PHS, Agriculture to Set Up Rural Information Center Health Service

The Health Resources and Services Administration (HRSA) of the Public Health Service and the National Agricultural Library of the U.S. Department of Agriculture have signed an interagency agreement to establish a Rural Information Center Health Service (RICHS) within the Library's Rural Information Center.

The primary goal of RICHS is to provide timely information to persons and organizations interested in rural health issues, with special emphasis on hospitals and health programs and services.

Rural health research centers, administered by HRSA's Office of Rural Health Policy, will tie into RICHS by helping to shape its development and by providing copies of research findings (papers, monographs, and articles) for RICHS' collection. The centers will interact in a sort of advisory capacity as well.

Major objectives of RICHS include

- developing a national computerized system for identifying, collecting, and organizing information resources;
- developing information resources based on what is collected (including literature that may not have been published in a refereed journal);
- establishing systems for assessing user needs and promoting and disseminating the information resources; and
- establishing a ready reference telephone service.

During the fiscal year that ends on September 30,1990, initial planning will be undertaken, an 800 telephone number will be acquired, at least one health information specialist will be hired, and six local area network (LAN) workstations will be purchased, all for the Library's Rural Information Center in Beltsville, MD. RICHS was promoted during the summer of 1990 with limited implementation of services to begin in October 1990.

I have been designated by the Office of Rural Health Policy as liaison to the Library's Rural Information Center staff to develop RICHS' data base.

The National Agricultural Library uses the AGRICOLA (AGRICultural OnLine Access) data base which contains more than 2.6 million bibliographic citations to literature on all aspects of agriculture, including plant and animal science, economics, food and nutrition, forestry, entomology, engineering, and rural sociology. The data base contains records for literature citations of journal articles, monographs, bibliographies, theses, patents, software, audiovisual materials, and technical reports from 1970 to the present. The literature cited is primarily in English, but more than one-third of the data base comprises citations in Western European, Slavic, Oriental, and African languages.

AGRICOLA is accessed from direct dial-up computer terminals through two commercial data base vendors: DIALAG Information Services, Inc. (Files 10 and 110) or BRS Information Technologies (Files CAIN and CAIB). As such, these two data bases can be accessed for health information that may not be contained in the AGRICOLA database.

The Office of Rural Health Policy anticipates that RICHS will be fully operational by September 1991. The Office also plans to be able to access the developing RICHS files from one or two of its own terminals in Rockville, MD. This will permit direct search for articles to support the work of the National Advisory Committee on Rural Health and to keep abreast of current rural health events.

Office of Rural Health Policy

The Office of Rural Health Policy was established within HRSA in August 1987 and authorized by Congress in December 1987. The major responsibility of the Office is to work within its parent Public Health Service and Department of Health and Human Services and with other Federal agencies, States, national associations, foundations, and private sector organizations to seek solutions to health care problems in rural communities.

In particular, the Office

- advises the Secretary of Health and Human Services (HHS) on the effects that Medicare and Medicaid programs have on access to health care by rural populations, especially with regard to the financial viability of small rural hospitals and the recruitment and retention of health professionals. The Office helps the Department develop regulations and policies responsive to the resolution of these issues:
- coordinates rural health research within the Department and administers the Rural Health Research Centers Grant Program,
- provides staff support to the National Advisory Committee on Rural Health,
- articulates the views of rural constituencies within the Federal establishment;
- collaborates with HRSA's Office of Migrant Health, and
- is developing a program of technical assistance for rural hospitals in trouble, to be implemented in the fiscal year that ends in September 1991.

National Advisory Committee

One major Office activity is staffing the National Advisory Committee on Rural Health that was chartered on October 30, 1987. The 18-member Committee convened its first meeting on September 19, 1988, in Washington, DC. The Committee advises the Secretary of HHS on the priorities and strategies that should be considered in addressing the issues and unique problems related to providing and financing health care services in rural areas.

The Committee is chaired by former Governor Robert D. Ray of Iowa and includes members from both the public and private sectors with a broad range of experience in rural health.

In 1989, the Committee developed 32 recommendations on rural health, including several that deal with Medicare payments to rural hospitals and physicians. The recommendations, contained in the November 1989 Annual Report to the Secretary, are currently being analyzed in light of present and proposed public health policy development.

