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REGIONAL MEDICAL PROGRAMS

BENEFITING PEOPLE AND IMPLEMENTING LOCAL HEALTH SERVICES

An evaluative study supported by Department of Health, Education and Welfare funds and conducted by the Public Accountability Reporting Group.

PUBLIC ACCOUNTABILITY REPORTING GROUP

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THE PUBLIC ACCOUNTABILITY REPORTING GROUP (PAR) IS A COOPERATIVE ARRANGEMENT AMONG THE NATION'S RMPs. IT WAS FORMED TO DEVELOP NATIONAL DESCRIPTIVE AND EVALUATIVE INFORMATION ABOUT RMP PROGRAMS. PAR OPERATES IN COOPERATION WITH THE DIVISION OF REGIONAL MEDICAL PROGRAMS AND UNDER THE AUSPICES OF THE COORDINATOR'S EXECUTIVE COMMITTEE.

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ABSTRACT

REGIONAL MEDICAL PROGRAMS: BENEFITING PEOPLE AND IMPLEMENTING LOCAL HEALTH SERVICES

More than 9 million people received direct health care services in Regional Medical Program (RMP) activities in 1973. An estimated 12 million additional persons benefited as a direct result of the use of new skills acquired by local health professionals in RMP training programs. Despite a year marked by lack of clarity in health policy at the Federal Administration level and illegal impoundments of Congressional appropriations, the RMPs continued to record substantial accomplishments in expanding and improving local services for people.

Other findings of a March, 1974 national survey of the Nation's 53 RMPs revealed that in 1973:

. . . over 150,000 health professionals received training in *quality assurance medical audit* programs, *new types of health manpower* roles (e.g., nurse practitioners, physician assistants and emergency medical technicians) and *new skills* (e.g., kidney tissue typing and neonatal intensive care).

. . . more than 3500 local health care facilities participated in RMP initiated quality assurance medical audit programs designed to improve specific acts of medical care. Programs frequently result also in moderating costs of care.

Since July, 1971:

. . . the RMPs have initiated almost 2000 major, innovative demonstration projects. Projects were jointly funded by RMPs ($110 million) and other organizations ($53 million).

. . . over 80 per cent of the almost 1000 RMP projects not designed as "one-time" activities were continued by local financing mechanisms at an annual estimated level of $58 million after RMP funding support was completed.

. . . RMPs provided major technical assistance in over 6000 instances in creating new health services organizations and in securing over $350 million of non-RMP funds: (1) for other health organizations for needed improvements in local health services, and (2) for rapid, locally suitable implementation of new Federal initiatives.

RMPs' community-based process is shown to be an effectively functioning model of a Federally supported, largely locally controlled implementing agency which has major impact in strengthening local health care services systems in preparation for meeting increased demands and needs.

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SUMMARY

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BENEFITING PEOPLE AND IMPLEMENTING LOCAL HEALTH SERVICES

INTRODUCTION

A March, 1974 survey of the Nation's 53 RMPs revealed that, despite a year of Federal Administration confusion and illegal impoundments, the RMPs have continued to make substantial accomplishments as local implementing agencies which provide major assistance in developing needed health services for people.

This report of the survey is organized in two sections. *Section I, "Benefiting People,"* presents evidence of RMP accomplishments in providing health services for people. *Section II, "Implementing Local Health Services,"* describes the RMP community-based process, types of local expenditures, and specific accomplishments related to strengthening local health services systems in preparation for meeting increased demands and needs for health services.

The report clearly demonstrates the wasteful loss of needed services to people as a result of Federal administration mandates to dismantle RMPs as well as illegal Administration impoundments of Congressional appropriations.

SECTION I: BENEFITING PEOPLE

Despite these difficult circumstances, the RMPs recorded substantial accomplishments in 1973 directly benefiting people. Major findings presented in Section I include:

. . . More than 6.5 million people received *direct health services* from RMP demonstration projects.

. . . More than 2.5 million other patients received *services from new types of health manpower* (e.g., nurse practitioners and emergency medical services technicians and others) trained in RMP-initiated projects.

. . . More than 12 million people were served by health professionals using *new skills* acquired in RMP programs.

