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THE REGIONAL MEDICAL PROGRAM SERVICE'S URBAN HEALTH PROGRAM: AN ASSESSMENT

Roy Littlejohn Associates, Inc.

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The Regional Medical Program Service's

Urban Health Program:

An assessment

performed for

The Regional Medical Program Service,

Public Health Service,

Health Resources Administration

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November , 1973

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Regional Medical Program Service
Public Health Service
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Gentlemen:

Roy Littlejohn Associates is pleased to submit this report in accordance with our contract no. HSM 110-72-249.

It is our hope that this document will be of real assistance to your organization as it discharges its multi-faceted responsibilities.

Respectfully,

Roy Littlejohn Associates

Table of Contents

Page

Letter of transmittal

Acknowledgements. i

Introduction and Summary. 1

Chapter I. Reflections and Conclusions. 8

Chapter II. Social Legislation and the Sixties 17

Chapter III. The History of Regional Medical Programs . . 24

Chapter IV. Record Review. 37

Chapter V. Site Visits. 47

Appendix

ACKNOWLEDGEMENTS

The authors of this report are happy to have had the opportunity to study the efforts of RMP to deal with urban Health problems and hope they have done it justice. We would like to express gratitude to a number of persons who were key to this project effort.

First of all we wish to thank Harold Margulies, M.D. and Cleveland R. Chambliss who authorized and supported the entire Urban Health activity. We would also like to express our very deep appreciation to the Coordinator of the California Regional Medical Program, Mr. Paul D. Ward, and to Alvin A. Florin, M.D., the Coordinator of the New Jersey Regional Medical Program, who cheerfully accepted the absence of several of their employees for many weeks during the record review, the site visits, and the preparation of this report.

We would also like to thank the Coordinators of the various Regional Medical Programs for their courtesy in meeting with us and for their help in arranging our site visits. Special thanks should also go to those program staff members who had already been terminated due to the RMP phaseout process but who returned to talk with us about the ways in which they helped put together the programs within their Regions. The list of people deserving recognition seems endless; certainly it should include the Coordinators and program staff members who served onthe Urban Health Task Force with us and helped with the planning of the proposed conference, as well as the RMPS members who gave their invaluable advice and assistance in formulating the program, procuring records, and, in general, helping us to feel comfortable in the Parklawn Building.

Finally our thanks should be expressed to Ken Meissner, who wrote certain sections of the report and was responsible for overall editing, and to Mr. Roy Littlejohn and his associates, the contractors for this project, who graciously and patiently arranged the endless meetings and travel, provided us with technical assistance and advice, and were finally responsible for the completion of this report.

Last but not least, Dr. Mitchell would like to express personal thanks to his secretary, Ruth Wightman, who coordinated, typed, and edited for weeks on end.

INTRODUCTION AND SUMMARY

GENESIS OF THE URBAN HEALTH PROJECT

"In some areas of New York . . . there is one private doctor for every 200 persons, but in other areas the ratio is one to 12,000. Chicago's inner-city neighborhoods have some 1700 fewer physicians today than they had ten years ago." With those words the President of the United States on February 18, 1971, proposed that as part of a new "National Health Strategy" concentrated efforts should be focused on meeting the special health care needs of scarcity areas--rural and urban.

In developing tactics to implement the new National Health Strategy, it was essential then and is essential now that we have hard facts, not about the scope of the problem--there is no need to further document the shortcomings of inner-city health care services--but about the methods of implementation: Which have been effective, which have not, and under what circumstances? Unless we learn from our earlier efforts--successful and unsuccessful--we run the risk of repeating the errors the President pointed out in earlier programs of "reenforcing inequities and rewarding inefficiencies and placing the burden of greater new demands on the same old system which could not meet the old ones."

Among the various agencies established in the mid-1960s to deal with pressing social programs, the RMPs*, the Regional Medical Programs,

*About initials: Throughout this paper there will be references to RMP, RMPs, and RMPS. Short of renaming the agencies involved, there seems to be no way around this alphabet soup confusion. To set the record straight, here is how we will use these abbreviations: RMP--Regional Medical Program (this may refer to the overall program or to the local agency for a particular region such as the Georgia RMP); RMPs--a collective reference to the local Regional Medical Program agencies; RMPS--Regional Medical Program Service, the division within the Department of Health, Education and Welfare responsible for administration of the overall program and for maintaining contact with the local RMP agencies.

are unique. Within an all-encompassing structure which covered the entire nation as well as certain U.S. possessions, fifty-six Regional Programs were established with function-oriented boundaries defined by groups of local health care providers. (In many, but not all cases, these groups were established for the express purpose of planning and setting up Regional Medical Programs for their areas.) The purpose of this report is to document and help sharpen the RMP focus on Urban health problems.

Within a broadly-defined set of goals established by federal enabling legislation, and within a more specific framework defined in keeping with the goals of successive administrations, the RMPs set out to improve the quality and availability of American health care. Predictably, there have been marked differences in the way people connected with RMP in various localities perceived and went about accomplishing their mission. There have been dramatic successes as well as failures. Nor is it surprising in a program marked by experimentation and decentralization that many of the successes have been characterized by serendipity. Thus, it was decided that RMPs, in dealing with urban health problems, should take stock, find out what had worked, and document the special skills and competencies developed within individual regions.

Among the events which spurred this project was the initial RMP response to the Administration's urban initiative. In 1971, the Regions were asked to devote $1.8 million to Model Cities-related projects. This figure did not represent new, earmarked funds, however. The funds had to come from within the framework of existing Regional Program budgets. In many cases, this resulted in post-hoc planning; local staffs looked back on what they had already been doing to see which projects, with perhaps a slight shift of emphasis, could be classed as "Model Cities-related."

In response to the Administration's initiative and to related concerns, Dr. Harold Margulies, Director of the Regional Medical Programs Service within HEW, asked Mr. Cleveland R. Chambliss, RMPS Director of the Division of Operations and Development, to let a contract to evaluate and recommend changes in the RMPs' urban health care efforts. To assist in planning this project, an Advisory Committee on Urban Health was established. The initial appointees were Henry Wood, Director of Urban Health Planning, New Jersey RMP; John Hall, Ph.D., Director of Urban Health, Ohio State RMP; Teresita Moreno, Assistant Coordinator, Area V, California RMP; and John A. Mitchell, M.D., Deputy Director of the California RMP.

As the members of the Urban Health Task Force discussed the problem at the first planning session, held in February, 1972, it became clear that the RMPs were doing well in certain areas where concerned program staff members had addressed various aspects of the problem. They proposed that a way be found to tap the experience and expertise these staff members had developed and to make this information available to all the RMPs.

At a second meeting, on March 16, 1972, the Urban Health Task Force members drew up the initial contract for this project. Under that contract, a two-day national meeting on urban health methodologies was to be held through which persons with the appropriate background, particularly staff members from various RMPs who had been uniquely successful in dealing with some aspects of urban health concerns, would share their knowledge with a group of 200 participants composed largely of RMP coordinators, Regional Advisory Group (RAG) chairmen, staff members responsible for urban health planning for the fifty-six RMPs, and selected RMPS and DHEW regional office representatives.

This national meeting was to be followed by four two-day regional workshops in the Northeast, South Central, Mid-Continent, and Western areas of the United States for a group of sixty participants at each conference, including RMP representatives, selected governmental and local civic officials, community representatives, representatives of concerned state and city agencies, and provider-organization representatives. In each case the contractor was to prepare a report on the meetings, evaluate their impact, provide technical assistance, carry out follow-up studies, and submit a final evaluation of the entire project with conclusions and recommendations for action and future activities.

A minority-owned firm, Roy Littlejohn Associates, was then located through the Small Business Administration and chosen as contractor in accord with Section 8 (a) of the Small Business Act. After the original Urban Health Task Force was expanded to include various RMP staff members, preparations for the first conference, to be held in October 1972, began. However in the course of preparations for this conference, it became evident that certain communications and coordination difficulties

would have to be dealt with. It was also felt that the RMP Coordinators should have been consulted in the selection of Urban Health Task Force members.

In order to deal with these problems, the National Conference was postponed from October 1972 to May 1973 with the Regional Conferences to be held sometime during the summer of 1973. In the meantime, the HEW desk officers and representatives chosen by five regional consortia of RMP Coordinators were brought into the planning process.

At that point, as the project was well underway, it was announced that RMP was to be phased out by June 30, 1973. In the wake of this announcement, the National Conference on Urban Health was cancelled.

Due to the imminent phase-out and the fact that many key personnel had already begun to shift to other positions, it appeared quixotic at best to hold the conferences. However, in the course of preparations for the conference, it had become clear that the varied experience of the RMPs, and especially of certain RMP program staff members, represented a wealth of useful, and sometimes unique, knowledge.

Therefore it was decided that the project should continue but that the emphasis should shift to documentation of the experience of the RMPs with urban health problems. The fruit of that shift in emphasis is this report on the experience and involvement of the RMPs with urban health problems.

SUMMARY

The report begins with chapter one, presenting the reflections of the Urban health task force members on the information and data gathered together with some of the conclusions to be drawn from these data. And since RMP was just one of many social-change programs of the early

and mid-1960s, Chapter two outlines some of the major historical forces that helped to shape the response of Congress and the Executive Branch to a broad spectrum of problems. Brief descriptions of some of the key programs and agencies of the '60s are then given to convey some idea of the milieu in which RMP was established and began to mature.

Chapter three is an in-depth historical survey of RMP, beginning with an analysis of the original enabling legislation and of several statutory extensions. RMP's initial mandate was to make the fruits of biomedical research on certain diseases more readily available to everyone. As the program evolved, however, Congress made several substantial changes in the statutes which established it. Eventually, RMP was charged by law with enhancing the quality and availability of primary care with particular emphasis on upgrading health services for residents of service-scarcity areas. These goals were to be achieved by fostering voluntary regional linkages among health care providers.

In chapter four data on the activities of all of the Regions, especially as they relate to the development of medical care services in medically underserved areas, are presented and reviewed. Due to the staggered reporting cycle and to the way the RMPS renewal application forms were structured, valid cross-comparisons were difficult. However certain trends were discernible. The regions were shifting their focus toward the development of services in scarcity areas. Staffing patterns were changing to include more minority group professionals and others who were trained in health systems development. Similarly, there was a trend in the funding of RMP projects away from a few massive, categorical-disease focused projects toward primary health care projects which were of shorter duration and often included matching funds from local governments and community groups. Many of these were seed-money

grants designed to develop viable projects which could obtain permanent funding elsewhere.

