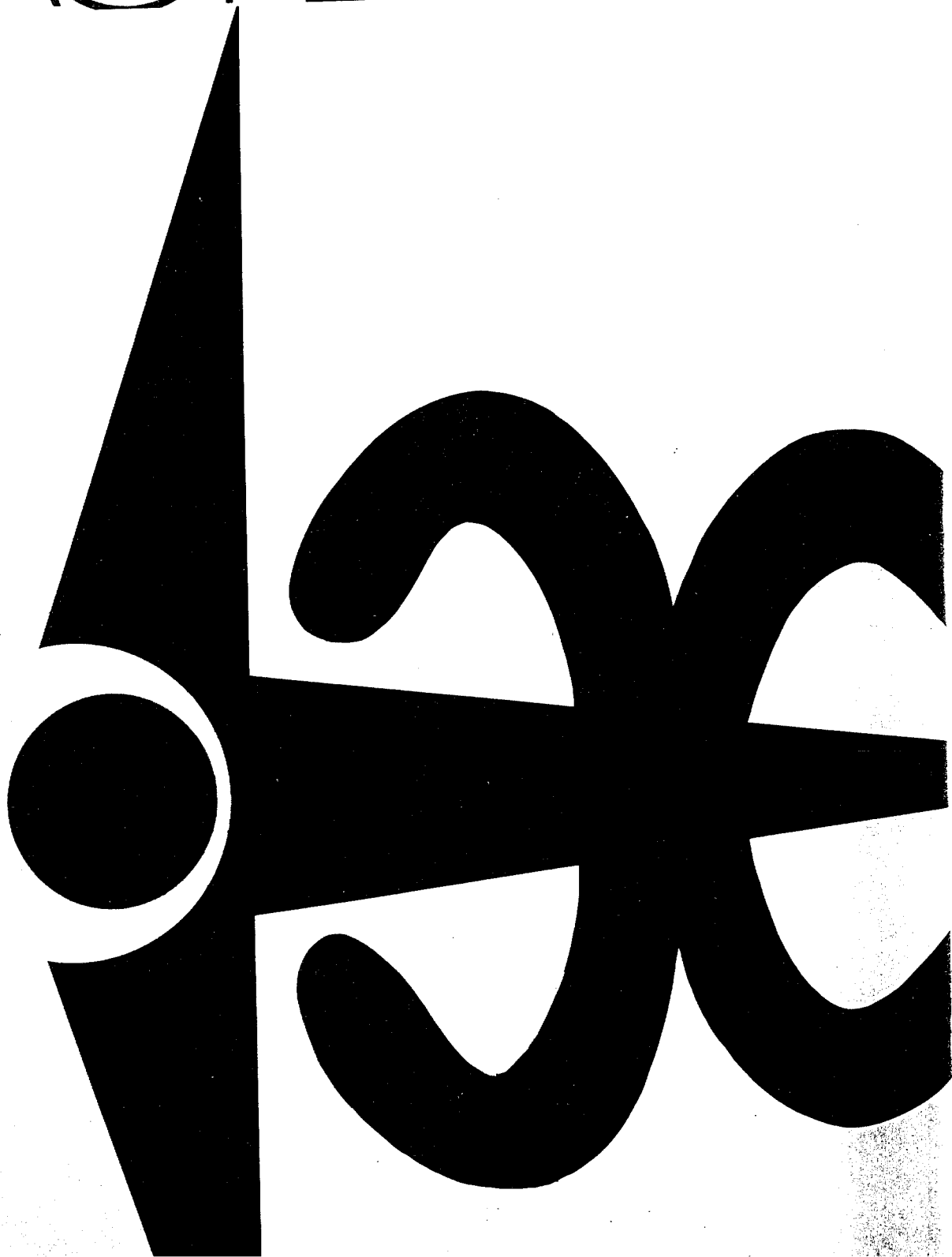






# FACT BOOK

REGIONAL INDUSTRIAL FIRM ORGANIZATION



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# foreword

"There is little reason to doubt that we are now beginning to move in the proper direction. The right of all citizens to have equal opportunity for good medical care is no longer contested. Nor is there any remaining controversy about the need to control medical costs; to redistribute and maximize the use of existing manpower; and to do all this, and perhaps more, without delay."

Address by Merlin K. DuVal, Jr., M.D.  
Assistant Secretary for Health  
and Scientific Affairs  
National Meeting of the Regional  
Medical Programs, January 18, 1972

Regional Medical Programs are a pluralistic approach to dealing with the nation's health problems. The Programs have developed a coalition of thousands of health providers and interested consumers to plan and implement activities for health care at the local level.

This Fact Book presents an updated report of how Regional Medical Programs have organized this effort and the progress they have made in achieving their goals. It is hoped that this publication will serve as a ready reference source for those interested in Regional Medical Program activities.



Harold Margulies, M.D.  
Director  
Regional Medical Programs Service

FACTBOOK

# mission & history

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## MISSION

LEGISLATIVE AND ADMINISTRATIVE HISTORY

APPROPRIATIONS AND BUDGETARY HISTORY

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The Regional Medical Programs (RMPs) seek to strengthen and improve the Nation's personal health care system in order to bring about more accessible, efficient, and high quality health care to the American public. To accomplish these ends the Regional Medical Programs:

- Promote and demonstrate among providers at the local level new techniques and innovative delivery patterns for improving health care, with particular attention to those diseases which are major causes of death and disability;
- Stimulate and support those activities which will both help existing health manpower to provide more and better care and result in the more effective utilization of new kinds and combinations of manpower;
- 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; and
- Identify or assist to develop and facilitate the implementation of new and specific mechanisms that provide quality control and improved standards of care.

Each RMP develops its programs through a consortium of providers and consumers which comes together to plan and implement activities to meet health needs which cannot be met by individual

practitioners, health professionals, hospitals, and other institutions acting alone. The RMP provides a framework deliberately designed to take into account local resources, patterns of practice and referrals, and needs. As such it is an important force for bringing about changes in the provision of personal health services and care.

The initial concept of Regional Medical Programs was to provide a vehicle by which scientific knowledge could be more readily transferred to the providers of health services, and by so doing, improve the quality of care provided with emphasis on heart disease, cancer, stroke, and related diseases. The implementation and experience of RMP over

### **Highlights of Legislative and Administrative History**

<b>1964 DECEMBER</b>	The Report of the President's Commission on Heart Disease, Cancer and Stroke presented 35 recommendations including development of regional complexes of medical facilities and resources.
<b>1965 JANUARY</b>	Companion administration bills—S. 596 and H.R. 3140—were introduced in the Senate by Senator Lister Hill (Ala.), and in the House by Representative Oren Harris (Ark.), giving concrete legislative form to presidential proposals.
<b>OCTOBER</b>	P.L. 89-239, the Heart Disease, Cancer and Stroke Amendments of 1965, was signed. The Commission concepts of "regional medical complexes" and "coordinated arrangements" were replaced by "regional medical programs" and "cooperative arrangements," thus emphasizing voluntary linkages.
<b>DECEMBER</b>	National Advisory Council on Regional Medical Programs met for the first time to advise on initial plans and policies.
<b>1966 FEBRUARY</b>	Dr. Robert Q. Marston appointed first Director of the Division of Regional Medical Programs and Associate Director of National Institutes of Health (NIH).
<b>APRIL</b>	First planning grants approved by National Advisory Council.
<b>1967 FEBRUARY</b>	First operational grants approved by National Advisory Council.
<b>JUNE</b>	The Surgeon General submitted the <b>Report on Regional Medical Programs to the President and the Congress</b> , summarizing progress made and recommending its extension.

**1968 MARCH**

Companion bills to extend Regional Medical Programs were introduced in the House by Harley O. Staggers (W.Va.) (H.R. 15758) and in the Senate by Senator Lister Hill (Ala.) (S. 3094).

**JULY**

Health Services and Mental Health Administration (HSMHA) established; Division of Regional Medical Programs changed from NIH to HSMHA.

**OCTOBER**

P.L. 90-574, extending the Regional Medical Programs for two years, was signed. Changes were: include territories outside of the 50 States; permit funding of interregional activities; permit dentists to refer patients; and permit participation of federal hospitals. Division of Regional Medical Programs became Regional Medical Programs Service.

**1970 JAN.-OCT.**

Bills extending RMP introduced; hearings held.

**OCTOBER**

P.L. 91-515 was signed into law. New provisions: emphasis on primary care and regionalization of health care resources; added prevention and rehabilitation; added kidney disease; added authority for new construction; required review of RMP application by Area-wide Comprehensive Health Planning agencies; emphasized health services delivery and manpower utilization.

**1972 SEPTEMBER**

Proposals for June 1973 legislative extension of RMP being drafted.

the past seven years, coupled with broadening of the initial concept especially as reflected in the most recent legislative extension, has clarified the nature and character of Regional Medical Programs. 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. RMP must relate primary care to specialized care, affect manpower distribution and utilization, and generally improve the system for delivering comprehensive care.

Even in its more specific mission and objectives, RMP does not function in isolation. Only by working with and contributing to related federal and other efforts at the local, state and regional levels, particularly state and areawide Comprehensive Health Planning activities, can the RMPs achieve their goals.

### Appropriations and Budgetary History

(dollars in thousands)

	Fiscal Year 1966	Fiscal Year 1967	Fiscal Year 1968	Fiscal Year 1969	Fiscal Year 1970	Fiscal Year 1971	Fiscal Year 1972
Authorization -----	\$50,000	\$90,000	\$200,000	\$65,000	\$120,000	\$125,000	\$150,000
Amount appropriated for grants -----	24,000	43,000	53,900	56,200	73,500	99,500	90,500
Amount actually available for grants <sup>1</sup> -----	24,000	43,934	48,900	72,365	78,500	70,298	135,000
Amount actually awarded for grants -----	2,066	27,052	43,635	72,365	78,202	70,298	111,400 <sup>2</sup>

Authorization—a grant of authority from the Congress to the executive branch to spend federal funds for specified purposes.

Appropriation—legal sanction by the Congress for a Government agency to obligate not more than a stated sum for specified purposes within a stated period.

<sup>1</sup> Includes unspent funds carried forward from previous year minus amounts held in reserve by the Office of Management and Budget.

<sup>2</sup> Does not include earmarked amounts for Emergency Medical Services (\$8.0 million), Cancer construction (\$5.0 million), Health Maintenance Organizations (\$9.4 million), Contracts (\$1.0 million), and evaluation activities (\$.6 million).