In 1990, the Committee is focusing on a broad range of issues regarding the uninsured and underinsured, including Medicaid reimbursement, eligibility, and coverage.

Rural Health Research Centers Grants

Another Office activity is the Rural Health Research Centers Grant Program.

Five centers were funded initially: Marshfield Medical Research Foundation, Marshfield, WI; University of North Dakota, Grand Forks; University of Washington, Seattle; University of Ari-

zona, Tucson; and the University of North Carolina, Chapel Hill.

These centers collect and analyze information, conduct applied research on rural health issues, and widely disseminate the results. The project directors of the five centers meet twice each year to collaborate and share information. Other researchers from the private sector often participate, as do other Federal rural health researchers, such as the Health Care Financing Administration, the Office of the Assistant Secretary for Health, Office of the Assistant Secretary for Planning and Evaluation, and the Office of the Inspector General, all at HHS; the Department of Agriculture, the Office of Technology Assessment, and both the Prospective Payment Assessment Commission, and the Physician Payment Review Commission.

Two additional centers will be funded this year; one devoted to the study of minority rural health issues.

—ARLENE GRANDERSON, Program Analyst, Office of Rural Health Policy, HRSA.

Additional details regarding RICHS can be obtained from the Office of Rural Health Policy, HRSA, Room 14-22 Parklawn Building, 5600 Fishers Lane, Rockville, MD, 20857, tel.(301) 443-0835.

New Maternal, Child Health Bureau Created in HRSA

A new Maternal and Child Health Bureau has been created in the Health Resources and Services Administration (HRSA) of the Public Health Service to give greater prominence to Federal efforts to improve the health of mothers, children, and adolescents.

The major program that the new bureau will carry out is the maternal and child health block grant to the States, which is authorized by Title V of the Social Security Act. Designed to develop and maintain State systems of care for mothers, infants, and children, particularly those with special health care needs, the program was formerly administered by HRSA's Bureau of Maternal and Child Health and Resources Development.

The new Bureau also will administer

- a related program of maternal and child health discretionary grants,
- emergency medical services for children,
- pediatric AIDS demonstration projects, and
- Health Head Start.

Dr. Vince L. Hutchins, a pediatrician and Deputy Director of the Bureau of Maternal and Child Health Resources Development, has been named Acting Director of the new Maternal and Child Health Bureau.

With the elevation of the maternal and child health program to bureau status, the remaining programs in the Bureau of Maternal and Child Health and Resources Development were consolidated into another new bureau, the Bureau of Health Resources Development. The Bureau of Maternal and Child Health and Resources Development was abolished in the reorganization.

Dr. Daniel F. Whiteside, Director of the former Bureau of Maternal and Child Health and Resources Development, has been named Acting Director of the Bureau of Health Resources Development.

The new Bureau of Health Resources Development will administer organ transplantation programs; the compliance, assistance, recovery, and loan monitoring activities of the health facilities program; and most of HRSA's AIDS programs, which include service demonstration projects, services planning grants, drug reimbursement, grants for renovation or construction of nonacute care facilities, and formula grants for home and community based services.

Nonreusable Syringe Developed for Third World Country Health Programs

A hypodermic syringe that can be used only once will soon be available in developing countries to help strengthen health programs by reducing the possibility of infection through the reuse of contaminated needles.

Dr. Ronald W. Roskens, administrator of the U.S. Agency for International Development (AID), announced the success of field trials for the syringe, which was developed with AID support in 1988.

With completion of the trials, conducted earlier this year in Pakistan, the last major hurdle to international approval and subsequent manufacture and distribution has been cleared.

Dr. Roskens made the announcement at the 17th annual dinner of the National Council for International Health.

"This nonreusable syringe is safe and effective and can be introduced into immunization programs as a direct replacement for disposable but potentially reusable syringes," he added.

The syringe, trademarked SoloShot, contains a flanged insert so that after the plunger is depressed for an injection, it cannot be pulled back for another use.

The Becton-Dickinson Co. of Elizabeth, NJ, will manufacture and market the syringes to national and international public health agencies under a 5-year licensing agreement.