In chapter five, key information gathered by Urban Health Task Force members in the course of site visits to a representative sample of Regions is presented. To some extent, the trends mentioned above were also evident in the course of the visits. As had been suspected, the activities of program staff members were discovered to be rather different from what might be expected after a simple review of renewal applications submitted by various Regions. A key staff function in most of the Regions was to serve as a "skills bank" for local groups in dealing with the types of problems that fell within the ambit of each Region's stated purposes and priorities. Certain common qualities of successful staff members were also identified. While it was apparent that these skills were, to some degree transferable, more study is needed to develop ways to facilitate the development of these qualities in other present or potential staff members.

Finally, a detailed examination of the methodology employed in this study is presented in appendix A.

CHAPTER I

REFLECTIONS AND CONCLUSIONS

The members of the Urban Health Task Force who prepared this report agree that while the purpose of the original contract to hold Urban Health Conferences was valid, the approach was too narrowly focused. In this immense country, cultural, social, economic and geographic considerations make a tight focus on Urban Health completely inappropriate. On the other hand, the systematic development of medical care resources for those who are medically underserved is an important function which has been carried out by many of the RMPs very successfully. The methods used to perform this function tend to be very similar although the strategies and tactics pursued by each RMP are based on its own determination of the local social and political climate. Much of this activity goes unreported for various reasons. One commonly encountered attitude was that the Regional Medical Program had to maintain a "low profile." Other program staff felt that efforts to deal with the health problems of underserved populations would meet with opposition from various groups--Congress, the Administration, organized medicine, hospital associations, voluntary health associations, and other unnamed groups. A few felt that this type of activity went beyond the mandate of RMP's enabling legislation.

The flexibility some of the programs demonstrated was quite impressive. In several of the regions the ability of the program staff to respond to the needs of the community was evident. The term <u>community</u> is used advisedly in this context. Extensive discussions have gone on around

the "search for the community." For purposes of this report it was felt that a number of communities were involved with RMP activities. There were medical provider communities, poverty communities, and communities of interest in medical affairs developed around specific needs or evolved through a Comprehensive Health Planning agency. In many cases, the medically-underserved community was not a community which could be considered economically deprived. Suburbia, exurbia, and sprawling rural farming communities also need new medical manpower, medical facilities, regionalization of services, and, particularly, improvement in the quality of available medical care. RMPs have addressed these issues on many occasions and have been highly successful in meeting these needs.

Still the problems of the impoverished, the sociologically -and culturally - deprived, and the alienated, particularly attracted the attention of the Urban Health Task Force. Some of the RMPs undertook to deal with problems in communities which included isolated Indian tribes living in the mountains and inner cities, Mexican-Americans, Puerto Ricans, Cubans, Portuguese, and others with language difficulties in addition to other poverty-related problems. Those RMPs which accepted this challenge early and found it difficult to identify leaders and build credibility with community groups now find themselves besieged by community groups who have learned that RMP is a key local resource with technical skills accessible to local groups.

The skills developed by these RMPs are certainly not new. They come from a variety of sources--universities, other federal programs, schools of public health, and the direct experience of people born in the communities they now serve through RMP. These skills typically involve the use of screening and survey techniques, and training of community health workers who ordinarily do the actual screening or survey field work. RMPs have learned

to design a program or project to fit the needs of a specific community and to find ways to fund these activities. In the sophisticated RMPs, however, this is only the beginning of involvement with the community. Incorporation of community corporations, training of community boards, installation of administrative and management systems, and program evaluation ordinarily continue even though the project may be funded with non-RMP dollars. The RMPs have been extremely successful in helping communities recruit well-qualified professional staff for community programs. Colleges of Medicine, other university resources, county medical societies, voluntary health agencies, and the RMP staff itself have frequently been the source for managers and operators of medical care projects in poverty communities. In at least two cases, care in free clinics is provided by the professional staff of Army Medical Reserve units.

The Regional Advisory Groups provide substantial input, information, and occasional technical support for many of these activities. Comprising a wide variety of skilled professionals, university scientists and administrators, community practitioners, allied health professionals, and representatives of the public, the Regional Advisory Groups provide not only technical skills but mature political and social judgment. Although many of the Regional Advisory Group membership lists appear to lean toward categorical disease programs, this is not necessarily true. In many cases the Regional Advisory Groups had quickly identified the need for assisting the underserved populations of the regions before the President's health message and the statutory changes which encouraged Regional Medical Programs to move in that direction.

The aspect of RMP which attracted many of the program staff, people who are involved in community health activities, as well as Regional Advisory

Group members who are also concerned with this type of activity, was the opportunity to provide small amounts of money in a short period of time to begin activities rapidly after needs have been identified. Thus RMPs were often able to help local government agencies move in new directions when local tax support could not provide for health care services developmental research. Also, through RMP, local community groups could be helped in organizing and seeking funds from private or public sources.

The academic background of persons employed by the various RMPs in community health activities was examined and as stated previously these backgrounds were varied. There seems to be little relationship between the academic preparation they had received and the skills they were applying in problem solving. All of them, however, seemed to have a thorough knowledge of the local and national health scenes, health agencies, health legislation and, above all, to have good, sound business and management skills. All of them were community organizers although we were unable to identify anyone who had received academic training as a community organizer.

Obviously these skills are, to some degree, transferable since in many cases a single staff member who had been extremely successful in developing new community health programs for underserved populations became the leader of a number of people who extended the successful activities to other parts of the region. This generally involved somewhat informal on-the-job training.

An attempt was made to try to isolate specific methods and techniques used by programs and staff members in developing and implementing RMP efforts to improve health care for the underserved which might be taught formally in an established educational institution. For the most part, this effort was

Programs are generally linked to public or private hospitals providing excellent patient linkages between primary care and secondary and tertiary services.

In some regions careful attention is paid to financing methods so that RMP projects rapidly become self-sufficient and the Regional Medical Program is able to reinvest resources in other problems. A review of the funding history of the RMPs indicates a definite tendency to move from funding a few large projects for prolonged periods toward funding many projects at a much lower cost for shorter periods.

One poorly documented but apparently valuable function of many of the RMPs was to bring together fragmented and disjointed categorical programs into a rational system of primary care. In several regions this was done through a committee of project directors for Maternal and Infant Care, Children and Youth, Family Planning, and health education projects. These led to cooperative rather than competing efforts, reorganization of charts, centralization of records, and avoidance of duplication of effort. These projects were also instrumental in developing useful patient information and referral systems, training health aides to provide comprehensive patient services, and, in some cases, providing "one-stop" services. There is some indication that the success of such efforts has encouraged the institutions involved to rationalize other patient care services.

Currently the organization and delivery of medical care services is being strongly influenced on several fronts. Three specific aspects of the changes which have occurred are clearly related to the influence some of the RMPs have had on the delivery system:

1. The mass migration of large population groups from farms into incorporated communities has required a reorganization of the medical care delivery system. According to the 1970 census, almost 60% of the population of the United States lived in or near 248 "urbanized areas" occupying 1% of the total land area. The Bureau of the Census defines an "urbanized area" as a place with a population of 50,000 or more in a contiguous, closely built-up area. At the same time the remaining farm population has tended to cluster around smaller towns and villages instead of remaining scattered across the land. Rural blacks and in-migrating ethnic populations have occupied much of the inner cities giving birth to new centers of population and a bewildering array of overlapping political jurisdictions.

2. The impact of new scientific and engineering knowledge on medicine has had much less influence on the health care available to disadvantaged population groups than has generally been realized. The gap between the best care available and that which is usually provided is wider now than it ever was. Little has been done to upgrade the quality of services available in the inner-cities or in the disadvantaged small towns and villages of our country. The distribution of primary care providers has continued to worsen and only experimental programs have been carried out to improve the distribution of these vitally needed services. Inner-city hospitals have become old and available services are deteriorating. Many rural hospitals built through the Hill-Burton Program are underutilized and poorly situated.

3. Changes in the financing of medical care have aggravated these problems. With the majority of the population, including the poor, having third-party coverage to pay for some or most of their medical care, there has been a substantial increase in demands on the system for more and better care. And as more federal dollars are committed to the purchase of health care, there is an increasing need to assess and upgrade the quality of the care provided. Increased demands which will soon be placed on the delivery system by some form of national health insurance are almost sure to overwhelm that system and cause a decrease in quality and a increase in the cost of care.

Some of the RMPs have made well-organized attempts to provide solutions to these problems. The decentralized operation of these RMPs has mobilized knowledgeable people within communities to solve local health care problems, while the same structure has served to promote regionalization of services on a logical basis when appropriate. Diverse strategies and tactics have been developed to secure support from local, regional, state, and national power centers. This has often required a long-range commitment on the part of the leaders of the programs.

In some Regions there is no evidence of organized efforts to address these issues in health care. In others there were only token efforts. There is some evidence that commitments made at the federal level have produced movement at the regional level. Job descriptions with titles such as Urban Health Coordinator and Coordinator for Community Health Services appear much more frequently in recent applications, and programmatic approaches to to the development of primary health care services for the underserved have

been developed in several Regions.

The collective experience of the RMPs substantiates a conclusion which many had reached individually--that the strongest and most universally expressed need among the disadvantaged, both urban and rural is for comprehensive primary medical care. Historically public health clinics, public hospitals, and "welfare medicine" have gained a reputation for being second-rate, fragmented, and degrading for the people forced to use them.

Many of the RMPs have learned to assist communities in developing high quality ambulatory health services with the dignity and convenience of the patient a high priority. Users are not sorted out by disease category or ability to pay. In most cases these gains have been achieved by building on and expanding already available services and facilities rather than by establishing new health facilities. These programs are deliberately aimed toward self sufficiency through carefully designed accounting and billing systems.

Through a broad-spectrum approach to the problems encountered, the RMPs have been proving that excellent comprehensive medical care can be made available to large numbers of disadvantaged individuals and families. This can be done in ways which reflect the dignity and humanity of the people served and without unduly disrupting traditional fee-for-service solo or group medical practice patterns.

CHAPTER II

SOCIAL LEGISLATION AND THE SIXTIES

The Regional Medical Program was created and has matured as one part of a major change in federal policy and should be seen in proper perspective as part of a complex matrix of social-change programs. The 1960s was an era of rapid, almost breathtaking, social change. It was an age of secular and institutional messiahs, of Marshall McLuhan and of Esalen--salvation through media or massage. By the end of the decade one widely read author, Alvin Toffler, echoing the early Greeks, proclaimed that the only thing modern man could be sure of was that he could not be sure of anything--only change, at an ever-accelerating rate--was certain. Toffler even gave a name to the syndrome of fears, anxiety, and maladjustment that resulted: Future Shock.