# characteristics

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GEOGRAPHIC AREA

DEMOGRAPHIC FACTS

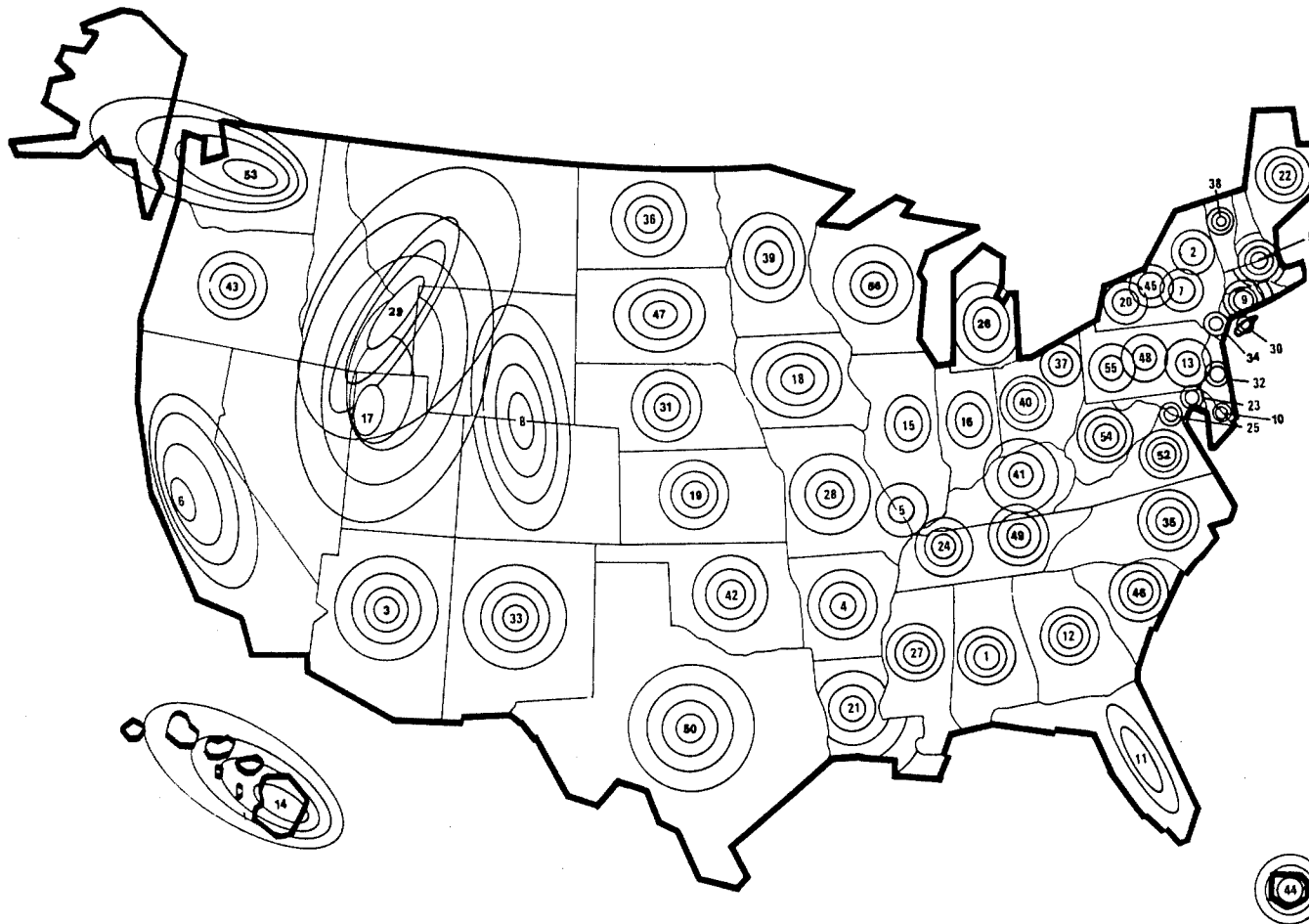
FUNDING

ORGANIZATIONAL AND OPERATIONAL STATUS

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## Geographic Area of Regional Medical Programs

1. **ALABAMA**—Covers the state of Alabama.
2. **ALBANY**—Includes 21 northeastern New York counties centered around Albany and contiguous portions of southern Vermont and Berkshire County in western Massachusetts. (Overlaps Tri-State and Northern New England RMPs.)
3. **ARIZONA**—Covers the state of Arizona.
4. **ARKANSAS**—Covers the state of Arkansas. (Overlaps in the northeast portion with Memphis RMP.)
5. **BI-STATE**—Includes southern Illinois and eastern Missouri counties centered around the St. Louis metropolitan area. (Overlaps Illinois RMP.)
6. **CALIFORNIA**—Covers the state of California. (Overlaps Mountain States RMP in sections of Nevada.)
7. **CENTRAL NEW YORK**—Includes 15 Central New York counties centered around Syracuse, and the Pennsylvania counties of Bradford and Susquehanna.
8. **COLORADO-WYOMING**—Covers the states of Colorado and Wyoming. (Overlaps Mountain States and Intermountain RMPs.)
9. **CONNECTICUT**—Covers the state of Connecticut.
10. **DELAWARE**—Covers the state of Delaware.
11. **FLORIDA**—Covers the state of Florida.
12. **GEORGIA**—Covers the state of Georgia.
13. **GREATER DELAWARE VALLEY**—Includes southeastern Pennsylvania (Philadelphia-Camden), northeastern Pennsylvania (Wilkes Barre-Scranton) and southern New Jersey counties. (Overlaps New Jersey RMP.)
14. **HAWAII**—Includes the state of Hawaii, American Samoa, Guam, and the Trust Territory of the Pacific Islands.
15. **ILLINOIS**—Covers the state of Illinois. (Overlaps Bi-State RMP in the southern portion of the state.)
16. **INDIANA**—Covers the state of Indiana. (Overlaps Ohio Valley RMP.)
17. **INTERMOUNTAIN**—Includes the state of Utah, portions of Wyoming, Montana, Idaho, Colorado and Nevada. (Overlaps Colorado-Wyoming and Mountain States RMPs.)
18. **IOWA**—Covers the state of Iowa.
19. **KANSAS**—Covers the state of Kansas.
20. **LAKES AREA**—Includes seven western New York counties centered around Buffalo, and the Pennsylvania counties of Erie and McKean.
21. **LOUISIANA**—Covers the state of Louisiana.
22. **MAINE**—Covers the state of Maine.
23. **MARYLAND**—Covers the state of Maryland and York County, Pennsylvania. (Overlaps in south-central Maryland with the Metropolitan Washington, D.C. RMP.)
24. **MEMPHIS**—Includes the western Tennessee area centered around Memphis; northern Mississippi; northeastern Arkansas; portions of southwestern Kentucky; and three counties in southwestern Missouri. (Overlaps Mississippi, Arkansas, and Ohio Valley RMPs.)
25. **METROPOLITAN WASHINGTON, D.C.**—Includes the District of Columbia and contiguous counties in Maryland and Virginia. (Overlaps Maryland and Virginia RMPs.)
26. **MICHIGAN**—Covers the state of Michigan.
27. **MISSISSIPPI**—Covers the state of Mississippi. (Overlaps in northern part of state with Memphis RMP.)
28. **MISSOURI**—Covers the state of Missouri, exclusive of the Metropolitan St. Louis area.
29. **MOUNTAIN STATES**—Includes portions of Idaho, Montana, Nevada and Wyoming. (Overlaps California, Intermountain and Colorado-Wyoming RMPs.)
30. **NASSAU-SUFFOLK**—Includes the counties of Nassau and Suffolk (Long Island) of the state of New York.
31. **NEBRASKA**—Covers the state of Nebraska.
32. **NEW JERSEY**—Covers the state of New Jersey. (Overlaps in seven southern counties with Greater Delaware Valley RMP.)
33. **NEW MEXICO**—Covers the state of New Mexico.
34. **NEW YORK METROPOLITAN**—Includes New York City and Westchester, Rockland, Orange and Putnam counties.
35. **NORTH CAROLINA**—Covers the state of North Carolina.
36. **NORTH DAKOTA**—Covers the state of North Dakota.
37. **NORTHEAST OHIO**—Includes 12 counties in Northeast Ohio centered around Cleveland.
38. **NORTHERN NEW ENGLAND**—Includes the state of Vermont and three contiguous counties in northeastern New York. (Overlaps Albany RMP.)
39. **NORTHLANDS**—Covers the state of Minnesota.
40. **OHIO**—Covers the central corridor of the state from the northwest to the southeast.
41. **OHIO VALLEY**—Includes most of Kentucky (101 of 120 counties), southwest Ohio (Cincinnati-Dayton and adjacent areas), contiguous parts of Indiana (21 counties) and West Virginia (2 counties). (Overlaps Indiana, Memphis, Tennessee Mid-South and West Virginia RMPs.)
42. **OKLAHOMA**—Covers the state of Oklahoma.
43. **OREGON**—Covers the state of Oregon.
44. **PUERTO RICO**—Covers the Commonwealth of Puerto Rico.
45. **ROCHESTER**—Includes ten counties centered around Rochester, New York.
46. **SOUTH CAROLINA**—Covers the state of South Carolina.
47. **SOUTH DAKOTA**—Covers the state of South Dakota.



48. **SUSQUEHANNA VALLEY**—Includes 27 counties in central Pennsylvania centered around the Harrisburg-Hershey area.

49. **TENNESSEE MID-SOUTH**—Includes 84 counties in the central and eastern sections of Tennessee and portions of southwestern Kentucky. (Overlaps Ohio Valley RMP.)

50. **TEXAS**—Covers the state of Texas.

51. **TRI-STATE**—Covers the states of Massachusetts, New Hampshire and Rhode Island. (Overlaps in western Massachusetts with Albany RMP.)

52. **VIRGINIA**—Covers the state of Virginia. (Overlaps in northern section with Metropolitan Washington, D.C. RMP.)

53. **WASHINGTON/ALASKA**—Covers the states of Washington and Alaska.

54. **WEST VIRGINIA**—Covers the state of West Virginia. (Overlaps in two counties with Ohio Valley RMP.)

55. **WESTERN PENNSYLVANIA**—Includes 28 counties in Western Pennsylvania centered around Pittsburgh.

56. **WISCONSIN**—Covers the state of Wisconsin.

**Demographic Facts**

There are 56 Regional Medical Programs which cover the United States, Puerto Rico, and the Trust Territories of the Pacific. The Programs include the total 1972 population of the United States (estimated at 207 million) and vary considerably in size, funding, and geographic characteristics.

**LARGEST PROGRAM**

In population: California (20 million)  
 In size: Washington/Alaska (638,000 square miles)

**SMALLEST PROGRAM**

In population: Northern New England (445,000)  
 In size: Metropolitan Washington, D.C. (1,500 square miles)

**GEOGRAPHIC BOUNDARIES: Number of Programs which primarily**

Encompass single states ..... 34  
 Encompass two or more states ..... 4  
 Are parts of single states ..... 11  
 Are parts of two or more states ..... 7

**POPULATION: Number of Programs which have**

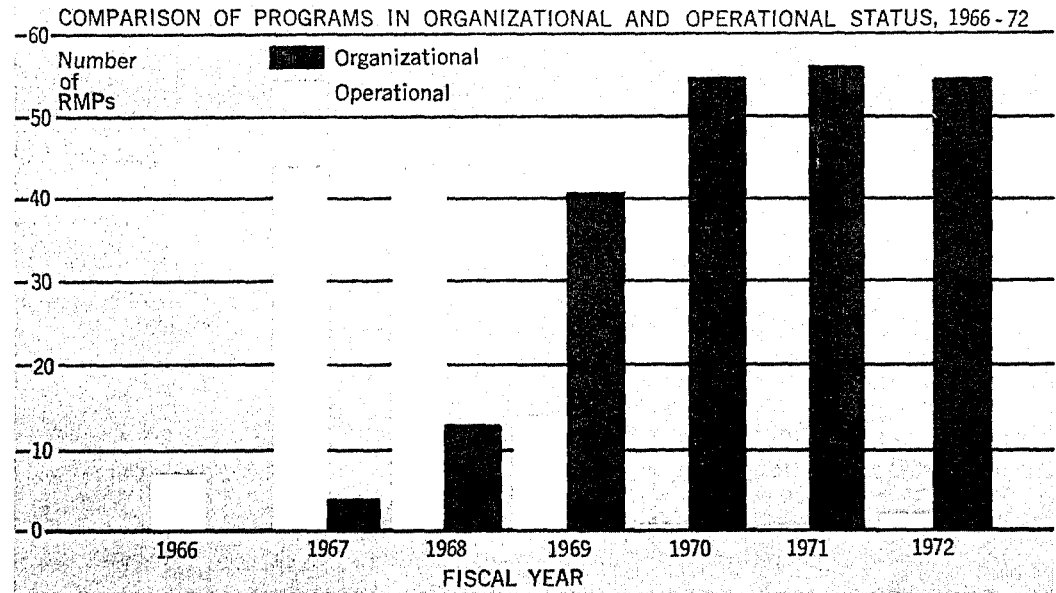
Less than 1 million persons ..... 6  
 1 million to 2 million ..... 11  
 2 million to 3 million ..... 13  
 3 million to 4 million ..... 8  
 4 million to 5 million ..... 5  
 Over 5 million ..... 13

**FUNDING LEVELS: Programs vary from**  
 Highest: California (\$10 million)  
 Lowest: Delaware (\$200 thousand)

**MEDIAN FUNDING LEVEL: \$1.1 million**

**FUNDING LEVEL RANGES: Programs with**  
 Less than \$500,000 ..... 4  
 \$500,000 - \$999,999 ..... 19  
 \$1 million - \$1,499,999 ..... 8  
 \$1.5 million - \$1,999,999 ..... 17  
 \$2.0 million - \$2,499,999 ..... 4  
 \$2.5 million and above ..... 4

**Organizational and Operational Status**



**Note:** Although all of the original 55 RMPs had achieved operational status by the end of the 1970 calendar year, there have been subsequent organizational and boundary modifications, as reflected in the organizational/operational status comparison shown above. Most significant among these have been the following: (1) in 1971, what had previously been the Nebraska-South Dakota RMP divided into two separate Programs, with Nebraska remaining in operational status and South Dakota receiving its initial organizational grant on July 1; (2) the State of Delaware split off from Greater Delaware Valley RMP and was awarded its first organizational grant as a separate Program in the spring of 1972; and (3) two Ohio Programs (Ohio State and Northwest Ohio) merged to form the Ohio RMP as of September 1972.