. . . More than 27,000 providers were trained in *quality assurance medical audit programs.*

More than 3,500 local health care facilities participated in initial exploration or actual implementation of *quality assurance medical audit programs.*

. . . More than 127,000 health *professionals received training in new skills* (e.g., kidney tissue typing, neonatal intensive care) or *as new types of health manpower* (e.g., physician assistants, nurse practitioners, emergency medical technicians).

SECTION II: IMPLEMENTING LOCAL HEALTH SERVICES

As Federally supported, largely locally controlled implementing agencies, RMPs have developed an effective blend of involved, expert and experienced volunteer boards of directors (Regional Advisory Groups), committee structures and professional staffs. RMPs assist a wide variety of local health interests to make locally suitable improvements in health care services for people.

Regional Advisory Groups invest RMP resources through a community-based process which includes two major components: (1) *Initiation of demonstration projects* (80% of RMP awards), and (2) *Non-project related community development activities* (12% of RMP awards), such as technical assistance and convening/facilitating.

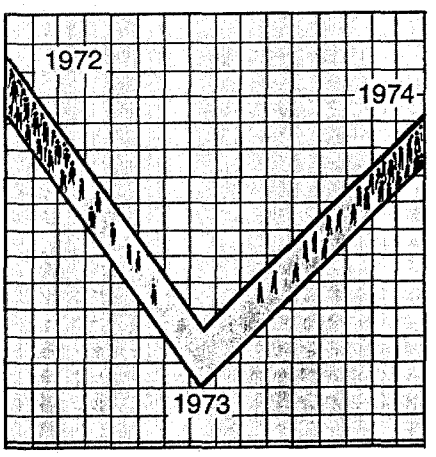

FIGURE A
Decline and Recovery in Service to People.

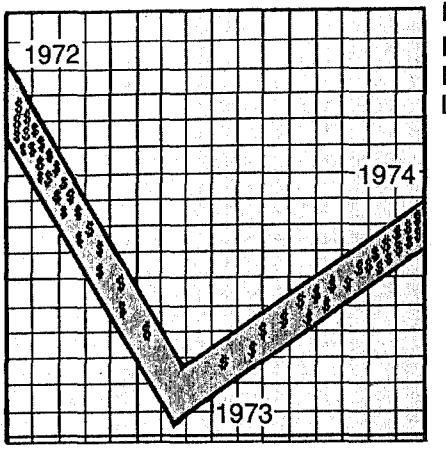

FIGURE B
Federal Funding Levels.

RMPs' administrative costs represent a modest (7-8%) investment of direct costs of the program.

RMP accomplishments which are directly associated with the community-based process described, since July 1, 1971, include the following:

. . . *Joint Funding* by other organizations in more than 1,000 demonstration projects provided a total amount of over $50 million in a three-year period for projects which were supported by RMP funds in a total amount of $110 million.

. . . *Continuation* of over 80% of RMP-initiated demonstration projects through regular financing mechanisms in local health care services systems; the estimated first year operational cost after completion of RMP funding support was over $58 million.

. . . Major, specific *technical assistance* to a wide array of local health interests which resulted in over 6,000 occasions where new health services and supportive organizations or formal cooperative arrangements for sharing resources were created.

. . . Major assistance by RMP program staffs in developing over 1,000 *applications for non-RMP funds* for other local health organizations to support the development of needed health care systems improvements and locally suitable versions of Federal initiatives.

. . . Major assistance in securing over *$350 million* in a three-year period of *non-RMP financial resources* for other local health organizations to support needed community health systems improvements.

COMMENT

Despite Federal Administration vagaries of financing and program direction, evidence reported indicates that the Nation's RMPs have continued to implement locally-needed, improved health services for people.

In addition to improving services to people, the RMPs have developed a community-based process which is an effectively functioning model of a federally supported, largely locally controlled implementing agency, which has major impact on local health care services systems.

The RMPs remain a major National resource capable of prudently and effectively assisting local communities to implement expanded health services for people.

SECTION I

REGIONAL MEDICAL PROGRAMS: BENEFITING PEOPLE

The Nation's RMPs have built a tangible, impressive record in assisting the orderly development and implementation of needed health services in hundreds of communities and areas across the Nation.

This section of the RMP evaluative study provides documentation of diminished, but continuing accomplishments despite more than a year of Federal administrative health policy uncertainty, phase-out directives, and unlawful impoundments of Congressional appropriations.

