of both non-profit and for-profit HMOs. In addition to defining HMOs and the fixed payment (capitation) method of financing, the Act requires all employers with twenty-five or more employees and covered by the Fair Labor Standards Act to offer an HMO option (dual choice) in its employee benefit plan. To qualify as an HMO, the health care organization must have consumers, i.e., subscribing members, comprising at least one-third of its policy-making body.

Over the last three years the Maryland Regional Medical Program has participated with other groups in the development of such an organization in Baltimore, The Maryland Health Maintenance Committee (MHMC). Incorporated (non-profit) in February 1971, the MHMC was funded by the Health Services and Mental Health Administration of the Department of Health, Education, and Welfare during Fiscal Years '72 and '73 to develop a network of prepaid group practice health centers in the State.

MRMP awarded some $80,000 in Fiscal Years '72 and '73 for research and development efforts in quality assurance and information systems for HMOs and demographic and third party enrollment analyses.

The Committee created a non-profit operational corporation, the Maryland Health Maintenance Plan (MHMP) which engaged in negotiations with the Blue Cross of Maryland. After sixteen months of negotiations, the two organizations signed an agreement in December, 1973 to collaborate, offering the Committee's network program to Blue Cross group subscribers as an alternative choice to traditional fee-for-service benefit programs.

It is expected that the Plan's agreement with Blue Cross will permit offering in the near future high quality care in conveniently located health centers in increasing numbers to the people of Maryland. It will encourage the progress of these centers to operational prepaid group practices through its development effort.

The Maryland Health Maintenance Plan is now anticipating enrollment from the first subscriber group: The State of Maryland is offering a dual choice program for its 50,000 employees and retirees and their approximately 100,000 dependents.

Already in agreement to deliver services to State of Maryland employees are the Columbia Medical Plan in Howard County and the Group Health Association of Washington, D.C., through its two Maryland centers, one in Rockville opening February 7 and one in Takoma Park, Montgomery County. In addition, the Chesapeake Physicians Professional Association of Baltimore City Hospitals has contracted to deliver services in east Baltimore in conjunction with the Eastpoint Health Center, Inc., a labor community corporation organized to establish a consumer-oriented HMO.

Negotiations are underway with a medical group at Mercy Hospital in downtown Baltimore; and merger discussions are in progress between the Plan and the First Maryland Health Care Corporation, funded by OEO to deliver services to "grey area" population. The merger is directed toward eliminating duplication and achieving maximum utilization of available resources and experience.

The Plan will serve as a unifying element as well as a development vehicle to bring about the high quality health care delivery intended by the new legislation. The Plan is in a unique position to take what has already been done in operating centers and use it to minimize development and operating costs in new centers.

The Maryland Regional Medical Program (MRMP) approved two companion programs in the Fall of 1971 — one involving funding support ($79,816) for the MHMC information system and evaluation effort, and the other involving funding support (approximately $140,000) to the Office of Health Care Programs of the Johns Hopkins Medical Institutions in an effort to develop an HMO information system that would have general applicability to HMOs of a variety of types and in a variety of settings. The MHMC and the Office of Health Care Programs conducted these two programs in concert.

In the near future, the MHMC's activities in management information systems will be based on the actual requirements of the operational network and its participating health centers. As a vehicle for consumer participation as well as a coordinator of provider reresources, the Plan will work to develop standards for medical groups practicing in the network program. A Medical Standards Board will be convened to plan for establishing quality assessment programs which satisfy the medical community and contribute to patient satisfaction.

One of the Plan's vital roles in information systems will be to use existing forms and systems, modifying them where necessary to satisfy the quality assurance and management data needs of emerging network health centers. As in other areas, the Plan will draw from the experience, procedures and methods already developed in our operating centers to assure the quality of care in new health facilities and minimize development costs by eliminating the necessity of doing what has already been done successfully.

When the Maryland Health Maintenance Plan begins its initial marketing and enrollment effort this Spring, with from two to five autonomous prepaid group practice centers linked organizationally, it will be the first time a prepaid group practice plan has initiated operations as a network.

Single copies of Public Law 93-222 "Health Maintenance Organization Act of 1973", which was signed by President Nixon on December 29, 1973, are available on request ot Maryland RMP, Suite 201, 550 North Broadway, Baltimore, Maryland 21205.

MRMP Regional Organ Procurement

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ney and the operating team could be together and testing the viability of the kidneys. With the advent of machinery for extended organ preservation, far better answers to this problem were obtained.

If the kidney procured can be maintained in a healthy state for 40 to 80 hours on this machine, a patient from even remote areas can be brought in and made ready for transplant. All the necessary tests to determine the match and the viability can be carried out. The characteristics of the kidney's perfusion on this machine is a major test of its viability. Small versions of this equipment are portable so that the kidney may be transported to the site of best matched recipient. Since the transplant programs of Maryland at University of Maryland Hospital and the Johns Hopkins Hospital participate in the Southeastern Regional Organ Procurement sharing program, it is often necessary to transport kidneys from Maryland to other parts of the region and from other centers into Maryland. With this machinery, there is no loss of transplantability of the transported organ.