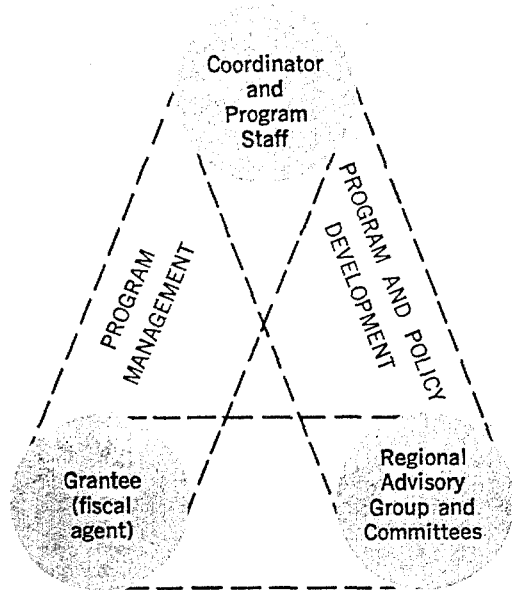
# organization

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BOARD  
GRANTEES  
REGIONAL ADVISORY GROUPS  
EXECUTIVE COMMITTEES  
COMMITTEES AND LOCAL ADVISORY GROUPS  
PROGRAM STAFF  
MINORITY AND FEMALE REPRESENTATION

---

ORGANIZATIONAL STRUCTURE OF A REGIONAL MEDICAL PROGRAM



**RESPONSIBILITIES AND RELATIONSHIPS**

There are three major components of a Regional Medical Program at the regional level: The Regional Advisory Group; the grantee organization; and the Chief Executive Officer (often referred to as the RMP Coordinator) with his or her program staff.

• **Regional Advisory Group:** The Regional Advisory Group has the responsibility for setting the general direction of the RMP and formulating program policies, objectives and priorities.

• **Grantee:** The grantee organization manages the grant of the Regional Medical Program in a manner which will implement the program established by the Regional Advisory Group and in accordance with Federal regulations and policies.

• **Chief Executive Officer (Coordinator):** The grantee's full-time employee who has day-to-day responsibility for the management of the RMP; he is also responsible to the Regional Advisory Group which establishes program policy. The Chief Executive Officer and his program staff provide support to the Regional Advisory Group and its subcommittees, including local advisory groups where they exist.

**Grantees of Regional Medical Programs**

**PURPOSE:** Each Regional Medical Program is fiscally administered by a grantee which may be a public or private non-profit institution, agency, or corporation. The grantee is responsible for management of the RMP grant in such a manner as to implement the program established by the Regional Advisory Group and in accordance with federal regulations and policies. This includes primarily fiscal control, fund accounting, and administrative support.

**Categories of Grantees, Fiscal Year 1972**

Grantee .....	56
<b>Universities</b> .....	<b>33</b>
Public .....	(26)
Private .....	( 7)
<b>Other</b> .....	<b>23</b>
New agencies/corporations .....	(16)
Existing corporations .....	( 3)
Medical societies .....	( 4)

**Regional Advisory Groups**

**PURPOSE:** The Regional Advisory Group (RAG) is the organized voluntary body of health providers and consumers in each RMP which has responsibility for program and project determinations and overall program direction.

A Regional Advisory Group, through membership composed of representatives from most health interests as well as many consumers in the Region, attempts to identify critical health needs in the area; develops, reviews, and approves appropriate activity proposals designed to meet those needs; and monitors and evaluates funded programs. The Regional Advisory Group has final decisionmaking authority concerning program content and policy in each RMP.

**SIZE:**

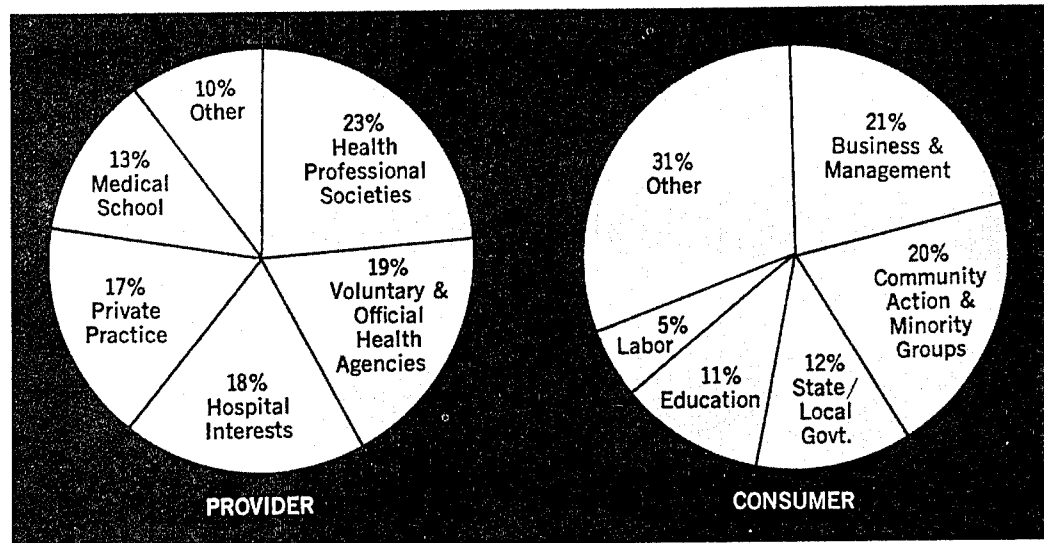
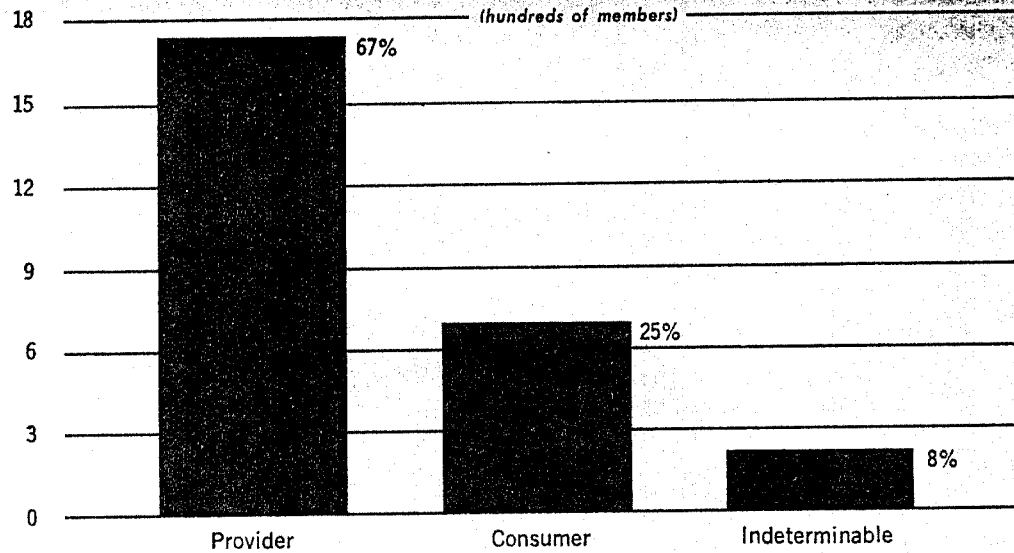
FY 1969	2,500 total membership 45 average group size
FY 1970	2,700 total membership 48 average group size
FY 1971	2,743 total membership 49 average group size
FY 1972	2,667 total membership 48 average group size

**RANGES, FISCAL YEAR 1972**

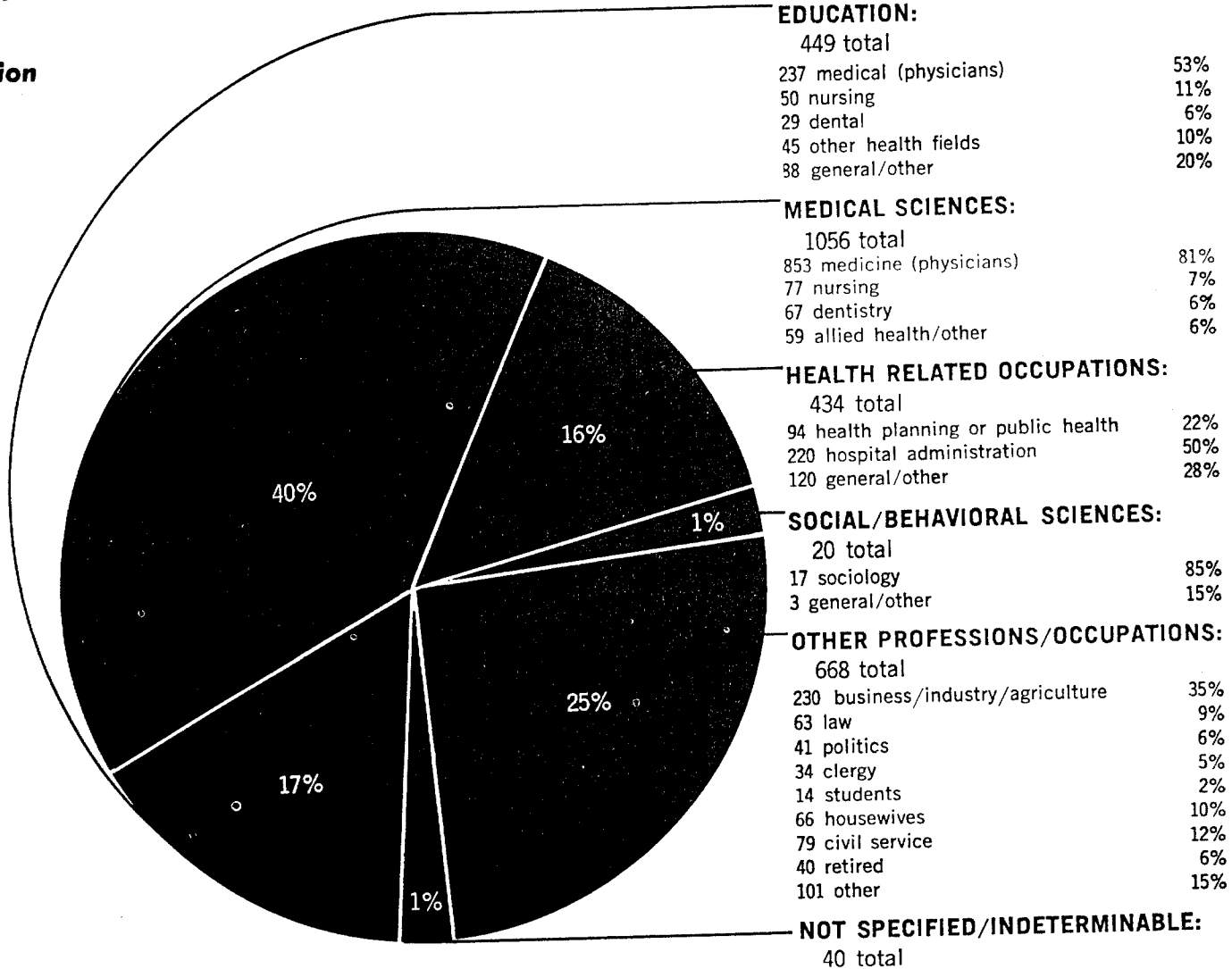
Size	No. of RAGs
10 - 39	21
40 - 69	27
70 - 99	6
100 - 129	1
130 - 159	1
<b>TOTAL</b>	<b>56</b>

**COMPOSITION:** Regional Advisory Groups are composed of volunteers, both health care providers and consumers. Membership is shown in the following charts, both by profession and by type of institution, organization, or group represented. Make-up of these groups has changed somewhat over the years since Regional Medical Programs have been in existence. Practicing physician representation, for

**COMPOSITION OF REGIONAL ADVISORY GROUPS BY CATEGORY OF REPRESENTATION, FISCAL YEAR 1972**



**Composition  
of  
Regional  
Advisory  
Groups  
by  
Profession  
Fiscal  
Year  
1972**





example, was 22% of the total membership in June of 1969; today it has increased to 32%. Additionally, consumer groups have experienced increasing representation from 15% of the '69 membership to 25% by the end of fiscal year 1972.