Becton-Dickinson will have exclusive worldwide rights under a royalty-free arrangement that will enable the company to make it available at a very low cost.

The instrument is designed primarily for immunization programs in developing countries to protect patients and health workers against infection from reuse of contaminated needles.

To help cut costs, practitioners there reuse disposable syringes, unaware that they cannot be sufficiently cleaned, even with sterilization, to prevent possible infection.

The syringe was developed with AID support by the Seattle-based Program for Appropriate Technology in Health.

It was one of several efforts aimed at devising improved, safer vaccination devices for which the Federal agency that dispenses foreign aid has provided a total of $1.1 million over the past 4 years.

The field trials, conducted by the AID-supported Resources for Child Health Project, were observed by the World Health Organization and Pakistani health officials.

Since 1985, AID has committed more than $1 billion to child survival activities in developing countries. Programs include nutrition, treatment for diarrheal diseases, polio eradication, and family planning, as well as immunization.

PHS Proposes 'Parallel Track' for New AIDS Drugs

The Public Health Service (PHS) has proposed speeding the availability of investigational new drugs for AIDS and HIV-related diseases by means of a "parallel track" mechanism.

The proposed parallel track policy statement was published for public comment in the *Federal Register* on May 21, 1990.

Normally, the development of a new experimental drug proceeds through a systematic series of clinical trials that yield data on the safety and efficacy of the drug. These data are used by the Public Health Service's Food and Drug Administration (FDA) to determine whether the drug should be approved for marketing. The clinical trials of a drug may take years to complete, although FDA has recently implemented initiatives that speed up the clinical trials and approval process, especially for treating patients with life-threatening illnesses, including AIDS.

The PHS plan would permit promising investigational AIDS drugs to be made available to selected patients concurrent with the beginning of controlled clinical trials which determine the efficacy of the drug (hence the name "parallel track"). Drugs approved for parallel track would be made available through a special protocol for persons with HIV infection whose disease is immediately life-threatening, who have no therapeutic alternatives, and who cannot participate in the controlled clinical studies.

"We are proposing this initiative," said Dr. James O. Mason, Assistant Secretary for Health of the Department of Health and Human Services, "because of its potential for prolonging lives. It is an appropriate step to take at this time."

Dr. Mason cautioned, however, that the parallel track mechanism is not a substitute for properly conducted and controlled clinical trials.

"We believe we have built sufficient safeguards into parallel track," Dr. Mason said, "to ensure that it neither compromises the drug approval and clinical trials process nor delays the speedy delivery of promising investigational agents from the laboratory to the bedside."

The parallel track policy statement accompanying the proposed regulation outlined criteria for selection of investigational agents and discussed the review of parallel track proposals, protocol development and approval, and eligibility for patient and physician participation. The statement described protocol monitoring and patient data collection procedures and discussed public education and economic considerations.

Finally, the document discussed relevant human subject protection regulations, the role of informed consent, the process for periodic review of the data, and the criteria for terminating the protocols, if necessary.

The parallel track policy will be limited for the time being to persons with AIDS or HIV-related diseases. Because people with other life-threatening diseases might also wish to have investigational drugs made available through a parallel track mechanism, PHS also requested comments on whether the policy of expanded availability should be extended beyond AIDS-related therapies to drugs for other life-threatening diseases.

The period for public comments on the proposed initiative expired on July 20, 1990.

Johnson Foundation Funds Projects for Quality Care in Homes and Clinics

In an effort to improve services for long-term and ambulatory care patients, the Robert Wood Johnson Foundation will make available up to $3 million to stimulate and support research and demonstration projects that will identify new and practical mechanisms to assure the delivery of high quality patient care.

"While quality assurance systems have been developed for most health care delivery settings, many providers of long-term and ambulatory care are saying that these systems are of limited value for solving the daily problems of patient care delivery," said Jeffrey C. Merrill, one of the foundation vice presidents who will oversee the program.

"As a consequence, significant gaps still exist in our ability to identify and solve patient care problems in long-term and ambulatory care settings," he said.