One of the byproducts of the age was a sometimes-bewildering array of new agencies designed to nurture and moderate social change. Although a description of the details of these programs is beyond the scope of this report, it should be noted that the unifying principle of these ambitious social programs, which seemed to echo the New Deal of the 1930s, was a resurgent populism. Born in an era of optimism amid the trappings of a latter-day Camelot, this movement reached a peak in the mid '60s. Civil disobedience and passive resistance were the hallmark of a civil rights movement which seemed destined to prevail. As Ghandi had before him, Dr. Martin Luther King called upon his fellow countrymen to remake an entire society not under the threat of overwhelming power but because it was the just thing to do. As the decade

drew to a close, Dr. King, who had, for many, become the voice of America's conscience, was silenced by an assassin's bullet--the third of the four great leaders of the decade to die in this manner (John Kennedy and Medgar Evers preceeded him, and Robert Kennedy followed him.) Dr. King had lived long enough, however, to see sorrow turn to anger, frustration, and rage.

In August 1965, Watts went up in flames sparking an era of violent confrontation. Television, the electronic wonder of an earlier age, made violence a commonplace sight in every American home: The Southeast Asian War, the riots in Newark, the Democratic Convention of 1968, the riots in Detroit, Soviet Tanks trampling on the gentle revolution in Czechoslovakia, the campaigns against "crime in the streets," the American people witnessed and seemed bewildered by all of these events. Symbolic of the changes which marked the '60s was the euphoric, dramatic hope embodied by Woodstock and the bloodstained denouement at Altamont--both captured on film and preserved in technicolor.

In the midst of all this, a "war on poverty" was declared. "For the first time in our history," said Lyndon B. Johnson, "it is possible to conquer poverty. We have the power to strike away the barriers to full participaiion in our society. Having the power, we have the duty." And thus a generation of social acfion programs and agencies, each with a more-or-less direct or indirect effect on health, was born.

The Economic Opportunity Act of 1964 resulted in a number of "anti poverty" programs including Community Action Programs, the Job Corps, Volunteers in Service to America, Work Training Programs, and a program to help students from poor families work their way through college. To indicate strong presidential support, the agency for the poverty war was lodged in the executive office and a new, independent bureaucracy was created.

By the end of January 1966, more than 900 grants had been made for the establishment or planning of Community Action Programs including programs for the fifty largest cities in the country. In line with this local participation and community action approach, the Office of Health Affairs had begun to develop the Neighborhood Health Centers concept which has had a profound and lasting effect on the development of health care services for the poor. New ethnic professionals appeared. Veteran minority group professionals achieved greater visibility. Poor whites found that they had a powerful voice and, when appropriate, allied themselves with other leaders of the poverty community, crossing what had once seemed to be impenetrable racial barriers as they did so.

A prominent element in the downward social and economic spiral in the large cities, which seemed to bar progress on many fronts while fostering a raft of new problems, was the lack of decent housing. In order to mount a program on an unprecedented scale to help city agencies demolish, build, or refurbish local living units, the Department of Housing and Urban Development (HUD) was created to administer Federal spending and to ensure compliance with Federal guidelines.

The Demonstration Cities and Metropolitan Development Act (Model Cities) was intended to enable cities to use resources already available through programs designed to help people help themselves. Most large cities had deteriorating central districts crowded with poor people--people who were poor in many ways: economically, educationally, nutritionally--the list seems endless.

The Model Cities Program carried civic renewal a giant step forward by requiring that local community representatives be involved in setting

goals and priorities and in helping to administer local projects. These requirements were given substance by requirements that other federally funded programs operating in the community--including RMP operational projects--file certificates of Model City relatedness with a sign-off by Model Cities officials.

For men and women previously locked into welfare subsistence or low paying, dead-end menial jobs, Manpower and Job Training Programs were initiated. New skills could be learned through employment with cooperating firms which provided classroom education in basic skills such as reading and arithmetic along with on-the-job training for vocational skill development. Supplemental payroll funds were provided by the federal government to offset the anticipated reduced productivity of these "apprentices." Other programs included New Careers, which supplied training and opportunities for entry to such fields as nursing and library assistance, and Operation Mainstream to help previously "unemployable" people support themselves with simple jobs.

The idealistic energies of young adults were, to some extent, harnessed through the Volunteers In Service To America (VISTA) program, sometimes described as a "domestic peace corps." VISTA volunteers fostered community development and attempted to encourage disadvantaged people to draw upon resources which were available but not well publicized. Their work was more successful in southern and rural regions than in the metropolitan ghettos.

Some of the Great Society programs were directly connected with health. The two most prominent were, of course, Medicare and Medicaid, Titles XVIII and XIX of the Social Security Act. In addition to changing the perspective on health care (to that of a basic human right rather than a privilege), these programs introduced a new actor on the urban health care scene, the Social

Security Administration. In seeking to inform older citizens of their rights under the new law, and especially to encourage participation in Part B of Medicare, the optional coverage for outpatient treatment provided at a nominal cost, the Medicare Alert program was instituted. Through this program, senior citizens were hired and sent out to visit with and inform others about the program and to encourage eligible citizens to enroll. This double benefit approach, which in providing benefits for a target group also provides meaningful employment for unemployed or underemployed members of that group, was a pattern followed successfully in many other programs including some of the RMPs which provided training for "community health aides" in the course of programs such as the Mobile Multiphasic Screening Project instituted by one of the Eastern industrial state RMPs.

Medicaid has been successful in some ways, disappointing in others. The facts that this program is administered and funded on a state-by-state basis and that the target population is somewhat unstable, with individuals gaining and losing eligibility as the economy fluctuates, have led to the discouraging paradox of a program which is often grossly underfunded while certain individuals manage to abuse the system and rake off substantial sums of money.

One other significant aspect of the Medicare and Medicaid programs has been the role of third-party payers, especially Blue Cross and Blue Shield. Partly because the medical community was apprehensive of a large-scale federal bureaucracy concerned with health care, partly because the federal government had neither the time, nor the resources, nor sufficient skilled manpower to staff such a bureaucracy, partly because the large third-party payers have a good deal of political "clout," the actual day-to-day administration of the Medicare and Medicaid programs was left to various third-party payer organizations operating under contract with the

Social Security administration.

This pattern, preserving a major role for organizations such as Blue Cross and Blue Shield in attempts at dealing with nationwide health programs, remains an important element of many current National Health proposals including the "National Health Insurance Standards Act" and the "Family Health Insurance Plan" proposed by President Nixon on February 18, 1971.

One other health-related program, the Partnership for Health Program (Public Law 89-749), deserves mention. With its enactment in November, 1966, the stage was set for Comprehensive Health Planning to be implemented for both public and private sectors at the state, area, and local levels. This planning effort was to include a majority of health consumers, defined by the Surgeon General as those who "live where the problems are."

Section 314(a) of the Act made grants available to each of the states for Comprehensive Health Planning. In order to qualify for these grants, each State had to designate a single agency to administer the planning process and submit a "plan for comprehensive health planning" for approval by HEW.

Section 314(b) provides grants for public or nonprofit, private agencies or organizations to develop comprehensive regional or local health planning; to develop and revise areawide health plans; and to coordinate existing and planned health services, manpower, and facilities.

In keeping with the concept of "partnership for health," large numbers of provider and consumer groups were involved in the development of state and areawide plans for health. These plans evaluate current health programs in view of current and future health needs and make recommendations for improvements; additionally, they establish state and areawide priorities.

CHAPTER III

THE HISTORY OF REGIONAL MEDICAL PROGRAMS

The role of the RMPs in general, and particularly with respect to urban health, has been shaped by a complex history of legislation, Administration directives, and departmental regulations. In 1965 the federal government set out to ensure that research on heart disease, cancer, and stroke would pay off in measurably improved health care services. A presidential commission headed by a well-known Texan, Houston's Dr. Michael E. De Bakey, came to the conclusion that to a substantial degree, medical research in these areas had not paid off in better health care for everyone. The fruits of this research were simply not being translated into new, more effective procedures standard throughout the health care delivery system. To meet this problem an amendment to the Public Health Service Act [42 USC, Ch. 6A] was passed by Congress and approved by the President. This legislation, "The Heart Disease, Cancer, and Stroke Amendments of 1965" [P.L. 89-239], authorized what has come to be known as RMP, the Regional Medical Program. The Program--programs actually, for some fifty-six regional bodies were established--has a number of characteristics that testify to the realities (perhaps the genius) of the American political process.

First of all this new network of agencies, although based on federal legislation, was to develop from the bottom up through the initiative of local groups. This feature reflected the fear of many, especially of health care professionals, that the program might turn into a huge, centralized, and stultifying federal bureaucracy. To quiet these fears, the law was deliberately vague as to structure and contours, referring

simply to "regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the field of heart disease, cancer, stroke, and related diseases." Health care professionals were invited to define viable regions--with boundaries that made sense in terms of efficient functioning--not necessarily based on state or political subdivision borders. The resulting structure emphasized voluntary cooperation and decentralized decision making. In view of this, it is not surprising that the RMPs have been strikingly successful in bringing together representatives of various groups and helping them organize and institute joint endeavors to improve the quality, availability and accessibility of health care services. Bringing these groups together has been not only a prime mission for all RMPs but a precondition for the organization, approval, and funding of each RMP.

At its inception, RMP had a well-defined function: to help the providers of health care in "making available to their patients the latest advances in . . . diagnosis and treatment," and a specific focus: heart disease, cancer, stroke, and related diseases. There were, in addition, certain key restrictions: RMP was not to underwrite the provision of services to individuals except as an incident to research, training, or demonstration activities and even then, only upon the referral of a practicing physician.

In addition, RMPs were to accomplish their mission without "interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals."

On October 15, 1968 (three and a half months after the expiration date of the original legislation) a two-year extension was enacted

[P.L. 90-574]. While the original law had authorized appropriations of up to $200,000,000 for the fiscal year ending June 30, 1968, less than one-third that amount, $65,000,000, was authorized for the period ending June 30, 1969, and $120,000,000 through June 1970. Aside from these drastic cuts in proposed funding, the first RMP extension law made only minor substantive changes: 1% of appropriations could be set aside for evaluations. Where appropriate, services could be provided for patients referred by a practicing dentist (but, as before, only in connection with research, training, and demonstration activities). Federal hospitals were to participate. Also, coverage was extended to the District of Columbia (which had a program effective as early as January 1, 1967--apparently without explicit legislative authority), and to Puerto Rico and other U.S. possessions. Finally, multi-program grants, for services to two or more regions, were to be permitted.