### Executive Committees

**PURPOSE:** An Executive or Steering Committee is a subgroup of the Regional Advisory Group which has as its primary function the surveillance and coordination of the Program between full RAG sessions. In addition, this group has the responsibility for acting as the day-to-day advisor to the Chief Executive Officer (Coordinator) and his staff on program matters. Executive Committees are either elected or appointed by the total RAG; as a rule, they are not as broadly representative as the larger body. Although these committees act in the RAG's stead between full meetings, they are not empowered to make final determinations concerning program policy, content or funding.

**SIZE:** Executive Committees range from **three members** (California and North Dakota RMPs) to **42 members** (Memphis RMP). Groups **average eleven** in total membership. Aggregate total membership of these bodies as of June 1972 was 452 (41 RMPs<sup>1</sup>), compared to approximately 460 in 1971.

**COMPOSITION:** Like Regional Advisory Group composition, that of Executive Committees appears also to have shifted emphasis over the past several years. In fiscal year 1969, for example, physician membership accounted for 67% of the total; this year, their proportion has declined to 50%.

---

#### Composition by Profession, Fiscal Year 1972:

---

Education .....	91 (20%)
Medical and Related Health Sciences	191 (42%)
Health Related Occupations .....	75 (17%)
Social/Behavioral Sciences .....	3 ( 1%)
Other Profession or Occupation .....	88 (19%)
Non-specified/indeterminable .....	4 ( 1%)
	452 (100%)

---

#### Composition by Category of Representation, Fiscal Year 1972:

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Provider .....	290 ( 65%)
Consumer .....	83 ( 18%)
Indeterminable .....	79 ( 17%)
	452 (100%)

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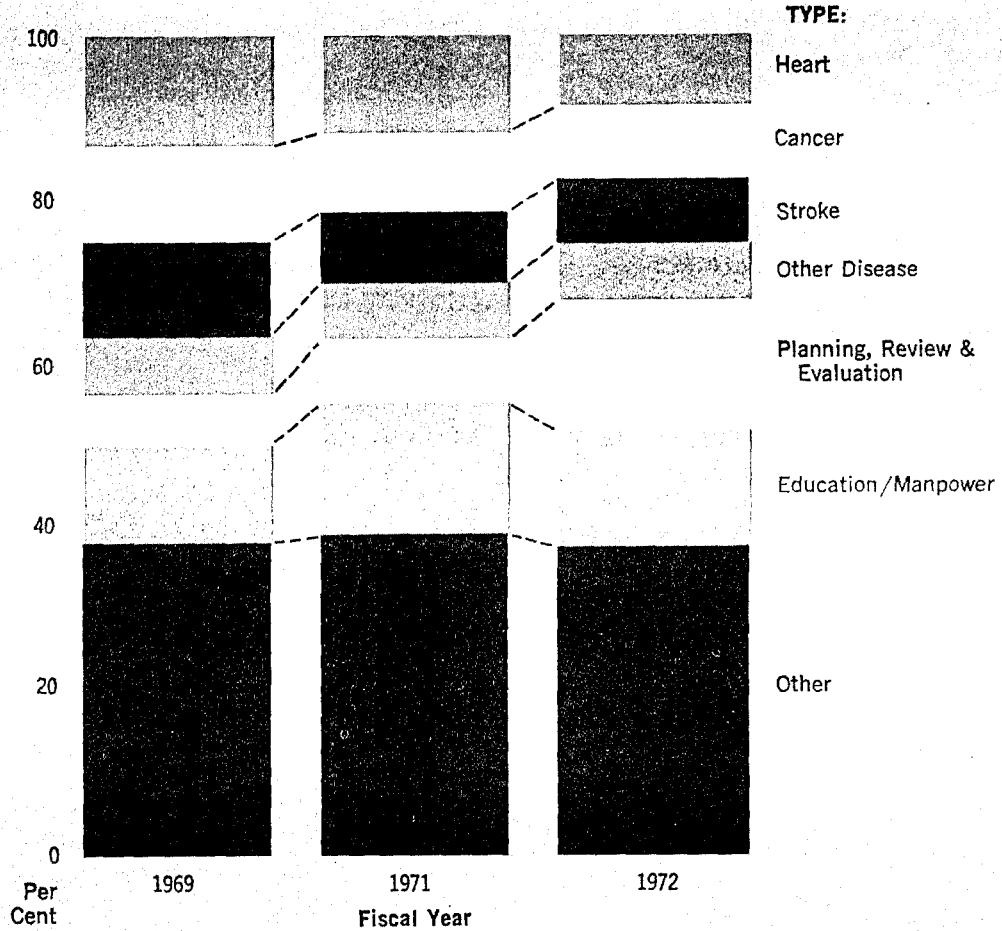
<sup>1</sup> 15 Programs either have no Executive Committee or have not reported membership composition.

### Committees and Local Advisory Groups

**PURPOSE:** Regional Advisory Group committees have major responsibilities for: (1) program activity development and review; and (2) monitoring and evaluation of funded activities. Most are composed of experts in a given field and as such have significant influence in terms of the scientific and professional competence of program activities. The last two years has seen a marked increase in the number of planning, review and evaluation committees, giving these functions an added and much needed emphasis.

Local Advisory Groups, although they are tied to the Regional Advisory Group (in many instances membership of the bodies overlaps), serve primarily in a liaison and program development capacity at the community level. Generally, they attempt to foster cooperation among local health organizations and consumer groups, and in many instances provide linkages with CHP area-wide groups. Local groups serve as reactors to commu-

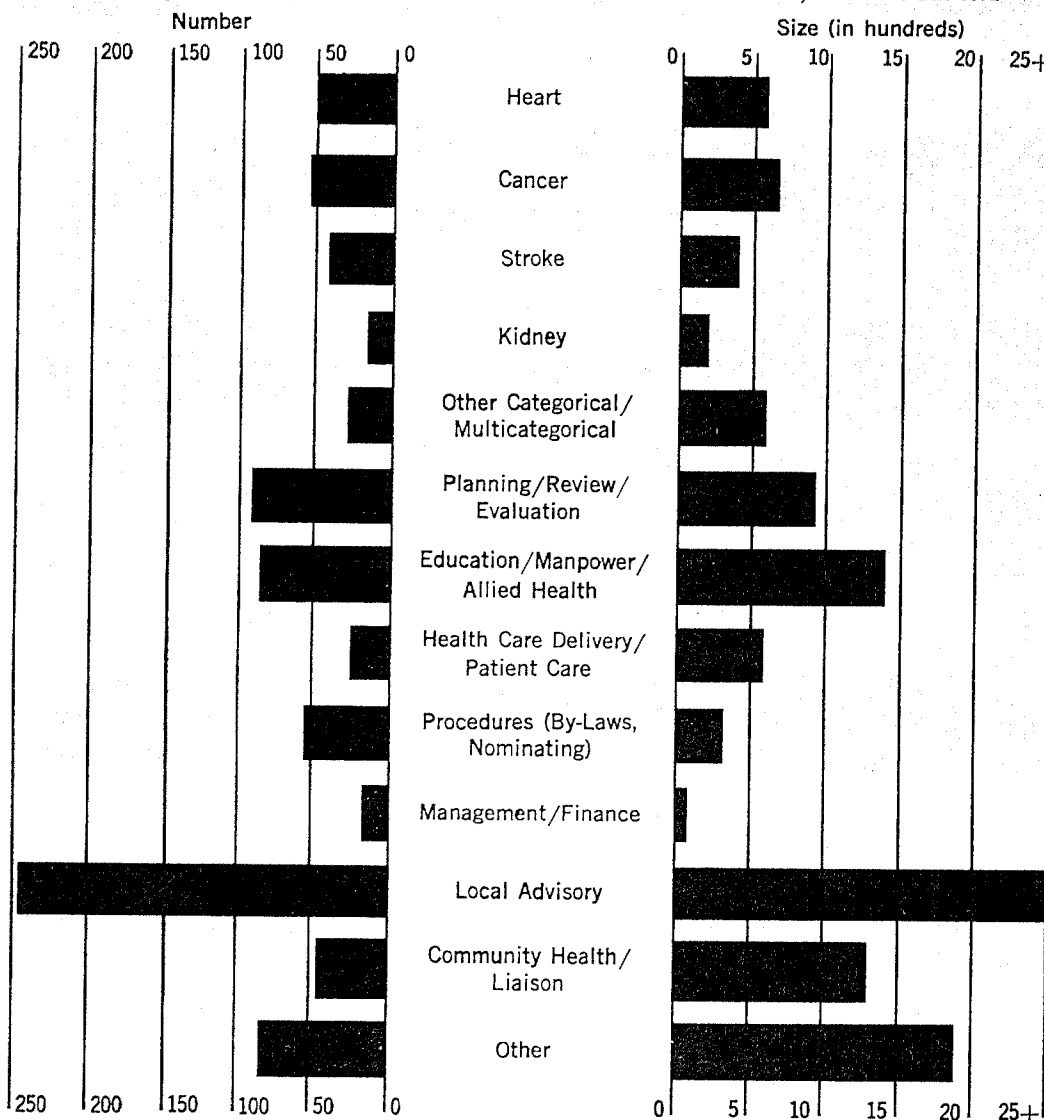
COMPARISON OF NUMBER OF COMMITTEES BY TYPE, FISCAL YEARS 1969, 1971, 1972



**HIGHLIGHTS:**

- Categorical disease committees have continually declined in emphasis, from 218 (44%) in FY 1969 to 192 (33%) in FY 1972.
- The largest percentage increase has been in planning, review and evaluation committees, which have more than tripled (from 30 to 93) in the three year period.

**NUMBER AND SIZE OF COMMITTEES AND LOCAL ADVISORY GROUPS, FISCAL YEAR 1972**



nity needs and problems and relate these, as well as possible solutions, to decision-making bodies at the regional level.

**NUMBER AND SIZE:** Comparison FY 1969-72

1969:	= 864	..... 10,163 Total Membership
1971:	= 875	..... 12,426 Total Membership
1972:	= 850	..... 12,315 Total Membership

**Note:** Total membership of these groups overlaps considerably with Regional Advisory Groups; in addition, committee memberships overlap to some extent with each other, so that totals shown are based on numbers of memberships rather than numbers of individual members.

## Program Staffs

**PURPOSE:** Program staffs are the salaried employees of the Regional Medical Program. They are responsible primarily for the conduct and administration of the Program and the provision of staff support to the Regional Advisory Group and its committees.