The types of projects that will be considered for funding under the foundation's 3-year initiative are

- research and development of tools that assess the quality of patient care and identify patient care problems and exemplary practices,
- demonstrations of new approaches to improving quality of care, and
- evaluations of policies and of systems designed to improve quality of care.

Projects considered for funding may develop new ways to identify problems in the quality of patient care in specific settings, test existing tools, design and demonstrate institution-wide systems to locate and solve patient care problems, or evaluate existing policies or improvement systems.

Projects involving clinical interventions, treatment, or drug therapies will not be considered under this initiative.

Institutions wishing to apply for funds are asked to submit five copies of a letter of intent of no more than four double-spaced pages to Phyllis Kane, Program Assistant, Robert Wood Johnson Foundation, P.O. Box 2316, Route 1 and College Road East, Princeton, NJ, 08543–2316.

Based on a review of the letter, the foundation may request a full proposal at a later date.

HHS to Fund Community Programs for Minority Men

A new $1.5 million grant program to help communities improve outreach and services to minority males at high risk of a wide range of health and human service problems has been announced by the Department of Health and Human Services (HHS).

"This is a time of great crisis for minority men," HHS Secretary Louis W. Sullivan, MD, said. "Far too many are in jail, leading lives touched by violence, abusing alcohol or other drugs, or engaged in other behaviors harmful to their health. Far too few are in decent jobs, in school, or being raised with the love, support, and guidance of both father and mother.

"This program will supplement our current efforts by helping build coalitions within communities. It will involve a broad range of organizations that can be mobilized on behalf of minority men—schools, churches, health and human service agencies, job training and anti-drug programs, fraternities, sororities, and many other public and private organizations," he said.

Dr. Sullivan added, "Only active, involved communities, neighborhoods, families, and individual mentors, providing support face-to-face and one-on-one, can help our young men develop the values that are critical to their health, well-being, and success—values like self-esteem, self-respect, and responsibility. We all must come together, to help these young men build a vision of the future in which they are viewed as solutions—not problems."

The grant program, announced in the May 31, 1990 *Federal Register*, will provide about $1 million for development of community coalitions that can work to meet the multiple health and human service needs of minority males.

It also will provide approximately $450,000 to support conferences and workshops for information exchange, strategy development, or education on relevant problems.

Applications also are being accepted for grants that would be funded in fiscal 1991 for demonstration projects to be carried out by coalitions working with high-risk minority male populations identified by the community.

Coalition and conference activities may focus on health problems such as alcohol, tobacco, or other chemical dependency; homicide, suicide, and unintentional injuries; and HIV infection and sexually transmitted diseases. They also may focus on human service issues such as unemployment or underemployment, homelessness, runaway or "throwaway" status, school dropout, child abuse and neglect, juvenile or criminal justice problems, teenage pregnancy and fatherhood, family dysfunction, and lack of adequate health insurance.

The program is a jointly funded effort of HHS' Family Support Administration, Health Care Financing Administration, Office of Human Development Services, Public Health Service, and Social Security Administration. It will be administered by the Public Health Service's Office of Minority Health, directed by William A. Robinson, MD.

Community Drug Prevention Programs Show Promise

Research findings from community-wide drug abuse prevention programs in two midwestern cities show significant promise in reducing adolescents' use of cigarettes, alcohol, marijuana, and—for the first time—crack and cocaine.

Reductions of at least 25 percent were seen in cigarette smoking, 20 percent in drinking, and 30 percent in marijuana use.

Preliminary findings on cocaine use also show that nonprogram participants were more than twice as likely to have used cocaine in the past month as program participants.

Evaluation of the Midwestern Drug Abuse Prevention Research Project was funded by the Public Health Service's National Institute on Drug Abuse (NIDA) and conducted by researchers from the University of Southern California.

Dr. Charles R. Schuster, director of NIDA, said, "This program is unique because it utilizes all components in the community—schools, parents, the media and community groups—which contribute to changing the social norms for drug use and providing a healthy drug-free environment for all people."

The researchers found that changing social norms is more effective than just changing individual resistance skills or providing information on the consequences of drug use.

The program was implemented through support from private foundation grants beginning in 1984 in 50 middle and junior high schools in Kansas City, MO, and in 1987 in 57 schools in Marion County, IN, where Indianapolis is located.