Although hemodialysis and transplantation have been available in Maryland for the last six years and more, the ability to effectively procure organs has been limited by the absence of such equipment and staff trained in its operation. The Maryland Regional Medical Program through a grant to the combined Johns Hopkins/ University of Maryland transplant program has made this available. Also through help from MRMP a shared tissue typing exists. Now a cooperative organ preservation lab in University of Maryland Hospital maintains a group of organ preservation machines to be continuously ready when organs are procured. The equipment will be shared by all procurement teams in the region and portable units will be available at Johns Hopkins Hospital and Baltimore City Hospitals as well as University of Maryland Hospital. The console machine which is not portable, but can carry out more extended preservation will be maintained in the central laboratory.

HMO Information System

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duplicative expensive drugs are deleted from the formulary or are limited in their use.

- Effect of changes in manpower mixes on utilization. In both the Columbia Medical Plan and East Baltimore Medical Plan, the number and type of health care manpower has changed with time.
- To assess the relationship of these changes to services provided, a retrospective analysis of utilization data stored from the encounter form is being carried out.

Regional Medical Programs Are Back in Business

The reappearance of HORIZONS, MRMP's publication, signals the end of a long series of on-again off-again non-events and vicissitudes set in motion by the "phase-out" telegram of February 1, 1973 from Dr. Harold Margulies, who was then director of Regional Medical Programs Service. Detailed chronological account of the zig-zag events since then may be left to historians and to constitutional lawyers interested in the interaction between executive, legislative, and judicial branches of government during a period of national stress.

Insofar as the Maryland Regional Medical Program is concerned, the matter has now been resolved (temporarily at least) by recent actions. In October, 1973, the President signed the HEW appropriation bill for fiscal year 1974 which contained $81,953,-000 for the Regional Medical Programs. At the same time he announced release of $1.1 billion in impounded health and education funds, *but* with the stipulation that the funds are to be stretched over fiscal years 1974 and 1975 (and perhaps longer). However, on February 7, 1974 Judge Flannery of the District Court of Washington ruled that RMP impounded funds for FY 1973 and FY 1974 be released forthwith (see page 4).

As a result of this, the Division of Regional Medical Program (DRMP), the new name for RMPS, is hosting a National Conference of Regional Medical Programs on March 18-19, 1974 at Arlington, Virginia to discuss the future course for 1975. The Chairman of the Maryland Regional Advisory Group, Mr. J. Cookman Boyd, Jr., and the MRMP Coordinator, Dr. Edward Davens, will attend this meeting.

According to present information, at least $97 million in impounded RMP funds for FY 1973 and 1974 are to be released. MRMP will be expected to submit two applications: One on May 1, 1974 and the second on July 1, 1974. These applications will include funds for program staff expense from July 1, 1974 through June 30, 1975 and new projects as approved and priority ranked by the Maryland Regional Advisory Group. The RAG will meet in mid-April to act on the May 1 application and again in June for the July 1 application.

A variety of interesting project applications by various health groups and agencies which deal with improvements in the delivery of health care services are currently in preparation. These pending applications are directed to quality assurance of health

continued on next page

RMP Back in Business

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care, improving nursing care of the aged and chronically ill, comprehensive approach to hypertension control, implementation of the recently issued Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC), data systems for manpower planning and criteria determination in large hospital out-patient departments, and local planning by a health services/education consortium to improve access to primary care, continuity of care, and a health services regionalization model.

One feature of the new turn of events is $4.275 million has been set aside on request by the Congress for proposals on a national competitive basis to develop models for "Comprehensive Arthritis Care Programs." Such a proposal is being developed in Maryland for review by MRMP process and then submitted to Washington.

A high level health official in HEW has stated that a bipartisan concensus exists among both the Congress and the Administration that the three programs — RMP, CHP, and Hill-Burton —should be consolidated as an important step in preparing for national health insurance.

With this in mind, MRMP will exert special effort to ensure that all projects or proposals brought before the Regional Advisory Group for approval and setting of priorities will receive careful review and comment either by the Maryland Comprehensive Health Planning Agency (the "A" Agency) or by the Areawide Comprehensive Health Planning Agency (the "B" Agency) as appropriate. The objective is to fund only projects that will fit comfortably and merit continuation in the anticipated reorganization by Congress of the key functions of regulation, planning and implementation.

horizons

Vol. 8, No. 1 March 1974

Published bi-monthly by the Maryland Regional Medical Program with offices in the Five Fifty Building, 550 North Broadway, Baltimore, Maryland 21205

Appropriate Motto for MRMP?

"and it ought to be remembered that there is nothing more difficult to take in hand, more powerless to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions, and luke warm defenders in those who may do well under the new. This coolness arises partly from fear of the opponents, who have the laws on their side, and partly from the incredulity of men, who do not readily believe in new things until they have had a long experience of them. Thus it happens that whenever those who are hostile have the opportunity to attack they do it like partisans, whilst the others defend luke warmly, in such wise that the prince is endangered along with them."

from the Prince: Nicolo Machiavelli, published 1513 translated by W. K. Marriott

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