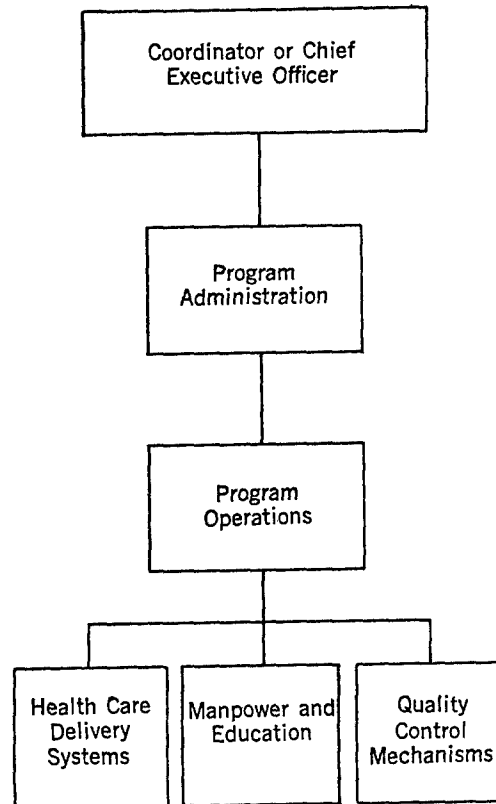
**SIZE:**<sup>1</sup> Comparison of staff size in full-time equivalents, fiscal years 1969-72:

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FY 1969	– 1,546 total	– 28 average staff
FY 1971	– 1,640 total	– 29 average staff
FY 1972	– 1,374 total	– 25 average staff

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### SAMPLE ORGANIZATION CHART:



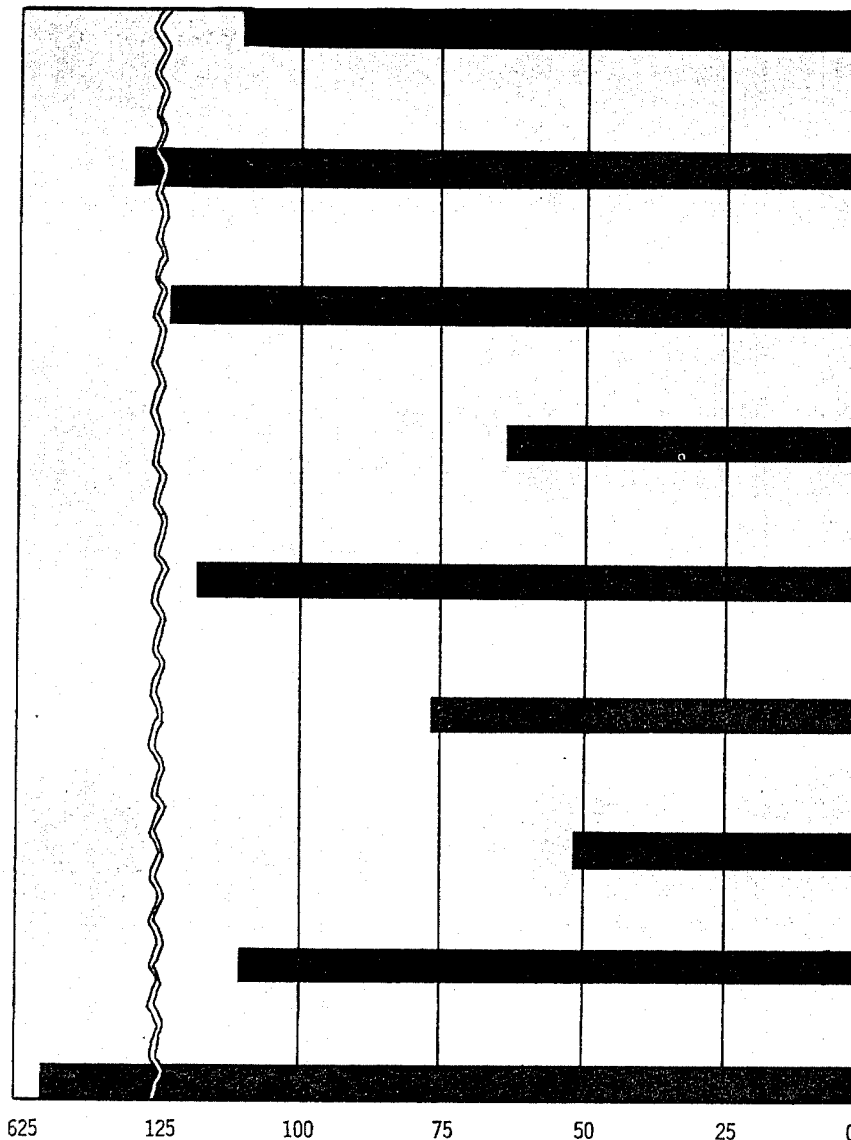
**COMPOSITION:** Program staffs attract persons with a variety of professional and technical competencies. Along with the new directions of RMP, the composition of these staffs has altered to some degree over the past three years. Most notable among these shifts are . . .

- Although the actual number of staff employed has decreased considerably, the percentage of physicians has steadily declined from 15% in June of 1969 to only 10% in June 1972.
- Accountants, business administrators, and other financial management personnel have increased to the extent that they now make up 9% of program staffs, as opposed to the 5% they accounted for in FY 1969.
- The percentage of persons in related health (non-medical) and social science professions has risen from the FY 1969 proportion of 10% to 14% of the present total.

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<sup>1</sup> Does not include reported vacancies, which totaled 321 at the end of fiscal year 1972.

**Program Staff Composition by  
Professional Category, Fiscal Year 1972**



**EDUCATION: 111 total**

36 medical (physicians) (33%)	14 allied health (12%)
17 nursing (16%)	40 general/other (36%)
4 dental (3%)	

**MEDICAL SCIENCES: 149 total**

96 medicine (physicians) (64%)	10 allied health (7%)
35 nursing (24%)	4 general/other (3%)
4 dentistry (2%)	

**HEALTH RELATED OCCUPATIONS: total 123**

73 health planning/public health (60%)
30 hospital administration (25%)
20 general/other (15%)

**SOCIAL/BEHAVIORAL SCIENCES: total 66**

21 psychology (32%)	13 economics (19%)
11 sociology (17%)	21 general/other (32%)

**ADMINISTRATION/MGMT.: total 119**

15 grants (12%)	27 business administration (23%)
14 accounting (11%)	63 general/other (54%)

**OTHER SCIENCES: total 76**

8 physical/biological (11%)	7 computer programming (10%)
16 statistics (20%)	19 communications media (25%)
20 operations research/systems analysis (27%)	6 other (7%)

**PUBLIC INFORMATION/RELATIONS: total 52**

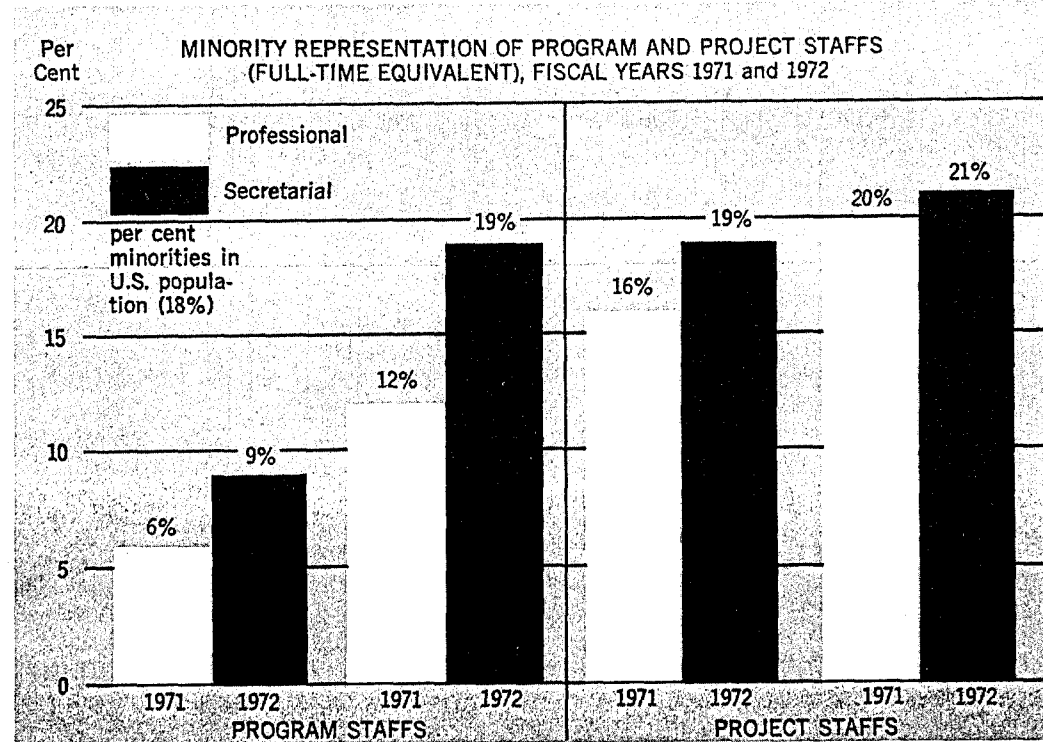
**OTHER PROFESSIONAL and TECHNICAL: total 110**

**SECRETARIAL/CLERICAL: total 569**

625 125 100 75 50 25 0 Number (Full-time Equivalents)

### Minority and Female Representation

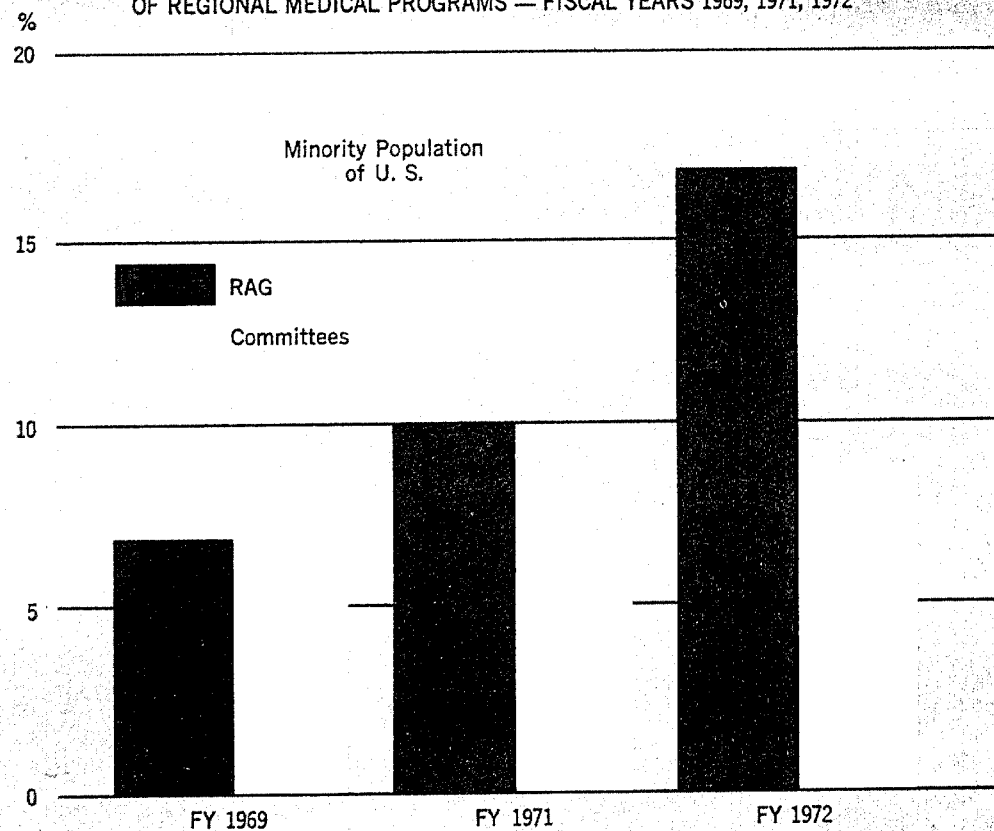
Appropriate participation of minority groups (Blacks, American Indians, Spanish-Americans, Asians, and others, such as Polynesians) and women at all levels of RMP planning, decisionmaking, and implementation is requisite to responsive and relevant program development. The data presented in the following charts reflect minority and female representation on program and project staffs, Regional Advisory Groups, and committees of RAGs.



**HIGHLIGHTS:**

- Minority representation on program staffs has increased considerably in the last year: the current ratio is 12%.
- Minorities exceed parity in both categories (professional and secretarial) of project personnel.