The life of the Program was once more extended, this time for three years, on October 30, 1970. As before, the second extension [P.L. 91-515], was enacted four months after the expiration date under previous legislation. Authorized appropriations for the first year were only $5,000,000 more than for the period ending June 30, 1970. But by the third year of the extention, the fiscal year ending June 1973, the maximum permissible appropriation was to double, to a quarter of a billion dollars.

Along with this expanded funding, the new law called for significant expansion in RMP's responsibilities, both categorical and functional. The new categorical authority extended RMP's focus to include kidney disease. In addition, certain noncategorical responsibilities were added. Chief among these were "to strengthen and improve primary care and the relationship between specialized and primary care;" and "to improve health services for persons residing in areas with limited health services."

Regionalism which had begun as a compromise approach, emerged as a major program strength and almost an end in itself. The De Bakey report and the initial legislative proposals had called for a network of regional centers for research as well as diagnosis and treatment stations. Some existing facilities were to be included in this network, but many would be newly built. In August 1965, five AMA representatives met with the President and the Secretary of HEW. The bill's provisions, the President was told, were "jeopardizing AMA's attempts to work with the Secretary of HEW . . . relating to the medicare law." And so, the regional centers and stations were discarded. The final enacted version, as mentioned above, contained only vague references to encouraging and assisting in "the establishment of regional cooperative arrangements . . ." But the RMPs had been so successful in building programs based on such voluntary, co-operative arrangements, and these collaborations had been so fruitful, that the 1970 legislation, in providing for RMP to take responsibility for strengthening and improving primary care, specified that this was to be done by promoting and fostering "regional linkages among health care institutions and providers."

In addition to an expanded categorical focus and new, noncategorical goals, RMP was asked to promote prevention and rehabilitation. (The original mandate had referred only to diagnosis and treatment.) RMP's responsibility for generally improving available health manpower and facilities was tied to more specific aims--upgrading quality and enhancing capacity. And, as mentioned previously, RMP was given another new, non-categorical assignment--"to improve health services for persons residing in areas with limited health services."

In mid-1973, as the second legislative extension was about to expire, RMP stood accused of losing sight of its purpose, exceeding its authority,

and failing to develop a consistent unified approach. Faced with extinction, RMP was extended for one more year. Ironically, this was the first time the program's operating authorization was extended before the expiration of enabling legislation for the previous period.

Obviously the 1970 renewal, P.L. 91-515, in addition to extending RMP's authorization, provided a much wider scope and broader range of purposes. What may be less obvious (but no less true) is that these changes, like the inclusion of authorization for the District of Columbia in the first RMP renewal law, were largely an after-the-fact ratification of things which had already been done. In examining the development of these broadly-based activities, two intertwined threads may be traced. First, pressure from below: from the start many RMP staff members looked at their mandate as authorizing a wide range of activities designed to extend the highest quality health care to everyone, especially to those who, by circumstance, had not had access to health care on a par with other members of society--the isolated, rural poor and the alienated, inner-city poor. Second, there were, from the start, pressures from above, from Administration spokesmen and from ranking HEW officials, seeking to have regional groups interpret their mission in the light of then-current Administration policy.

Two strategies began to emerge. One, was for RMP to provide services rather than funds. At the end of 1968, RMP was still largely in the planning phase. In connection with the process of pulling providers together, defining appropriate regional boundaries, establishing patterns of organization, and framing and following through on coherent requests for planning funds, RMP staff members had begun to build up a reservoir of vital skills--concrete knowhow about getting things done within the complex matrix of social and political customs, structures, and organizations

that surround the U.S. health care system. These skills, as they developed, made it possible for RMP to provide a broad spectrum of support on a number of levels. By assigning staff members to work with representatives of other agencies and of community groups, the RMPs made substantial contributions to programs such as neighborhood health centers.

The second strategy emerged as the regions began to look once more at the legislation establishing the program. With a more-or-less expansive reading of the specific functional and categorical purposes specified in the enabling legislation, it was possible to find all sorts of overlaps between the mission of RMP and the nationwide priorities established through the political process. For example, from its inception, RMP was involved in health manpower training. This was seen as one of the keys to translating new knowledge into improved care. In carrying out this part of its mission, RMP soon became involved in providing job training for people who had previously had few, if any marketable skills. Also, RMP was involved in helping to define and establish a number of new allied health professions. These development activities often could be, and sometimes were, designed to build on the skills of people already employed in the system at lower, less rewarding levels. In some cases, new career ladders were evolved. New opportunities for advancement could be opened for people who had been stuck in previously "dead end" positions. And since these programs were directly relevant to RMP's stated purpose, they were eligible for sponsorship and funding through RMP.

In a similar manner, another facet of RMP's purpose emerged. From the outset, RMP was concerned with the fact that new medical knowledge was not being reflected in widely available improved health care. At first this was seen as basically a matter of communications. Available knowledge was not being widely disseminated. As it turned out, communication was

only part of the problem. The reason many people were not benefitting from the fruits of biomedical research was that they had limited access to health care of any kind. Title XIX of the Social Security Act (Medicaid) was designed to help many of these people, but funding tended to be inadequate and coverage was often spotty--in many states the "working poor" were excluded, for example. Further, it was discovered that funding alone was not enough. Often, there were no available facilities. Sometimes when the government became a "third-party payer" the facilities that had been available all along remained the only sources of medical care. People who had always had to put up with impersonal, inefficient hospital outpatient clinics still had to look to these clinics. But now a new layer of red tape had been added--an up-to-date, valid Medicaid card was required. In order for members of certain groups to benefit from advances in the treatment of heart disease, cancer, and stroke, new ways of providing health care in general had to be established. Thus, well before the legislative mandate embodied in P.L. 91-515 (the second RMP extension law), many Regions were involved, in a number of ways, in strengthening and improving primary care.

On February 18, 1971, President Nixon delivered a message to Congress describing a "new National Health Strategy that [would] marshall a variety of forces in a coordinated assault on a variety of problems." The new strategy was to be built on four basic principles: (1) assuring equal access; (2) balancing supply and demand; (3) organizing for efficiency by emphasizing health maintenance and preserving cost consciousness; and (4) building on strengths--structuring incentives to help rationalize the existing system and reorient it toward common goals without sacrificing the diversity which characterized the system and made it strong.

Based on these four principles, the President proposed a six-point program which would " . . . begin with measures designed to increase and improve the supply of medical care and conclude with a program which [would] help people pay for the care they require."

On March 24, 1971, the RMP Coordinators, at a meeting in Atlanta, Georgia, unanimously adopted a position paper outlining eight key aspects of the programs proposed by the President in which they felt RMPs should play an important role:

"1. Health Maintenance Organizations

RMPs provide the best and most economical way in which a federally supported health program can furnish immediate assistance to organizations and institutions, both urban and rural, interested in developing HMOs and other innovative systems of health care delivery. The RMPs' advantageous relationship with private physicians and community hospitals will be a key factor in the successful development of such systems."

2. Demonstration and promotion of new techniques for improving the efficiency and effectiveness of health care

RMPs have already become deeply involved in such demonstrations. They have one of the best records in promoting these new techniques to the practicing professionals and community hospitals as well as implementing them in the teaching programs of the medical schools.

For example, new techniques for screening and early diagnosis and patient and family education for promoting community prevention of disease have been demonstrated by many RMPs."

"3. The establishment of a series of new Area Health Education Centers as recommended by the Carnegie Commission on Higher Education

Regionalization has been the hallmark of RMP from its inception. The cooperative arrangements developed between the medical schools and key community hospitals and other groups by RMPs constitute an impressive start in the implementation of Area Health Education Centers."

"4. The Emergency Health Personnel Act

This act has important implications for innovative ways of solving the health care crisis in rural as well as urban ghetto areas and other problems such as health care for migrant workers. However, the act does not explicitly provide for supervision of the personnel assigned to these areas. The RMP Coordinators propose an important role for RMPs in the implementation of this act, particularly in the cooperative arrangements with nearby health facilities and with the area medical schools to assure proper supervision and adequate consultation for the assignees."

"5. Meeting the health manpower crisis

There exists already a severe shortage of nearly every type of health manpower. The demand inevitably will mount rapidly in the event of national health insurance. The RMPs' accomplishments in the recruitment, training, and development of new skills in the health care fields have been conspicuous. These, as well as innovative approaches

to training physician assistants, and improving medical communication and transportation, are in urgent need of support and expansion."

"6. Accessibility of health care

RMP has as a major goal the improvement of accessibility to health care. Examples of RMP-supported activities are regionalization of emergency medical services, expansion of urban and rural primary care, and extension of rehabilitation and other specialized services."

"7. The accomplishments of RMPs in categorical diseases contribute directly to improvements in the total health care system. The important role of RMP in the improvement of quality of care should not be overlooked. For example, work of the Inter-Society Commission on Heart Diseases, funded by an RMP contract, established quality standards. Local RMPs are assisting the providers in meeting these standards."

"8. Finally, the RMPs have encouraged and supported Comprehensive Health Planning Agencies at both state and areawide levels. They have stimulated the organization of many B agencies, and have effected several CHP-RMP mergers. Recognizing the complementary roles of these two programs in the improvement of health care, Regional Medical Programs will continue this close collaboration with CHP."

About three months later, on June 30, 1971, Dr. Vernon E. Wilson, HSMHA Administrator, issued a seven-page document, the Statement of Purpose for Regional Medical Programs, to specify what RMPs are, what their evolving mission had become, and the basis on which they would be judged by HEW evaluators. Specifically, it was stated the "RMP is a

framework or organization within which all providers can come together to meet health needs that cannot be met by individual practitioners, professionals, hospitals, and other institutions acting alone. It is also a structure deliberately designed to take into account local resources, patterns of practice and referrals, and needs. As such it is a potentially important force for bringing about and assisting with changes in the provision of personal health services and care."

Three of the programs' unique characteristics were described:

"1. RMP is primarily linked to and works through providers, especially practicing health professionals; this means the private sector largely."

"2. RMP is essentially a voluntary approach drawing heavily upon existing health resources."