Major findings after 5 years of evaluating the program in Kansas City include

- 36 percent of students who participated in the program drank alcohol in the last month, while 50.1 percent of adolescents not in the program admitted the same behavior.
- 24.1 percent of the students taking part in the study smoked cigarettes in the last month, while 32 percent of the teens not receiving the program's prevention messages were smoking.
- 14.2 percent of the program students had tried marijuana in the last month compared with 20.2 percent of the nonparticipating adolescents.

Preliminary analyses of eight of the Kansas City study schools (in which students are tracked individually over time) have shown that 1.6 percent of the program students used cocaine in the last month, including crack, while 3.7 percent of the nonprogram adolescents used cocaine or crack in the last month. Further analyses also indicate that while 17.8 percent of students in the drug prevention program tried amphetamines one or more times in their lives, 22.2 percent of their nonprogram peers admitted the same behavior.

"This study clearly demonstrates that a comprehensive prevention program can work in reducing not only the use of cigarettes and alcohol, but also the use of illicit drugs as well," said Dr. Mary Ann Pentz, principal investigator of the study.

The Midwestern Prevention Research Project was designed on the basis of recent research which indicates that a comprehensive prevention program may be more successful than a program which relies on the schools alone to teach students to resist drugs.

"School-based programs may not be enough to change students' drug use over the long term, mainly because there are so many competing pressures for students to use drugs once they leave the school setting," Dr. Pentz said.

The five components of the comprehensive drug abuse prevention program include

School: Each year, students entering middle or junior high school for the first time receive instruction on how to recognize and respond to social pressures and resist involvement with drugs and alcohol.

Parents: Through homework assignments, parents are encouraged to establish family rules concerning substance use, discuss the consequences of use, and share their reasons for not wanting their child to become involved with alcohol or other drugs. Parents are also trained to implement prevention activities in and around all schools and to enhance their communication and rule-setting skills with their children.

Mass media: Press materials are developed and distributed to increase general community awareness of and interest in participation in the program. Video contests, commercials, talk shows, and news shows are also used to illustrate prevention skills and reinforce participants in the program.

Community: Community leaders identify additional areas of need for prevention programming and focus their energy on encouraging schools, law enforcement, and other agencies to support healthy and rewarding activities for young people.

Policy: As attitudes change, policies are made to support these changes; for example, implementing laws prohibiting smoking in public places and sales of alcohol to minors.

The Public Health Service's Office for Substance Abuse Prevention is conducting services demonstrations which flow from these findings and further extend this work into comprehensive community prevention projects across the nation. In addition, this Office and the National Institute on Alcohol Abuse and Alcoholism are coordinating a joint research effort which will further enhance these community prevention efforts.

New Director Named for WHO AIDS Program

Dr. Michael H. Merson of the United States has been named Director of the World Health Organization (WHO) Global Program on AIDS. He had been Acting Director since March 26, 1990.

Dr. Merson has been an international civil servant with WHO for 12 years,

working as a medical officer and program manager for the Diarrheal Diseases Control Program from 1978 to 1980, and as the Program Director since January 1984. In August 1987, Dr. Merson was also given responsibility for the WHO Acute Respiratory Infections Control Program.

Dr. Merson, 45, received his medical degree in 1970 from the State University of New York Downstate Medical Center in Brooklyn. He did his medical internship and residency at Johns Hopkins Hospital in Baltimore from 1970 to 1972, before joining the Public Health Service's Centers for Disease Control in Atlanta.

At CDC, Dr. Merson served as Chief of the Enteric Diseases Branch, Bacterial Diseases Division. He also trained as a fellow in infectious diseases in the Beth-Israel Children's Hospital Program, Harvard Medical School, from 1975 to 1976, and was a fellow in infectious diseases in Baltimore City Hospitals, Johns Hopkins University, from 1976 to 1977.

He has also served as supervisor of a medical ward aboard the hospital ship, SS Hope, in northeast Brazil and Chief Medical Epidemiologist, Cholera Research Laboratory, in Dhaka, Bangladesh. He has received two commendation medals from the Public Health Service and the Arthur S. Flemming Award.