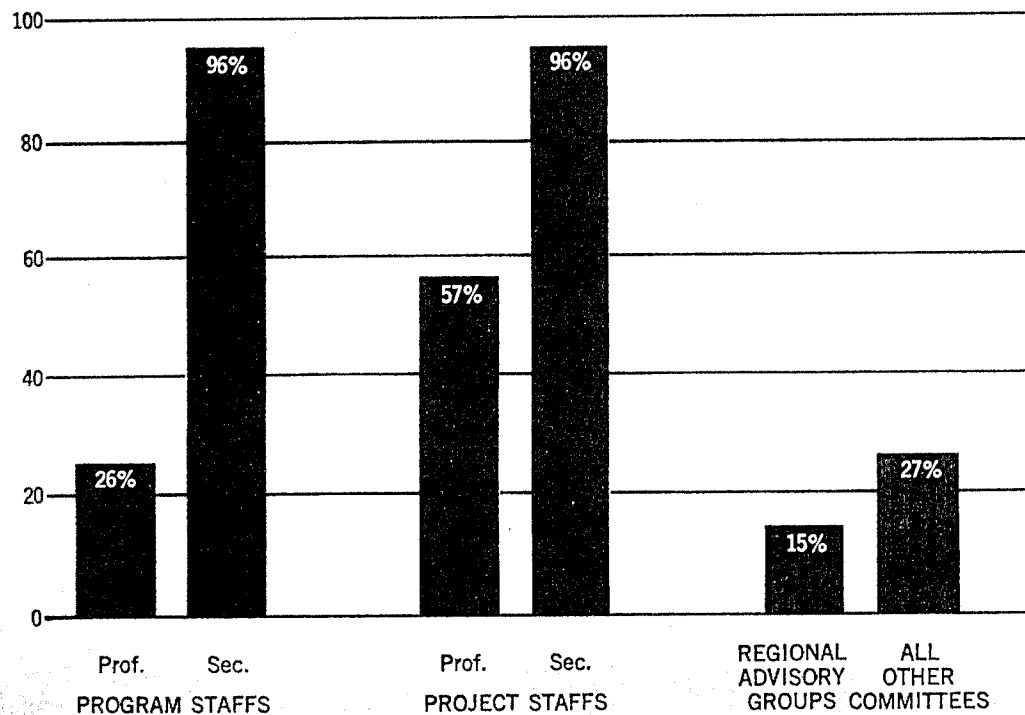
MINORITY REPRESENTATION ON REGIONAL ADVISORY GROUPS AND OTHER COMMITTEES  
OF REGIONAL MEDICAL PROGRAMS — FISCAL YEARS 1969, 1971, 1972



**HIGHLIGHTS:**

- Minority representation on Regional Advisory Groups has increased from 10% to 17% during the past year and closely approximates parity involvement.
- Though supporting committees of the Regional Advisory Groups (technical review groups, local advisory groups, etc.) have also experienced an increase in minority representation, involvement remains at a less than desirable level. Fiscal year 1973 should show more accomplishment in this area.

FEMALE REPRESENTATION IN REGIONAL MEDICAL PROGRAMS,  
FISCAL YEAR 1972



**HIGHLIGHTS:**

- A majority (57%) of the professional project personnel are women.
- Female representation on Regional Advisory Groups has risen slightly in the past year (from 14% to 15%) and is expected to show considerably more progress by 1973.
- Although, as depicted above, females make up 26% of professionals on program staffs, it should be noted that the vast majority of these women are **not** in decisionmaking positions, and tend to be members of the traditionally female professions such as nursing, education, and allied health fields.



# program activities

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DEVELOPMENT

IMPLEMENTATION AND PROGRESS—OPERATIONAL ACTIVITIES

FUNCTIONAL EMPHASIS

DISEASE FOCUS

PROGRAM CONCERNS

REINVESTMENT OF FUNDS

EVALUATION

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## Development

Program development for each Regional Medical Program is carried out primarily by its Program staff in cooperation with the Regional Advisory Group and its sub-structure. While the voluntary bodies determine the general program direction and framework within which the RMP operates, Program employees are directly

responsible for its actual development. The cycle is completed by staff provision of information and feedback to the Regional Advisory Group.

Program staffs function in a number of ways, involving not only developmental activities, but also such tasks as administration, coordination, and evaluation of Program components. A breakdown of these functions according to staff resources allocated follows:

	Estimated Amount	Percent Staff Funds
<b>Program Direction and Administration:</b> .....	\$.9.5M	27%
Overall direction and coordination, policy development, financial management, project coordination, communication and information activities, program evaluation.		
<b>Project Development, Review and Management:</b> .....	7.7M	22
Assistance to local applicants in project design and conduct, processing of individual operational applications, staff support to project review groups, project monitoring and evaluation.		
<b>Professional Consultation, Community Relations and Liaison:</b> .....	9.1M	26
Staff assistance to other health programs, facilitation of cooperative relationships, development of and assistance to sub-RMP groups, etc.		

	Estimated Amount	Percent Staff Funds
<b>Planning Studies and Inventories:</b> .....	3.7M	11%
Staff time and/or sub-contract costs for studies designed to provide guidelines in development of program objectives, baseline data, etc.		
<b>Feasibility Studies:</b> .....	2.7M	7
Staff time and/or sub-contract expenditures for activities designed to assess the potential of prototype programs or techniques for larger scale application.		
<b>Central Regional Services:</b> .....	1.8M	5
Centralized services supported on a continuing basis, such as libraries, data banks, etc.		
<b>Other:</b> .....	.7M	2
Staff time devoted to any number of other activities, ranging from the conduct of seminars and workshops to the development of delivery models.		
<b>TOTAL</b>	<b>\$35.2M</b>	<b>100%</b>

Among the functions listed above, several may be described as being of a primarily developmental nature. These, along with examples of how they are carried out, appear opposite:

**PROFESSIONAL CONSULTATION AND ASSISTANCE:**

- The Wayne State component of the Michigan RMP has, over the past several years, provided extensive and continuing technical assistance to the Detroit Model Cities Program in developing comprehensive, prepaid health care for approximately 10,000 inner city residents. Funding for initiation of this program has now been received from the Department of Housing and Urban Development and other sources.

- The departure earlier this year of the only two physicians in Mono County, California, left its 5,000 residents without medical services. Through efforts of Area VI (Loma Linda) of the California RMP, physicians from neighboring areas were obtained to fill this gap temporarily. Area VI staff are now studying Mono County's additional medical needs with a view to providing permanent physicians for the local hospital.

**PLANNING STUDIES AND INVENTORIES:**

- In 1969 a community health survey in the San Fernando Valley was undertaken by Area IV (UCLA) of the California RMP. An extreme shortage of health manpower was found to exist. As a result representatives from San Fernando Valley State College began meeting with physicians and other providers and the RMP. These discussions in turn have led to the de-

velopment of the San Fernando Health Consortium, again with funding help from Area V (University of Southern California) as well as IV.

- A survey by the Texas RMP showed that 19 counties in the State had no practicing physicians and that the 1970 physician-to-population in Southwestern Texas was 1:1,017. This past year the University of Texas Medical School at San Antonio announced establishment of the State's first bachelor degree program to train physicians assistants.

- The Maryland RMP was a co-sponsor of a recent Evaluation of Emergency Medical Resources Seminar in Baltimore conducted with the cooperation of the Maryland Hospital Association. This recent study identified 16 specific findings and corresponding challenges in non-linked services now available, and has recommended an initial plan of action.

#### **FEASIBILITY STUDIES:**

- Eight seniors studying medicine, nursing and pharmacy at the University of New Mexico School of Medicine last year formed a Rural Health Committee to address the dual problem of providing comprehensive health care throughout the state while at the same time obtaining clinical experience. Initial financing by the New Mexico RMP has enabled the Committee to open and work in a small clinic in Hatch, a small town having no physician.

- A pilot-project to screen Pittsburgh school children for sickle cell anemia was initiated last year by the Western Pennsylvania RMP. Testing will provide an indication of the problem in school age groups, with data analysis to be performed by the Allegheny County Health Department and the University of Pittsburgh Health Center.

- A small but growing number of Programs (e.g., Wisconsin, Tri-State, Northlands, Bi-State) are initiating contract programs in specified problem areas to encourage feasibility studies and pilot projects. The Wisconsin RMP, for example, announced such a program soliciting proposals in three areas—sharing of resources or services by two or more hospitals, development of health services for medically deprived areas, and pre-admission testing. The total available was \$100,000. Like Wisconsin, most Programs that have initiated similar activities are setting relatively modest amounts aside for this purpose from funds budgeted for program activities.

#### **Implementation and Progress— Operational Activities**

Once a Regional Medical Program has achieved operational status, awarded grant funds are allocated for both **pro-**

**gram** and **operational** activities. Program activities, as noted in the previous section, are defined as those functions central to the RMP's operation. They encompass all activities performed by the Program staff, including administration, consultation, project development and management, evaluation, and so forth.

Operational projects, on the other hand, are those activities conducted by outside institutions and organizations but supported totally or in part by RMP grant funds. Each such activity must go through the Program's review process and be approved by the Regional Advisory Group. With 54 Regional Medical Programs now in operational status, fiscal year 1972 showed a total of over one thousand operational projects supported with \$76 million dollars in RMP funds.

There has been a marked expansion in both the level and scope of RMP operational activities during fiscal year 1972, as well as a fairly emphatic change in their nature. Expansion in the level of activities was a direct result of the significant increase in grant funds available as compared to prior years; expansion in scope and change in nature reflect a continuing trend which has become increasingly evident during the last several years, that of a comprehensive approach to medical care and its delivery. This section deals with such activities and presents some indications as to their success in terms of national and local objectives. They are described in a number of ways, including (1) **functional emphasis** (con-

taining education, organization and delivery of patient care, etc.), (2) **disease focus**, (3) **priority concerns**, and (4) **reinvestment** of RMP funds.

**FUNCTIONAL EMPHASIS:** RMP operational activities are described according to major functions as follows:

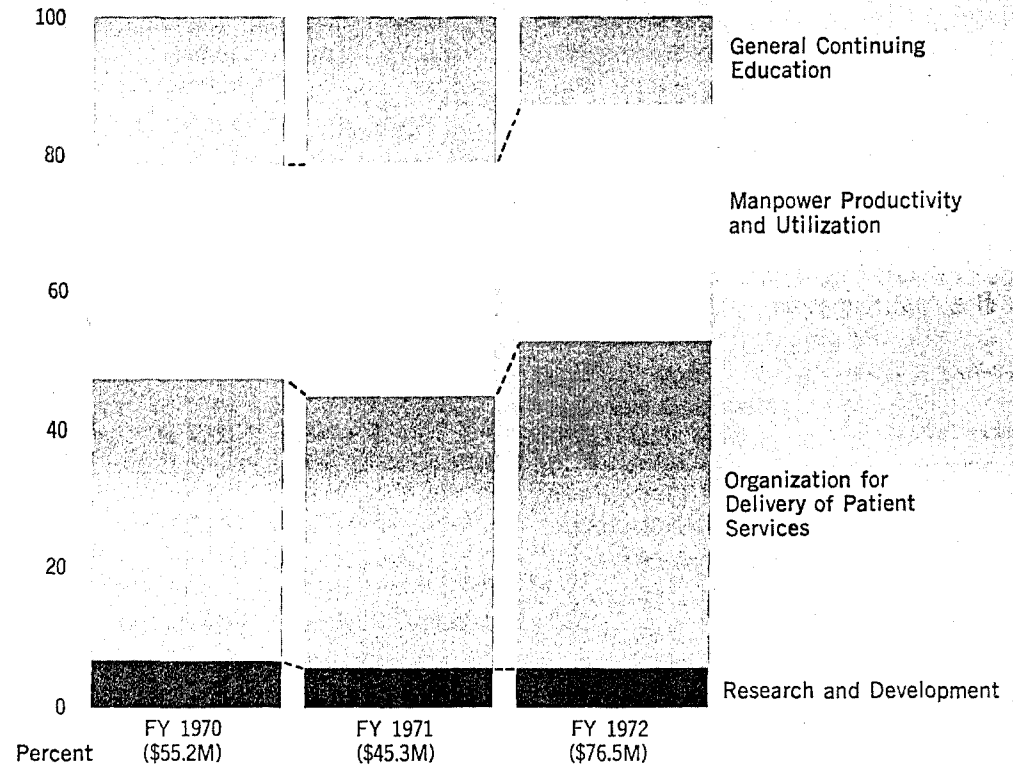
• **Improving Manpower Productivity and Distribution:** Pertains to those activities which emphasize: (1) upgrading the performance of existing personnel through addition of new skills and (2) expanding the manpower pool through the development of new categories of health and allied health professionals, training of new health personnel, and recruitment or reactivation of health personnel.