"3. Though RMP continues to have a categorical emphasis, to be effective that emphasis frequently must be subsumed within or made subservient to broader and more comprehensive approaches."*

This document went on to itemize RMP's specific mission and objectives, principally to:

"1. Promote and demonstrate among providers at the local level both new techniques and innovative delivery patterns for improving the accessibility, efficiency, and effectiveness of health care. At this time the latter would include, for example, encouraging provider acceptance of and extending resources supportive of, Health Maintenance Organizations."

"2. Stimulate and support those activities that will both help existing

*This third statement is quite significant. This is one of the first HEW-prepared documents specifically referring to the need for a broad construction of the enabling legislation's categorical purpose provisions.

health manpower to provide more and better care and will result in the more effective utilization of new kinds (or combinations) of health manpower. Further, to do this in a way that will insure that professional, scientific, and technical activities of all kinds (e.g. information training) do indeed lead to professional growth and development and are appropriately placed within the context of medical practice and the community. At this time emphasis will be on activities which most effectively and immediately lead to provision of care in urban and rural areas presently underserved."

"3. Encourage providers to accept, and enable them to initiate, regionalization of health facilities, manpower, and other resources so that more appropriate and better care will be accessible and available at the local and regional levels. In fields where there are marked scarcities of resources, such as kidney disease, particular stress will be placed on regionalization so that the cost of such care may be moderated."

"4. Identify or assist to develop and facilitate the implementation of new and specific mechanisms that provide quality control and improved standards of care. Such quality guidelines and performance review mechanisms will be required especially in relation to new and more effective comprehensive systems of health services."

During 1972 and early 1973, the RMPs began to invest their energies and develop expertise in the organization and implementation of emergency medical services. These efforts were quite consonant with the emphasis on urban health care since it was in the scarcity areas--both

urban and rural--that emergency services were so essential, so often overburdened, and so much in need of upgrading. In fact, as the RMPs began to deal with EMS programs, it became evident that many of the problems faced and skills needed were the same whether in an isolated rural area or in an underserved, inner-city ghetto. As a result, it was seen that the Urban Health Project would have a far more widespread impact than had originally been projected.

This is the background against which the announcement came that RMP was to be phased out of existence within a matter of months. Despite the fact that the program was, in fact, extended for another year, through June 1974, the future remains uncertain. As a result, many projects have already been phased out, key personnel have been terminated or have left on their own initiative in many areas, and long-range planning has been severely disrupted. However, as the Urban Health Task Force discovered, in the course of its site visits, a wide range of projects had been initiated and/or supported by RMP staff members and RMP funds, and as late as mid-1973 many of these projects were still going strong. To supplement the information gathered in the course of the site visits, which would only cover a representative sampling of the Regions, various sources of information were examined, and information on the nature and extent of each Region's involvement with urban health was extracted.

CHAPTER IV

RECORD REVIEW

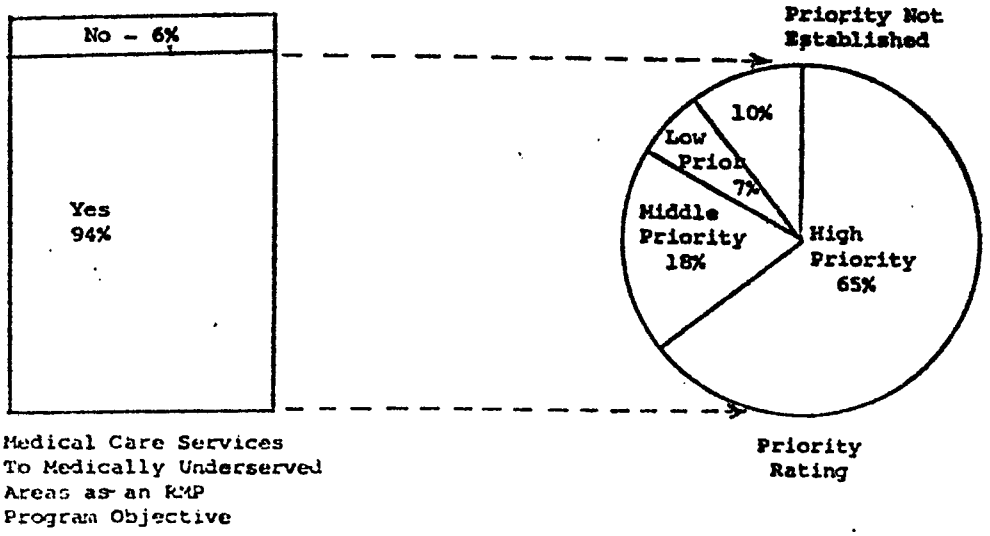
Upon review of the data compiled from each Region's most recent renewal application and related documents, it was evident that each region had, in fact, developed along independent lines. The resulting diversity was impressive. Because each region had developed its own staffing pattern, and because of variations in the types of grantee and composition of RAGs, there were significant differences in the characteristics of the applications and progress reports submitted to the Regional Medical Program Service. Attempts to make valid cross comparisons were complicated by differences in the status of the regions, the periods for which progress reports were rendered, and the different stages of development of the regions. Two regions--Ohio and Delaware--could not be evaluated at all because of recent changes in status.

The stated objectives of the regions were examined in order to determine each region's intentions with regard to the development of medical care services in medically underserved areas, both urban and rural. Because of lack of consistency in statements of objectives and priority ranking, the Task Force used the technique of placing all of the objectives into three groups. A high priority was assigned to any objective statement that was listed in the top one third of the objectives; a medium priority to those where the statement fell into the middle one-third of the objectives; or a low priority where the objective statement was among the last one-third of the objectives.

Fifty-four applications were reviewed, and improvement of services to

medically underserved areas was a stated objective in fifty-one. Thirty-three regions listed it as a high priority; nine, as a medium priority; four, as a low priority; and five regions listed this objective but did not differentiate between objectives as to priority. Three regions failed to mention medically underserved areas in their objective statements (see Figure 1).

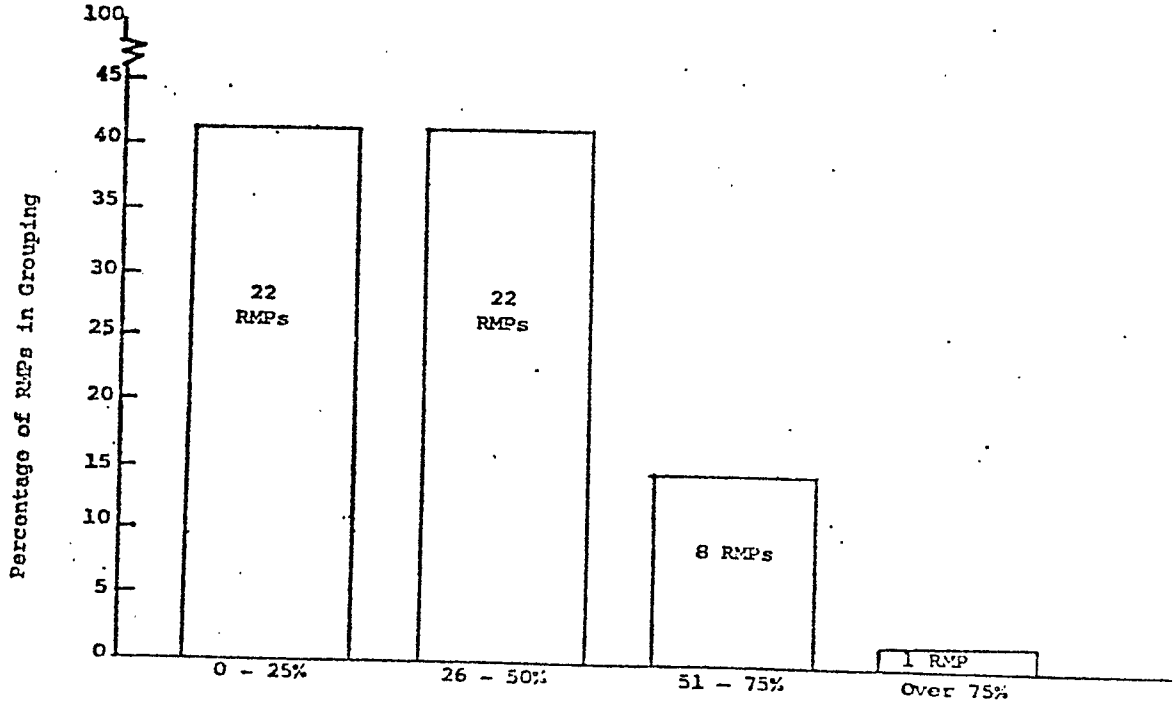
FIGURE I
SITE VISIT TEAM
Urban Health Task Force - RMPS
Objectives of 54 RMPs Regarding
Medical Care Services in Medically Underserved Areas
SPRING 1973



The Task Force then examined the operational projects which had been funded during the period studied. Using the project objectives statements, the projects were assigned to one of two groups--those whose objectives appeared substantially to emphasize improvement of medical care for an underserved population group and those which did not describe this as a stated objective. These data were then analyzed to associate the objectives set by each region with actual dollar allocations. Some very strong trends were evident. Useful data were obtained for fifty-three of the regions. Twenty-two of the regions committed up to 25% of their operational-project dollars to medical care for the underserved. Another

twenty-two regions allocated between 26% and 50% of their operational dollars to such projects, and eight regions committed between 51% and 75% of its operational funds in the manner (see Figure II).

FIGURE II
SITE VISIT TEAM
URBAN HEALTH TASK FORCE - RMPS
FUNDING ALLOCATION OF 53 RMPs FOR
OPERATIONAL PROJECTS RELATED TO MEDICAL CARE
FOR THE MEDICALLY UNDERSERVED
SPRING 1973

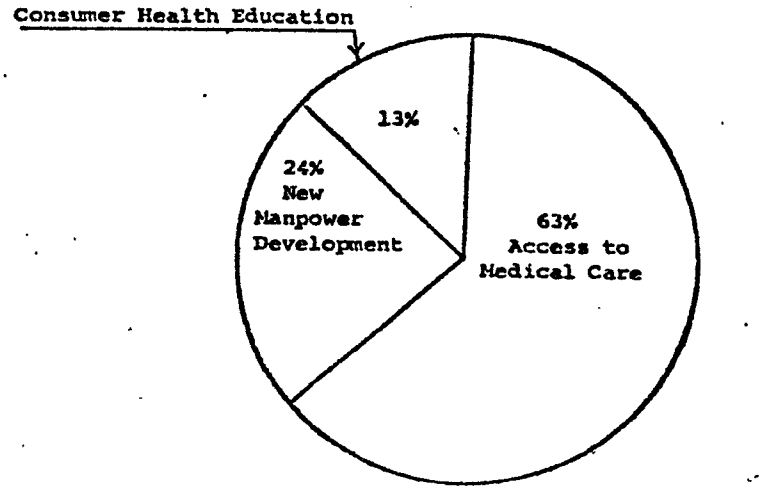


Percentage of funds allocated to operational projects related to medical care for the medically underserved.