HHS Data Bank Designed to Track Incompetent Physicians and Dentists

The National Practitioner Data Bank of the Department of Health and Human Services (HHS) was officially opened on September 1, 1990. It is intended to reduce the possibility that incompetent physicians and dentists may move their practices from State to State without detection.

The data bank was authorized by the Health Care Quality Improvement Act of 1986 which also encourages peer review by immunizing health care entities that conduct professional peer review with due process and in good faith in furtherance of quality patient care from private antitrust suits.

The data bank will store information on

- all medical malpractice payments made on behalf of a physician, dentist, or other licensed practitioner;
- disciplinary licensure actions by State medical and dental boards;
- professional review actions of a practitioner's professional competence or conduct which adversely affect clinical privileges for more than 30 days; and
- adverse actions by professional societies against a physician or dentist following review of professional competence or conduct.

Hospitals are required to consult the data bank every 2 years concerning medical staff members or holders of clinical privileges or when a physician, dentist, or other practitioner seeks to join the staff or receive privileges.

In addition, any health care entities with formal peer review processes may query the data bank when a physician or dentist applies for clinical privileges or appointment to the staff. State licensing boards, individual physicians, dentists, and other health care practitioners, or an attorney may consult the data bank under certain conditions.

There is a fee of $2 per name for each request for information except when a practitioner seeks information on his or her own file. Anyone who reports to or queries the data bank under false pretenses may be subject to criminal penalties.

A toll-free data bank telephone service has been established. The number is 1–800–767–6732.

CDC Launches New AIDS-HIV Public Education Campaign

The newest phase of the Centers for Disease Control (CDC) AIDS education campaign is designed to help people assess their risk of infection by the human immunodeficiency virus (HIV) that causes AIDS.

This is the fifth phase of the "America Responds to AIDS" campaign and is entitled "Preventing HIV Infection and AIDS: Taking the Next Steps."

James O. Mason, MD, the Assistant Secretary for Health of CDC's parent Department of Health and Human Services, said in announcing the new undertaking,

"Today, I'm asking every American to take three steps. First, find out how HIV infection occurs. Second, don't engage in the sexual and drug-abusing behaviors that cause transmission of the virus; if you have never engaged in those practices, don't start. Third, if you have had many sex partners in the last 10 years or have abused intravenous drugs, tell your doctor and ask to be tested for HIV infection. Early diagnosis and treatment of HIV infection can protect your life and prevent transmission of the virus to others."

Between 37,000 and 42,000 Americans are expected to die of AIDS in 1990, pushing the AIDS death toll in this country since 1981 to more than 100,000. CDC estimates that from 600,000 to 1 million people are already infected. About 50,000 more people will become infected in 1990. Most infected persons remain well for many years, not showing any outward signs of infection. As a result, they see no need to be tested.

According to CDC officials, a person, regardless of sexual orientation, is at risk of HIV infection if, since 1978, they have contracted a sexually transmitted disease, had many sexual partners, or shared a needle to inject drugs. The danger is greatest if they have had sex with someone who is infected with HIV.

The important thing, the officials said, is that there is solid evidence that early diagnosis and treatment can help those infected stay healthier and live longer.

CDC is the agency which leads the nation's HIV and AIDS prevention efforts. CDC offers "America Responds to AIDS" education materials; the National AIDS Hotline (1–800–342–AIDS); the National AIDS Information Clearinghouse; coalition building with national, State and local organizations; outreach to the entertainment community; and public health communications assistance to State AIDS programs.

In developing the Phase V campaign, CDC consulted State health departments and leading AIDS, health, education, minority, business and labor organizations and individuals.

CDC is releasing a series of new multimedia public service advertisements (PSAs)—such as the one on the opposite page—as part of the campaign.

The PSAs—radio and television announcements, print advertisements, transit cards, and posters—include messages for general audiences and for those who think they could be infected with HIV. The materials are available in Spanish as well as English.

Free copies of Phase V materials from the America Responds to AIDS campaign or other selected HIV-AIDS publications and audiovisual materials are available from the National AIDS Information Clearinghouse, P.O. Box 6003, Rockville, MD, 20850; telephone (800) 458-5231.