• **General Continuing Education:** Those activities aimed at either providing or studying some aspect of continuing education. General continuing education is defined as education above and beyond what is normally considered appropriate for qualification or entrance into a health or health-related profession. Continuing education programs are generally designed to maintain or improve the level of practice of the health professional.

• **Organization for Delivery of Patient Services:** Activities which relate directly to patient care delivery through demonstrations of new techniques, development and demonstration of organizational models for delivery, and improving coordination of patient services.

• **Research and Development:** Activities which emphasize the testing or investigation of prototypes for new systems, processes, techniques, etc.

FUNCTIONAL EMPHASIS OF OPERATIONAL PROJECTS, FISCAL YEARS 1969-1972



**Highlights**

- Emphasis on continuing education activities continues to decrease, from approximately 21% of total funding in FY 1970 to only 16% in FY 1972.
- At the same time that education and training activities have shown a decrease, support of patient care demonstration programs has increased by over four million dollars in the three year period.

**DISEASE FOCUS:** Perhaps one of the major indicators of Regional Medical Programs' changing mission is the rather marked decrease in specific categorical disease targeted activities. The overwhelming percentage of operational funds in fiscal year 1972 was allocated for activities which dealt with health care or delivery systems in general, rather than with specific disease entities. The only exception to this was in activities directed toward kidney disease, whose proportionate share of total operational funds has doubled since last year. The following table presents highlights of this trend over the past five years:

Disease Category	Percentage of funds		
	FY 68	FY 71	FY 72
Heart disease & hypertension	34%	26%	10%
Cancer	9	13	9
Stroke	12	12	5
Kidney disease	—	4	8
Related diseases	8	6	7
Multicategorical and/or comprehensive	37	36	61
<b>TOTAL</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

In noting the numbers of health professionals and others receiving educational services through RMP operational funds, one can again see a continuing deemphasis on categorical disease areas. For example, while 51% of those receiving services in FY 68 were trained in coronary care and other heart disease programs, the

same was true of only 31% in FY 72. Data presented below describe the trend away from RMP sponsored education programs in specific categorical disease areas:

Disease Category	Percentage of Persons Trained by Disease Category Fiscal Years 1969-72			
	FY 69	FY 70	FY 71	FY 72
Heart disease	46%	48%	49%	31%
Cancer	4	7	7	7
Stroke	8	13	10	12
Related diseases, including Kidney	8	15	10	6
Multicategorical or not related to specific disease entities	34	17	24	45
<b>TOTALS</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

#### PRIORITY CONCERNS:

■ **Availability and Accessibility of Health Care:** Regional Medical Programs are supporting a wide variety of activities aimed at increasing the availability and accessibility of health care. They address such problems as the acute lack of health manpower and services in rural and inner-city areas; the poor utilization of physicians and allied health manpower in most medical trade areas; and the uneven availability and accessibility of health services, again most scarce in rural and inner-city areas.

**Manpower development, distribution, and utilization**—RMP emphasis in terms of education and manpower has undergone considerable change in the recent past. Programs aimed at providing continuing education (primarily for physicians and nurses) are now being considered in terms of health service needs. Those programs designed to upgrade nursing and allied health personnel through the addition of skills and to create, train, and utilize new categories of personnel are increasing. Over 20% (\$17 million) of operational funds during the past year were allocated for utilization and development activities, as opposed to the \$12 million targeted for continuing education. In addition, health professionals receiving these kinds of training services (addition of new skills or training in new professions) reached a high in FY 72 of almost 62,000—a fivefold increase over the FY 69 level. The following examples are illustrative of typical RMP efforts in this area:

- In Syracuse, New York, the Central New York RMP has provided a grant to a community hospital for the conduct of a seven-month course for registered nurses; the course has as its objective the availability of health care services to areas with inadequate physician coverage by teaching nurses how to render primary patient care.
- Pediatric nurse practitioner and nurse clinician programs are being started with RMP financial and other assistance

in a number of Programs, such as California and Kansas; in the latter instance, it was determined by survey that most physicians preferred to hire nurses retrained for expanded assistant roles rather than ex-medical corpsmen or newly trained personnel.

- Part of the stroke program of the Puerto Rico RMP trains high school graduates to become "Asistentes de Salud Familiar." Their mission is to help the patient maintain good health and bring together the patient and the community in cooperation with health professionals.

**Minority populations, inner-city, and rural areas:** In fiscal year 1972, activities directed at special target populations such as Blacks, Spanish-Americans, and Indians more than doubled, from 46 projects and \$5.4 million to 147 projects with \$17 million in RMP funding. Some examples of RMP activities targeted for these underserved groups follow:

- More than 5,000 black children in Grand Rapids, Michigan have been screened in a free program of testing for the crippling fatal disease of sickle-cell anemia, a hereditary condition which primarily attacks black people. Begun 16 months ago, the tests are part of a demonstration program funded by a grant from the Michigan RMP. The project also provides screening for relatives of carriers, as well as genetic counseling for affected families. The total program is de-

signed to build a prototype model whereby the new low-cost testing and follow-up procedures can be made available to all black people within a community.

- The people of some three communities in northern New Mexico have set up clinics designed to bring medical care directly to the poor of the towns and remote mountain villages in the area. Special courses in emergency medical care provided by the New Mexico RMP train community members to be self-reliant in treating illnesses and accidents. The New Mexico RMP's "Operation Home Run" in Santa Fe has provided surplus medical equipment to La Clinica de la Gente, the first full-time outpatient clinic of its kind in that city.

- The California RMP has awarded funds to the Central Valley Indian Health project to improve health care services for 2,000 rural Indians. Part of the money will be used to equip health aids with shortwave radios to improve communications between the isolated Indians and physicians located at Valley Medical Center in Fresno.

- Under the sponsorship of the Lakes Area RMP in Western New York, the Rural Externship Program has become an effective means of directing health manpower toward delivery of primary care in underserved rural areas. The program places teams of health science students from a variety of disciplines in a number of rural health care settings for a period of eight weeks during the summer. By so

doing, the project provides rural communities and community hospitals with access to health science students and a means of attracting them to careers in rural medicine.

At the same time, this program provides health science students with firsthand exposure to primary care and to health care settings not currently utilized in their formal clinical curricula. During the summer of 1971, the Rural Externship Program placed 22 students in 11 communities in outlying areas of the region. During the eight weeks they spent on assignment, the students were exposed to over 50 professional preceptors. It is anticipated that the program will be expanded to 50 students during the next phase of operation.

■ **Quality of care:** Improvement in the quality of health services provided has been addressed by the Regional Medical Programs since its establishment in 1966. The primary focus has been on the individual patient encounter and improving quality of services provided through such individual encounters.

**Provider education:** The primary means of accomplishing this task has been through RMP continuing education efforts: during the past year alone, registrations in RMP-sponsored courses, workshops, and seminars of this type totaled over 132,000. During the same period, RMP teleconferences and other rapid

media educational programs reached a total audience of 37,000 individuals.

Continuing education efforts have been concentrated on upgrading skills and knowledge in areas of identified deficiency. In New Mexico, which is the first state to make relicensure for physicians contingent on formal credits, the New Mexico RMP is developing three types of continuing education programs designed to assist the physician in fulfilling the mandates of the new law. The New Mexico RMP is one of a few agencies in the state with an active, viable program of continuing education. Most of its programs, which are given in communities throughout the state, are designed to be practical in nature, making liberal use of case material and often incorporating actual patient visits. Physicians have found the follow-up program with current patients most helpful, and are able to relate what was presented directly to patient care.

**Communications systems:** In order to provide medical information which is needed quickly, a variety of communications systems have been supported. These activities, such as dial access, usually involve a system through which a health professional (normally a physician or nurse), may request information or medical consultation via telephone. In Alabama, for example, a Medical Information Service Via Telephone (MIST) has been initiated by the RMP. Physicians practicing

in small towns and isolated rural areas of Alabama have instant access to specialists at the University of Alabama in Birmingham through the MIST. Calls can be placed free of charge from any point in Alabama, at any time of the day or night, on the MIST circuit. MIST has not only served as a prototype for similar programs in other RMPs, but has been duplicated in the form of "Medicall," the first nationwide, low-cost telephone consultation service available to every U.S. physician.

**Quality of health services:** Efforts to improve the quality of health services delivered have centered on patient care demonstrations involving innovations in health care patterns. Between fiscal years 1971 and 1972, patient care demonstration projects (operational activities) rose from 150 and \$15.4 million to 250 and \$31.4 million, an increase of over 100 percent.

Some of these efforts have clearly demonstrated that early, continuing care can pay dividends. In North Carolina, for example, a Comprehensive Stroke Program was initiated which included among its range of activities the publication of guidelines for community stroke programs, educational activities such as training programs for nurses, annual stroke workshops, and stroke consultation service for physicians through the cooperation of the neurological staffs of the three medical centers. A family-patient

education unit was also designed to help patients and their families learn to cope with long-term effects of stroke disability. Operating in 19 counties, this program, funded by the North Carolina RMP, has resulted in a decrease in mortality, fewer in-hospital complications, shorter hospital stay, and reduction in hospital charges.

That improvement in the quality of care can reduce mortality has also been shown in New York, where the New York Metropolitan RMP, in cooperation with Harlem Hospital, has undertaken a program for stroke management in the inner-city area. Coupling a comprehensive prevention and treatment program with a detection and information effort in the community, the preliminary mortality rate of those brought to the hospital suffering from stroke has dropped from 48% to 27% in the nine months since the project's inception.

#### **REINVESTMENT OF FUNDS:**

The concept of time-limited support has always been central to Regional Medical Programs. This concept embodies the idea of "seed money," or RMP investment in a specific activity only for the period of time necessary to get it begun and accepted by the community. The extent of incorporation of RMP funded activities within the regular local health care financing system, therefore, has become a significant measure of RMP effectiveness.



National policy mandates termination of RMP support after a three-year period, although allowances of up to 24 months after that time are made to ensure orderly termination or "phasing out" of projects. An analysis of terminated activities made in the spring of 1971 indicated that only about 40% of RMP-initiated operational programs had been ended within the specified time limit; it did suggest, however, that most of those phased out were being continued by other health organizations or groups.

There are indications that this earlier performance has improved considerably during the last year and a half. Based upon data available from recent reports from about one-third of the Programs, it is estimated that RMP support, in dollar terms, is being phased out within three years in some 75-80% of all operational projects. These same data indicate, again in terms of dollars, that roughly 60% of those projects from which RMP grant support is being withdrawn will be continued from other sources, at approximately 80% of their RMP funding level.

A multiplicity of these other sources is involved; they include in-kind as well as dollar support, as noted in the examples below:

- The Progressive Coronary Care Program, supported for three years at an annual cost of approximately \$100,000 by the Northern New England RMP, is being continued with joint funding from participating hospitals and the Vermont Heart Association.

- A comprehensive Regional Radiation Therapy Program for the St. Louis area, which includes training of radiation therapy technicians, radiation planning and physics services, and multidisciplinary cancer conferences, was initiated several years ago with monies from the Bi-State RMP. It will be continued with support from multiple sources. These include contributions from each of the nine participating hospitals, tuition fees, and third party payments which will largely offset the continuing consultation and therapy planning costs.

In many cases, of course, RMP activities are deliberately discontinued with no further funding sought from within the community. Because of the RMP nature, that is, to a large extent one of demonstration and testing, evaluation of some activities proves them to be either of little value in meeting health care needs or unsuccessful in terms of achieving their stated objectives. In other instances, activities may have time-limited objectives, which, once met, do not call for continuation.

### **Evaluation**

Evaluation is used by the Regional Medical Programs to measure progress and impact and as a tool to aid management in decisionmaking and future planning. The increased pressure to demonstrate accomplishments has heightened the

significance of evaluation activities in the past two years. A recently completed study of the evaluation function in the RMPs provides the following information:

- Fifty-three of the 56 RMPs have an Evaluation Director. About half of the Directors hold a doctorate and most of the others a masters degree. Over 40% have backgrounds in the social and behavioral sciences, 15% in education and slightly over 10% in medicine or public health. In addition to the Evaluation Directors, there are an additional 110 professional evaluation staff in the 56 RMPs. About 90% of these additional staff members are full time and 80% have been trained in the behavioral or social sciences.