As the applications were reviewed, it became apparent that three very specific techniques were employed by most of the regions in dealing with medical problems of the underserved. Many of the operational projects contained more than one of these elements; however in order to categorize the projects for statistical purposes, the Task Force agreed on three general methods or categories which could be considered the primary purpose

of each project. These were: development of primary medical care services, training of new types of health manpower, and consumer health education. During the study period, 272 funded operational projects were identified. Of these, 172 were aimed at the development of primary medical care services including emergency medical services; 64 dealt with training of new types of health manpower specifically to provide health care for the underserved; and 36 dealt with consumer health education (see Figure III).

FIGURE III
SITE VISIT TEAM
URBAN HEALTH TASK FORCE - RMPS
ALLOCATION OF 272 RMP OPERATIONAL PROJECTS
FOR THE MEDICALLY UNDERSERVED
BY TYPE OF MAJOR ACTIVITY
SPRING 1973



MAJOR TYPES OF OPERATIONAL ACTIVITIES

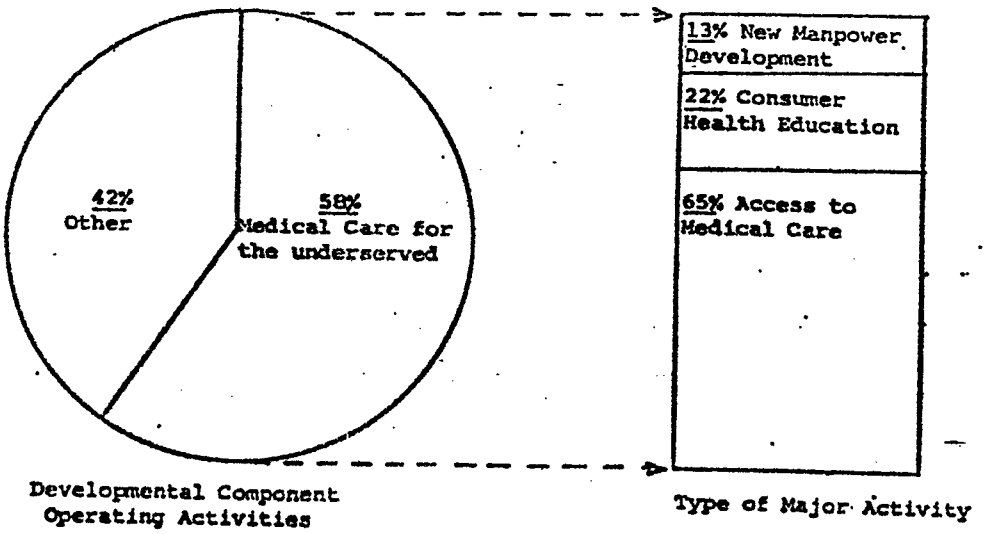
As the applications were examined it became obvious that the regions had used different methods of allocating money for specific operational activities. It seemed useful, therefore, to look at the percentage of dollars allocated by each region to program staff and to operational activities and to examine the extremes in order to determine whether or not there actually was a difference in the operational activities conducted by

the various regions. The percentage of total grant awards allocated to operational activities as a proportion of total dollars awarded to the region varied from a low of 10% to a high of 82%. The mean was 54%.

Developmental Component funds had been instituted to provide mature regions with discretionary funds, so that they might respond more rapidly to new initiatives in keeping with local priorities. Twenty-three regions were identified as having been authorized to use this method. Of these, seven regions provided enough information in their applications for analysis. Most of the other regions had not been authorized to use a Developmental Component for long enough to have reported activities.

Ninety-five Developmental Component activities were identified, fifty-five of which were clearly related to medical care for the underserved. These projects were categorized as follows: thirty-six involved access to medical care, twelve related to consumer health education, and seven to new manpower development (see Figure IV).

FIGURE IV
SITE VISIT TEAM
URBAN HEALTH TASK FORCE - RMPS
95 DEVELOPMENTAL COMPONENT OPERATIONAL ACTIVITIES
PERCENTAGE RELATED TO MEDICAL CARE OF THE UNDERSERVED
BY TYPE OF MAJOR ACTIVITY
SPRING 1973



It appears that Developmental Component funds were being used to comply with new program directions.

Next the most easily measured method of utilizing program staff dollars to move in new directions was examined. This was the data on page 11 of each application under the title, "Core-Supported Feasibility and Planning Studies," Applications from each region were reviewed to determine how different RMPs used this method of allocating funds or program staff time to achieve their objectives. Usable data were obtained from fifty-four applications.

Obviously, there were vast differences between the regions in their interpretations of the term, feasibility and planning studies. This made it difficult to find similarities which could be classified and recorded. For purposes of this report, the total number of feasibility and planning studies and the funds committed to such efforts were recorded. (In the course of doing so it was noted that the amounts recorded on RMPS Form 8 of each renewal application under Core Activity Summary for Feasibility and Planning Studies seldom agreed with the amounts recorded on the descriptions of activities. The funds recorded here are compiled from the totals reported on RMPS Form 11.) In addition, the number of activities and total funds apparently committed by each Region to improving medical services for the underserved were recorded. These activities were further broken down into the three categories: New Health Manpower, Consumer Health Education, and Development of Primary Health Care Services.

The number of feasibility and planning studies varied from zero in six regions to a high of 104 in one region. Expenditures, among the regions that reported such activities, ranged from $200 to $387,820 in one year. No valid statistical analysis was possible since program years (reporting periods) varied from ten to twenty-seven months; further, there was no

consistent definition of terms or method of utilization, and the regions vary in size and population; so much of the data reported are not readily comparable.

The total number of feasibility and planning studies was 734 with an overall funding of $3,797,682. Of these, 214 projects (total funding: $1,300,000) were relevant to services for the underserved. There were 131 projects concerned with developing new medical services, 45 with new health manpower, and 38 with consumer health education. Thirteen regions reported no activities related to the medical problems of underserved populations. In a number of cases feasibility and planning studies were reported but no costs were recorded since the activity had led to a project funded as a developmental component project, an operational project or an on-going program staff activity (see Table I).

TABLE I
SITE VISIT TEAM
URBAN HEALTH TASK FORCE - RMPS
217 FEASIBILITY AND PLANNING STUDIES RELATED
TO MEDICAL CARE FOR THE MEDICALLY UNDERSERVED
BY TYPE OF MAJOR ACTIVITY
SPRING 1973

Type of Major Activity	Number	Percent
TOTAL	214	100.0%
Access to Medical Care	131	61.2
New Manpower Development	45	21.0
Consumer Health Education	38	17.8

Interestingly, a number of regions provided RMPS Form 11 data on activities proposed for the next program year. The proportion and nature of the proposed activities suggest a continued shift in priorities with

increased emphasis on medical services for the underserved and minority ethnic groups, and on consumer involvement. In addition it was noted that a number of the on-going program staff activities reported could be considered relevant to the development of new medical services, but this type of reporting was very inconsistent and could not be used for statistical purposes.

It also proved impossible to analyze staff assignments and job descriptions and compare them with previous years since the application (RMPS Form 6) for the most of the region did not contain a description of prior-year staffing. However a significant number of the applications contained job descriptions which were variously titled but which appeared to be oriented toward the development of new medical services, community involvement, and/or the development of new health manpower. These often appeared to be newly-created positions.

This strongly suggests that most of the Regions would have been moving toward a different type of program in response to federal initiatives in their next program year. This was confirmed during site visits to the various regions.

A number of regions appeared to spend substantial funds through the contract mechanism. Among those reported were: contracts to develop new emergency medical services; to develop curricula for new health professionals; and to develop financing and management capabilities for various new services including HMOs, health screening, and health surveys. Because these also were not reported consistently and required detailed analysis of annual staff reports and annual Regional Advisory Group reports, it was impossible to develop statistically sound data. But again the data conveyed impression that contract money was being used to move

rapidly along the course charted by new federal initiatives and in keeping with responsibilities newly assigned to RMP.

An effort was also made to determine what, if any, relationship there was between the assignment of a high priority to medical care for the underserved and the allocation of all funds by the various regions. The analysis reflected that a large proportion of the regions which had given medical care for the underserved a high priority in their statement of objectives, had invested between 25% and 75% of their total resources in operational and/or program staff activities which would further these objectives. The applications for each of the Regions which deviated substantially from this correlation were examined in an attempt to determine the cause for this deviation. For the most part the anomaly appeared to result from the fact that long-range, large-scale projects had been funded prior to the change in directions, and that proposed new projects would have brought these regions more closely into alignment with their stated objectives. The anomalous regions tended to be those which were mature and had begun operational activities early with substantial commitments to categorical disease programs.

The data strongly suggest that most of the regions in the country had made rather substantial changes in their objectives in keeping with the new federal initiatives and RMP priorities. A variety of methods had been used to reach underserved communities which included alienated ethnic minorities, members of the youth culture, isolated rural communities, and impacted inner-city areas. The most common method for developing such activities appears to be screening and health surveys, many of which were conducted as Developmental Component activities, feasibility studies, or pilot projects, but some of which were also funded with contract monies or undertaken directly by program staff. There appears to

have been a substantial change in the investment the various RMPs had made in moving in these new directions, and impressions gleaned from the continuing applications suggest that the majority of RMPs had intended a substantially increased investment in this effort. Further there appear to have been two significant changes in program staff personnel: greater representation of minority ethnic groups and a wider variety of technical expertise.

Perhaps the most important conclusion to be drawn was that the raw data were not a good evaluative tool since there was no consistency in the way the various RMPs spent money or reported their expenditures. The raw data for each region had to be interpreted on the basis of narrative reports and a crude analysis of the type of financing each region utilized. One region, for example, reported a Developmental Component with specific project numbers and project reports, all funded as feasibility studies and pilot projects. Since this money was then allocated to program staff, a greatly exaggerated picture of the functional activities of this region was given.