- It is estimated that in 1971, \$3.5-4 million was spent for evaluation activities with an additional \$1.5 million or so expended for the collection and analyses of health and demographic data. This constitutes about 10% of the total program staff budget.

- Nearly all the present RMP evaluation efforts and activities are directed at assessing operational activities and projects. There is, conversely, little evaluation of program staff activities.

- Certain promising new approaches and techniques are being tried by a number of RMPs. Project site visits and evaluation committees, for example, are being utilized increasingly. These and other devices may prove helpful in tying evalua-

tion more closely to regional decision-making.

- Total program evaluation as opposed to the evaluation of individual projects, though actually being implemented in only a few RMPs, is in the developmental stages in many Regions.

Regional Medical Programs Service and various RMPs are also working collaboratively in several areas related to evaluation; these include:

- The development of an Ad Hoc Evaluation Group (composed of Evaluation Directors and Program Coordinators) which meets with the staff of the RMPS Office of Planning and Evaluation to discuss mutual problems and to share experiences in evaluation activities.

- The development, under contract with RMPS, by the Washington/Alaska RMP

of a Management Evaluation and Reporting System for RMPs. This system will be modified and installed in an additional nine Regions during fiscal year 1973.

- The development and field testing in eight Regions of a problem-oriented approach for program evaluation. This Information Support System for Management, Control, and Evaluation of RMPs was developed under contract by the Center for Community Health and Medical Care at Harvard. It seeks to evaluate RMPs in terms of the relevance of their activities to locally identified priority problems, the geographic scope of those activities, and their impact. The approach and methodology developed will be disseminated through a series of seminars for key RMP staff.

# REGIONAL MEDICAL PROGRAMS SERVICE

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ORGANIZATION AND FUNCTIONS

HIGHLIGHTS OF FISCAL YEAR 1972

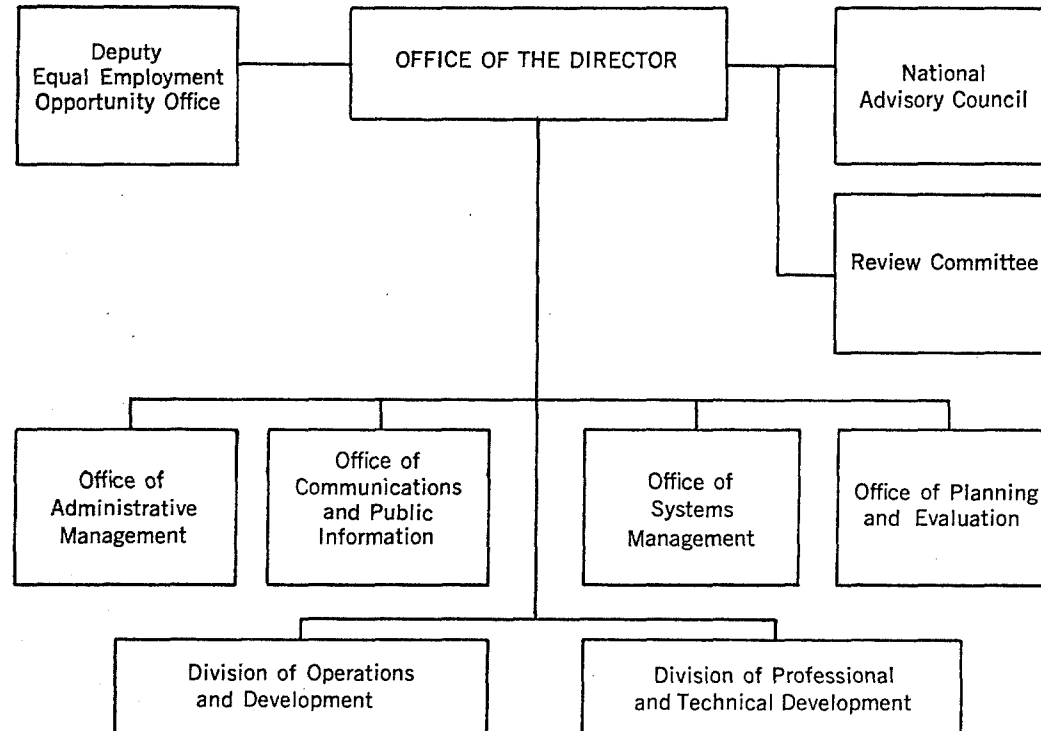
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## Organization and Functions

## Staff

The Regional Medical Programs Service (RMPS), including both its employed staff and its voluntary structure, has several major responsibilities. Specifically, these include: (1) development and coordination of policies affecting conduct of the program; (2) overall guidance and direction of both the Service and its RMP components; (3) monitoring and evaluating the performance of RMPs; (4) accountability for RMP to Congressional and other interests for purposes of budgetary and legislative extension; (5) technical and professional assistance to RMPs; and (6) the determination of RMP funding levels.

Interrelation of the various RMPS components can be seen from the organization chart below:



Functions of the individual units within RMPS vary widely. Briefly, these may be described as follows:

**Office of the Director:** establishes objectives and policies and directs the activities of the Regional Medical Programs Service; develops and coordinates policy and operational relationships with public and private organizations which support and carry out health programs related to the objectives of the Service; and establishes and maintains liaison with leaders in the medical community, state and local officials, and members of Congress directly related to this mission.

**Office of Administrative Management:** plans, directs and evaluates the administrative management activities of the Service; develops and implements management policies, procedures, and systems; provides guidance to the staff of the Director of HSMHA's Office of Financial Management, including program policy interpretation in budget formulation and execution, preparation of program planning and budgeting data, and the financial management of grants; and serves as the focal point for liaison with officials of the Office of the Administrator and the Office of the Secretary on financial, personnel, organization, supply, contracts, and other management matters.

**Office of Communications and Public Information:** advises the Director on policies and activities dealing with communications and public information designed to achieve understanding and acceptance of the objectives and ac-

tivities of the Service; directs staff in developing programs and plans for effective liaison with representatives of the national news media and other information outlets, including those at the Federal level and those of the national voluntary health and health-related organizations; maintains liaison with the information staffs of the Regional Medical Programs to ensure the development of an integrated effort for the achievement of maximum understanding, acceptance, and support for all Regional Medical Program related efforts.

**Office of Systems Management:** plans, develops, and coordinates the Service's management information system, including data obtained from applications, awards, contracts, progress reports, and other documents; conducts statistical analyses and assists components of the Service by collecting and analyzing specific data required for planning, evaluation, program development, and grants and contract review; provides computer programming and tabulating services for the Service; develops and coordinates Service-wide programs for determining the requirements for and the utilization of Automatic Data Processing equipment; and upon request, provides the regional organizations with technical advice and assistance in data systems design.

**Office of Planning and Evaluation:** provides primary staff support to the Director on program planning and evaluation and maintains liaison with planning

and evaluation offices of the Administration and the Department; formulates and articulates program goals and objectives for the Director; performs long and short-range planning, and conducts and directs program evaluation studies; collaborates with counterpart offices and budget and fiscal offices in development and implementation of the Department's Program Planning and Budgeting System; and monitors planning and evaluation activities of Regional Medical Programs and, upon request, provides technical advice and assistance to them on these program aspects.

**Division of Operations and Development:** promotes and sustains, through professional advice and assistance to Regional Medical Programs: development of cooperative arrangements for the regionalization of health resources; enhancement of the capabilities of providers of care at the community level; and improvement of the quality of health care and the strengthening of the health care system throughout the nation by placing special emphasis upon communication and cooperation with the professional sector. This Division is composed of five branches: Grants Management, Eastern Operations, South Central Operations, Mid-Continent Operations, and Western Operations.

**Division of Professional and Technical Development:** plans, develops, and co-

ordinates a program of continuing education and pilot demonstrations directed toward improving the availability and quality of the health care system; aids in the continuing development and operation of Regional Medical Programs throughout the Nation through professional and technical assistance and project review; develops, tests, and evaluates methods of disseminating and applying knowledge; promotes the application of the latest techniques in the health care field; develops and coordinates a program of demonstrations which will lead to improvement in the availability and quality of primary health care; and supports continuing education and the development and utilization of allied health manpower.

### **Voluntary Structure**

**National Review Committee:** reviews RMP grant applications and makes recommendations to the National Advisory Council with respect to approval and appropriate funding levels. Composed of leaders in medicine, health, and other related fields, this body provides the major analytic review of applications, utilizing in its review the RMPS review criteria for establishing the relative merit of individual RMPs. In addition, the Committee may make recommendations to the Council regarding the approval and special funding of project applications for nationally earmarked funds.

**National Advisory Council:** (1) provides assistance and advice in the preparation of regulations for and policy matters arising with respect to the administration of Regional Medical Programs, and (2) makes recommendations to the Director, RMPS, concerning approval and funding of RMP grant applications. In reviewing applications, the Council considers the appropriateness of proposed programs and their consistency with RMPS policies.

### **Highlights of Fiscal Year 1972**

**DECENTRALIZATION:** During the past year major steps have been taken toward the further decentralization of decision-making authority from the national (HSMHA/RMPS) to the local (RMP) level. Each Program now has sole responsibility for both determining technical adequacy of activity proposals and priority funding of approved proposals. Further, this decisionmaking power has been vested entirely in the Regional Advisory Group of each Program—only this body has final decisionmaking authority on program concerns of the RMP.

The role of the Regional Medical Programs Service in the decentralization process has been on several levels. First, the issuance of an official policy statement regarding the respective responsibilities of the Regional Advisory Group, grantee, and Chief Executive Officer (Pro-

gram Coordinator) has made clear that the Regional Advisory Group, rather than the grantee institution, has responsibility for the determination of Program direction, scope, and priorities. Secondly, RMPS has undertaken an investigation of the adequacy of the individual review processes in the various RMPs. Having developed a series of criteria for assessing these processes, the Service is now in the process of visiting all RMPs for purposes of verification and certification of systems in use.

**RMP REVIEW CRITERIA:** In an attempt to strengthen its own review and approval process, RMPS has developed a set of national review criteria aimed at assessing the individual Regional Medical Programs. These measures attempt to evaluate an RMP in the three major areas of performance, process and structure, and quality of the current proposal. Staff, site visitors, and the National Review Committee utilize these measures (as weighted) to arrive at an overall Program score which permits qualitative ranking of RMPs; these rankings, in turn, assist in determination of Program funding levels.

**KIDNEY DISEASE LIFE PLAN:** In fiscal year 1972, Regional Medical Programs became increasingly concerned with the development and implementation of regionalized, end-stage kidney disease programs. At the national level this was reflected in the development, by RMPS,

of a long-range "life plan" approach for dealing with the major problems represented by the 8-10,000 new patients afflicted with end-stage kidney disease every year. The principal aim of the "life plan" approach is the efficient linkage and orderly growth of scarce resources throughout the United States. The program guidelines developed by RMPS and approved by the National Advisory Council seek to exploit the opportunities for regionalization of end-stage kidney disease programs without sacrificing quality and accountability. These guidelines require, that in order to be eligible for grant support, RMP-proposed activities should include certain specified components such as early identification, rapid referral, adequate organ procurement and preservation facilities, etc.

The advantages of such an approach are multiple: it would allow patients to have access to conservative treatment before kidney function stops; it would simplify and expedite organ procurement; and it would ensure that almost all patients will be involved in dialysis outside of the hospital.

**EMERGENCY MEDICAL SERVICES:** Emergency medical services (EMS) was highlighted as a national health priority in the President's Health Message in January 1972. Regional Medical Programs Service had responsibility for developing guidelines for RMP proposals in this area, and did so early in the calendar year. By the end of the fiscal year, in fact, 36

RMPs had responded with over 50 EMS proposals. The rapidity of response was due in large part to RMPS assistance in the development of the various proposals. The Service is now in the process of developing and designing measurement tools for evaluating RMP Emergency Medical Systems programs across the nation.