The extent to which the information in the renewal applications gave a distorted impression became evident as the Urban Health Task Force members made their site visits to the Regions selected.

CHAPTER V

SITE VISITS

In the course of this study, twelve Regions were visited by the Urban Health Task Force. These were Bi-State, Tri-State, Greater Delaware Valley, Metropolitan Washington, Ohio Valley, Washington/Alaska, Metropolitan New York, Alabama, Rochester, Illinois, Georgia, and Tennessee-Mid/South. Although many staff members and most projects had been terminated as a result of the phaseout, in each case sufficient staff and volunteer personnel were brought together to provide a great deal of information. Even before the visits were begun, some impressionistic information on a wide range of program staff activities throughout the United States had been available. Although these activities had received some attention, there has been no organized effort to describe the skills, methods, or output of program staff members. Thus, the Regions visited were chosen to provide a diverse sample with different kinds of problems--cultural, geographic, ethnic, and economic--and a variety of problem-solving approaches.

Although there were differences in methods and techniques in each locale, there were also some significant similarities. For the most part, the development of demonstration grant proposals to be funded by Regional Medical Programs was only one staff function. The Regional Medical Programs at the local level helped meet acute medical care needs through financial support, technical support, educational activities, and systems organization. RMP staff members familiar with the intricacies of the health care system were frequently able, in the course of a short term commitment, to enhance

the capability of communities to meet their own health needs.

The RMP program staff members appear to function as a "skills bank" readily available to communities. Where a specific skill is needed but is not possessed by anyone on the program staff, competent consultations may be possible with members of voluntary committees or with consultants specially hired by RMP on behalf of a community. Since many of these activities do not involve expenditures of money, and, in fact, become part of routine day-to-day program operations, much of the activity is not reflected in annual progress reports.

In Seattle, Washington, the Model Cities health director said his organization had received only a few thousand dollars through RMP, but that his relationship with the Washington/Alaska RMP was invaluable. Data for the original model neighborhood health plan were provided by RMP. The director had always been able to call upon RMP for help with evaluation methods, data collection, and the preparation of alternative models for consideration by community committees. Personnel from a prepaid health plan and a dental plan located in the model neighborhood indicated that RMP had helped them prepare documents, provide information and data, and develop operational plans. These programs had received $9,000 and $11,000 "mini grants" which had enabled them to begin programs to train community-based allied health personnel who were then supported with Model Cities funds.

In Washington, D.C., the RMP responded to a need expressed by the Mayor's Health Committee for nurse-midwives to serve in neighborhood health centers. The curriculum developed through RMP is now being implemented at D.C. General Hospital. In Philadelphia, a medical school RMP coordinator was asked by a hospital administrator to attend a community meeting called to discuss an

OEO health center application. The RMP responded by providing technical assistance in the preparation of a $2.5 million Health Network proposal which was funded.

Staff from several of the RMPs mentioned that in addition to eliciting participation by members of medical school faculties in the health affairs of their communities, they had frequently been able to mobilize other members of university communities to join in dealing with these problems. Faculty members and students of urban planning, education, social work, economics, engineering, architecture, and law were thus mobilized. In the Tennessee/Mid-South RMP, students and faculty from the School of Medicine, a School of Nursing, School of Social Work, and College of Law were providing services for poverty communities. In Philadelphia the Lincoln-Davies School of Health Economics, the School of Social Work, and the Department of Urban Planning joined RMP in developing health programs for an assigned target population.

In every Region visited there was evidence of skillful utilization of non-RMP, non-university resources, most of them local and committed to continuing activities after RMP funding was discontinued. These were usually cost-sharing arrangements involving many different types of local organization. For example, in Birmingham, Alabama, RMP provided funds to the Roosevelt City Community Corporation for a health survey and screening program in four separate, incorporated small cities. The survey involved cooperation with the areawide CHP Agency, the County Health Department, the Medical School, and professional and community volunteers. From this project, a full fledged prepaid comprehensive health plan has evolved to provide for the medical-care needs of a target population of about 22,000 people, 60% of them black. The bulk of the funding for this project now comes from DHEW and from the Appalachia Regional Commission, but each of the towns has made a small cash

contribution and large in-kind contributions. Local business firms have provided $18,000 in cash and additional in-kind contributions. The marketing committee and finance committees are chaired by vice presidents from Blue Cross-Blue Shield and from the banking industry.

Every Region visited had been involved in providing assistance for community groups applying for Federal grant funds. Typically these were applications to [Comprehensive Health Services, Family Health Center grant applications], and OEO Office of Health Affairs grant applications. Some of the Regions had also been involved with other Federal programs and agencies such as the Departments of Labor, Housing and Urban Development, Transportation, and Agriculture. Ohio Valley RMP program staff had worked extensively with both OEO and Model Cities including the Hunter Foundation in Lexington, an ambulatory-patient-care OEO project in Cincinnatti, the Pilot Cities OEO project, and Dayton Model Cities. Again, many of these efforts are not described in the Ohio Valley annual progress report since they do not result in funded RMP projects.

The components of RMP, as related to the development of new or improved health services for underserved communities, consisted of people, skills, money, and intangible resources. In trying to characterize the personnel involved in this process the inadequacy of the brief interviews which were conducted throughout the study must be realized. However, some common characteristics of both the people and the program were identified. First of all, successful RMP staff members were intimately known in the local and/or regional community. They were extremely knowledgeable about the culture, the political forces, and the broad local power forces within their areas. They were very well versed in the language and the programs of other local and federal health programs as well as those other programs with a significant impact on the health care scene. They came from a variety of academic

backgrounds: education, liberal arts, social work, behavioral sciences, basic science, and medicine. All were college graduates with at least a baccalaureate degree, and most had earned a Master's degree. Virtually all could be described as generalists rather than specialists. They had the ability to look at the total scene in a community and synthesize solutions to the health care problems they encountered. They were able to cope with overall problems while locating adequate technical assistance to solve specific operational problems. Invariably they had the total commitment of the program coordinator and the senior staff and were permitted to exercise independent judgment in operating within their own milieu. Finally they all appeared to be extroverted, warm, self-confident, accepting, and articulate. Above all, they seemed to be completely unafraid when operating within whatever community was involved.

During the course of several site visits, members of the team were accompanied by program staff personnel involved in community-based medical programs connected with the local RMP. They noted that these staff people appeared to be widely known and greatly respected from the halls of the university to the streets of the poverty neighborhoods. Warm interpersonal relationships between the RMP staff and providers and consumers at all levels made it possible for the team to be warmly and openly received in ghetto clinics as well as in established institutions of learning.

A wide range of skills was demonstrated in the RMPs site visited; some skills were common to all of the RMPs and others seemed to have been developed in response to specific local needs and priorities. For example, skills in management, health services systems, data collecting, information gathering and proposal writing were present in most of the RMPs. Education skills were also common throughout most of the RMPs visited. These included academic skills in the training of a wide variety of new health professionals and other skills useful to the community, such as skills in training members

of community boards to run new health service organizations. Skills essential to the development of categorical programs were very much in evidence, particularly with regard to the newest categorical disease focus assigned to RMP--chronic kidney disease. Expertise in Emergency Medical Services systems development was also beginning to develop in response to local as well as national priorities. In Georgia, EMS development had been singled out as a very high priority item by both the Regional Advisory Group and other public service organizations. Working jointly with other provider groups, the Georgia RMP had embarked on a program to systematically cover the entire state, particularly rural and small town communities, with Emergency Medical Service systems linked to existing provider institutions. In many cases this complex operation involved crossing community and political boundary lines and regionalizing services. Similarly there were RMP staff members developing cost-containment systems through cooperative purchasing arrangements, record keeping, and other costly services essential to health care institutions. Other Regions had employed a cadre of professionals skilled in the development of neighborhood health centers within urban communities.

A number of RMPs used similar methods to assist in the development of personal health services for scattered and isolated rural population groups. For example, the Rochester RMP, serving a ten-county, predominantly rural area, populated by scattered farm owners and a large number of migrant farm workers, addressed the problem of inadequate manpower and facilities on two fronts. The RMP joined other groups to assist in the development of a new rural comprehensive health care clinic (The Tri-County Family Medicine Program) which is now active and expects to be self-sufficient within another year. The Rochester RMP also provided funds to train nurse practitioners who are currently providing care in a second rural clinic, thus enabling local physicians to see many more patients.

A different approach was discovered in the course of a visit to the Illinois RMP which had organized a health center for senior citizens in the Flannery Homes Housing Project. Skillful use of physician assistants and sound administrative and management practices were demonstrated in this project. This is particularly significant since there are thirty-six similar senior citizens' housing projects in the city and there is a potential for replicating this project at each housing site.

During the site visits it became apparent that the characteristics of the program staffs were undergoing metamorphosis. People with substantial experience in dealing with categorical disease programs and continuing education of physicians were no longer on the staff in most places and seemed to have been replaced by people with a different array of skills relating to new program directions and new federal health initiatives.

As the Task Force looked at continuation applications and discussed with coordinators their plans for the coming year, it appeared that rather substantial changes would have occurred in the composition of program staff as additional people were employed to work with community groups in developing new and improved health services. There was obviously a much greater emphasis on employment of minority group professionals who might be able to relate more effectively to the ethnic monorities who had become high priority target groups.

It appeared that the allocation of RMP funds was also undergoing transformation. Many staff members reflected on the days of the large grants to major institutions related to categorical illness programs. By contrast, new project grants, in general, were in smaller amounts, for a substantially shorter time, and frequently were funded through new or emerging health-interested organizations. Since many of these grants went to locally-supported

institutions, cost sharing was usually built in. The Regions used a variety of techniques to provide quick turnaround on project applications including pilot projects, contracts, and especially Developmental Component funds where possible. Many of the operational projects in which RMPs joined with local governments to provide for the development of new health care services exemplify this trend.

In some cases relatively large amounts of RMP funds have been committed to programs with an impact on minority groups and/or underserved communities. Large grants were made by the Metropolitan Washington RMP on a continuing basis to the Howard University/Freedmen's Hospital complex; apparently this has had a rather substantial impact on the quality and the amount of care available to residents of the area immediately surrounding Howard. Thus the Freedmen's Stroke Project and Howard University Cancer Project were included in the Metropolitan D.C. site visit. The director of the Cancer Project indicated that this RMP-funded project paved the way for a $5.1 million cancer research center grant from the National Cancer Institute. He said quite emphatically that without initial RMP seed money this center could never have been developed and would not be available to the Washington community. Even before the cancer center money had arrived, Freedmen's Hospital had developed the largest radiotherapy department in the District and had also developed the only approved radiotherapy program and school for radiotherapy technologists in the District. The Stroke Project has influenced the general level of care within the hospital since it was one of the first attempts to institute the team approach to medical care with regard to a categorical illness. There are also some medical audit elements built into the program which have resulted in rather substantial changes in the quality of care rendered in the hospital. Medical students and students of other

health professions now have an opportunity to observe continuity of care from the onset of acute stroke through progressive stages of treatment.

In the Tennessee-Mid/South region, a multiphasic screening project at Meharry University has had a number of interesting results. First of all, since it is the only multiphasic screening program available to residents throughout a large geographic area, it has provided a vital service. Second, it has linked the services of the screening program with local out-patient and in-patient institutions and with private providers of care from the surrounding community. Third, it has provided a basis for the development of a working relationship between the Meharry Medical College and Vanderbilt University School of Medicine which has continued and which has borne a great deal of fruit including the design and implementation of a number of student activities with an important impact even on parts of the South outside the Tennessee-Mid/South region.

The Metropolitan New York RMP's Harlem Stroke Project is another program which has affected a minority-group, underserved community. In addition to its categorical focus, this program has had a significant outreach effect involving the participation of a variety of community groups in its case-finding and follow-up activities. Fourteen community health workers have completed a six month training course and screened over 2,000 persons in 1971 as part of this project.

The diversity of the problems and problem-solving techniques encountered in the course of the site visits nearly defies generalization and summary analysis. As we have noted, individual staff members whose efforts have been most successful are united more by a common style than by common substantive skills.

Similarly, certain common problems and problem-solving approaches were

demonstrated both in heavily populated urban ghettoes, in sparsely populated rural areas, and sometimes even in recently settled suburbs. These commonalities have important implications for the approach originally adopted in this project and for the approach which ought to be adopted in further projects of a similar nature.

APPENDIX A

METHODOLOGY

In an effort to develop information that would be both reliable and useful in shaping future efforts to structure health care programs for medically underserved people, data for this study were compiled through site visits and through systematic reviews of certain documents. The site visits, carried out by a team of four staff members from the California and New Jersey RMPs, were made to twelve regions chosen as a representative sample in terms of geography as well as of the types of problems encountered and the ways in which these problems were managed. In the meantime, staff from the New Jersey and California RMPs reviewed the most recent annual applications submitted to RMPS by each of the fifty-six regions along with data on the funding history of each region generated from the RMPS Management Information System.

In addition, an extensive array of legislative documents, conference proceedings, Presidential statements, draft position papers, correspondence, Departmental/Regional communications media, press information releases, journal articles, news clippings, and similar or related material was reviewed. Through these documents, the development of RMP was traced within the context of the Program's evolving legislative mandate and shifting national health care priorities. This phase of the investigation was carried out by someone with prior professional experience in both health care and legal research who had had no previous involvement with RMP.

The regions visited were: Washington/Alaska, Rochester (upstate New York), Greater Delaware Valley (centered on Philadelphia), New York Metropolitan,

Tri-State (Massachusetts, New Hampshire, and Rhode Island), Ohio Valley (southern Ohio, southern Indiana, Kentucky and western West Virginia), Bi-State (principally greater St. Louis), Tennessee/Mid-South, Georgia, Illinois, Metropolitan Washington (District of Columbia and adjacent counties in Maryland and Virginia), and Alabama. To some extent the information gathered on these site visits was supplemented by the first-hand knowledge of team members based on their own experience with the New Jersey and California RMPs.

The site visits were made over a period from May 7 to July 17, 1973. In each case the Coordinator of the Region proposed to be visited was contacted, told the purpose of the proposed visit, and invited to have his Region participate. He was then asked to have the following people present to meet with the Urban Health Task Force: the Coordinator himself, RMP staff members, a Regional Advisory Group representative, local health leaders, and officials involved in dealing with urban health.

For the first two site visits, the four Task Force members, John A. Mitchell, M.D., Henry Wood, Marlene Checel, and Madeline Thoma, split up with two members meeting with the Washington/Alaska RMP and the other two meeting with the Rochester RMP. Following a conference on May 14, 1973 with Mr. Cleveland R. Chambliss, all four Task Force members visited the Greater Delaware Valley, New York Metropolitan, and Tri-State RMPs. The teams then split up again and went to the Ohio Valley, Bi-State, Tennessee/Mid-South, and Georgia RMPs and finished on May 24, 1973. Then, following a two-member visit to Illinois and a full team visit to Metropolitan Washington, the Urban Health Task Force met with Mr. Chambliss for a debriefing on June 12, 1973. The final site visit, made after the debriefing session because of scheduling difficulties, was made to Alabama on July 17, 1973.

In most cases the Urban Health Task Force members began their visit with a briefing by the Coordinator and his staff. The remainder of the time was usually spent in interviews with individuals associated with but not on the staff of the local RMP. These included RAG members; staff members of RMP-funded projects; volunteers or staff members from other federal programs such as Comprehensive Health Planning, Office of Economic Opportunity, and Model Cities; and local officials such as city councilmen, state health commission members, and others concerned with urban health problems. Information obtained in the course of these interviews was included in a report developed on each Region visited.

In the second phase of the project the most recent progress report and continuation application for each Region was reviewed by RMP staff members in California and New Jersey at the same time that the site visits were taking place. Initial plans had called for a detailed questionnaire to be submitted to each of the fifty-six regions in order to gather the necessary data. However, this proved not to be feasible.

A preliminary instrument for extracting the information contained in each application was developed, based in part on official RMPS reporting forms, before the first site visits were made. As this instrument was being used by the reviewers, a number of problems were discovered. First, and perhaps most serious, were the reporting periods involved. Since applications were submitted to RMPS at different times during the year and because some of the RMPs had extended program and funding years, some applications were quite recent and reflected the latest developments while others, submitted up to two years earlier and generally prepared over a period of six months to a year prior to submission, were extremely out of date. Thus comparisons between regions did not reflect fairly the

relative strengths and weaknesses of each program. Moreover, a preliminary review of the most recent applications indicated a dramatic shift in regional priorities dating from about the time that the Advisory Committee on Urban Health was formed and the original contract for this project was first announced. The older applications were prepared prior to the RMP emphasis on health care for the underserved and did not accurately reflect the activities which were being carried out in 1972 by those RMPs nor the directions in which they would move in 1973.

Yet a third weakness became evident when information collected through the application review was compared with what the Task Force members were discovering in the course of site visits. To a large extent, the urban-health-related activities of the Regions visited were not fairly reflected in their annual applications. A number of reasons were noted. First, the reporting forms had been developed by HEW before the involvement of RMPs with urban health had become a major concern. Thus, the forms were not designed to extract this information. Second, due to the relatively recent start of the program and the infrequency of reporting on a three year cycle, staff members in many Regions simply were not familiar enough with the forms and did not know how to use those elements of the reporting format which could be adapted to highlight vital activities and accomplishments. Third, and most dramatic, was the failure of the application forms to focus on a wide range of program staff activities other than those which culminated in RMP-financed projects

Thus RMP staff members might survey the health needs of a particular urban neighborhood; discover an urgent need for primary care facilities; work with local community leaders to organize a representative board;

assist in locating a suitable neighborhood health center site, hiring staff members, and negotiating clearances with local zoning boards and similar municipal agencies, and give the board members guidance in preparing a successful application for funding through some funding source such as OEO; and none of these activities would be reflected in the Region's annual application since-no RMP funded project resulted. They might simply be lumped in with program staff activities. It is important to note that all of the activities described above are entirely in keeping with RMP's mandate to strengthen and improve primary care, especially in service-scarcit areas, without itself financing the provision of care except in connection with a demonstration project. Yet, not only would these program staff activities fail to be highlighted, but by being lumped in with other program staff activities they would contribute to the impression that the Region in question was a "bloated" bureaucracy with wildly disproportionate administrative costs. At best, the neighborhood health center and/or its governing board might be listed on RMPS Form 8, Program Activities Summary. Unfortunately, this form often was little more than a "laundry list" which merely inventoried contacts without in any way indicating the nature or quality of the tranactions involved.

After completion of the site visits and the record review, the Urban Health Task Force reviewed the site visit reports and the record review summaries. In the course of this review, the Task Force freely referred back to source documents to substantiate unusual indicators or to clear up inconsistent data. The application and progress report format made it fairly easy to describe operational projects but the Task Force found that it was difficult to find much information on the activities of program staff. Frequently, it was necessary to read the narrative progress report

of the program staff or the RAG report to identify a program initiative. In many Regions, it was difficult to identify activities planned or carried out through the Developmental Component.

The Task Force then turned to financial data available from the RMPS Management Information System printouts and looked in detail at the Funding History List for each Region. For purposes of this report, information was taken from the program year which contained the most months of 1972. For example, if a region received an award for the periods Janaury 1971 through April 1972 and May 1972 through July 1973, the information for the later period, which covered eight months of 1972, was used. No effort was made to reduce the data to twelve-month periods since there was not enough information available. This method was utilized since the reporting periods varied from ten months to twenty months, and additionally, the starting and ending dates were staggered to fit the three times per year cycle of the National Advisory Council.

The Project Summary (RMPS Form 15), when it was well written, was the most useful document for the reviewers. Since project titles frequently failed to indicate the intent, scope, or direction of a project, they were of little use in an objective review. The project summaries, however, could be related to the funding history prepared through the Financial Data Record (RMPS Form 16) and summarized in the Management Information System printout. When all components of the system were used to report Developmental Component activities, it was possible to generate for inspection a concise, composite picture of a Region's Developmental Component efforts.

Regions were required to report on "Core Central Regional Service Activities" (RMPS Form 12) for the immediate past and future funding periods. An examination of these reports was attempted but could not be carried out

because some Regions did not report activities and others did not seem to agree on definitions of the term. The most frequently reported activities in continuing education for health professionals; but data gathering and health surveys were also reported.

To the greatest extent possible, only data which could be considered valid were used in preparing this report. Anecdotes, when cited, have been offered as examples of incidents that were reported and that are considered to be part of the tactical repertoire of many of the RMPs and are neither unique nor peculiar to any single Region. In the final analysis, it seems safe to say that the data included in this document are a fair, accurate reflection of the underlying reality and these data support the conclusions reached.