The major focus of Section I is on RMP efforts leading to increased and improved health services for people. It also provides updated information correlated with a previous evaluative report.[1]

Section I is organized as follows:

. . . A Chronology of and Comment on Recent RMP History.

. . . People Served by RMP Demonstration Projects.

. . . People Served by RMP Trained Health Professionals.

. . . People Benefited by RMP Initiated Improvements in Local Health Care Systems.

. . . Allocations of RMP Resources in People Services Programs.

. . . Comment.

RECENT RMP HISTORY

Since January 1973, the Nation's RMPs have experienced a series of curious events which have had marked impact on services to people.

Chronology

On January 29, 1973, the President's fiscal year 1974 budget message to Congress recommended zero funding for RMPs. The budget narrative contained a justification which, to many observers, was superficial, inaccurate and contradictory to previous public statements of Administration spokesmen. The "justification" also ignored the fact that many of its own charges (e.g., "no consistent theme in RMP programs") resulted from inconsistent and frequently changing Federal directives. Despite strong indications that the Administration's budget proposal was clearly contrary to Congressional intent, on February 7, 1973, the Administration directed the RMPs to close down operations by June 30, 1973.

Congressional action to continue the legislative authorization for RMPs followed in rapid sequence:

a. On March 25, 1973, the Senate passed, by a 72-19 vote, a one-year extension bill.

b. On May 31, the House of Representatives passed, by a 372-1 vote, a one-year extension.

c. On June 5, the Senate passed, by a unanimous 94-0 vote, the House amendments to the Senate bill.

d. On June 18, the President signed into law (PL 93-45) the bill which extended authorization for the RMP through June 30, 1974.

"Phase-out" orders to close down operations were rescinded. However, many RMPs had suffered significant disruptions of painstakingly developed community relationships, as well as losses of experienced key program and project staff.

A nominal restoration of new RMP operations began on July 1, 1973. The restoration was marred both by continuing Administration impoundments of RMP funds and by unclear Administration direction. In one instance, $6.9 million of RMP funds were "released" with the stipulation that the Congressionally appropriated funds could not be spent until a "new mission" was established for the RMPs for the extension year.

Not until September 7, 1973, however, did the Administration finally issue a new program mission ("priorities and options") for the year beginning July 1, 1973. The "priorities and options" sharply restricted the mission of the RMPs, seemed at variance with the legislative mandate, and required that all activities be completed by June 30, 1974. Administration intent appeared to be to release RMP funds: (a) at a level considerably less than the full amount of the Congressional appropriation, and (b) under time schedules which could serve only to hinder the RMPs' capability to work effectively at the local level.

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[1]Mitchell, J., et al., "The 56 RMPs: A Special Progress Report," *Drug Research Reports,* Vol. 16, No. 8, February 21, 1973.

On September 21, 1973, the National Association of Regional Medical Programs initiated civil action proceedings seeking three actions from the Administration: (1) release of $115 million of impounded RMP funds, (2) relief from the restrictive mission statement of September 7, 1973 and (3) relaxation of a June 30, 1974 termination date which had been set as a deadline by which RMPs must effectively complete projects.

On February 7, 1974 a Federal district court ordered release of $130 million of impounded funds to the RMPs, removal of the mandatory termination date of June 30, 1974, and lifting of the restrictive program "priorities and options."

Comment

The following summary of RMPs' accomplishments in developing health services for people unsurprisingly reflects a consistent pattern of lessened program impact in the past 18 months. The most marked effect of the "phase-out" orders is seen in the period July to December 1973. RMPs continued to achieve substantial results during this time; however, only in a few instances are the results at levels as high as those achieved in 1972 or those approved in 1973 operating schedules.

Based on recorded and forecasted results from operational activities in the current six months (January to June 1974), there is an upward trend toward higher levels of services to people. Carry-over of the funds released late in 1973, plus release of the additional awards has provided a sufficient financial base so that projections are realistically based on scheduled activities of operations currently in effect.

Although buffeted in the past year, the RMPs apparently have made substantial, quick recoveries. As local implementing agencies, they have maintained organizational capability as well as noteworthy records of accomplishment in the development of health services for people.

PEOPLE SERVED BY RMP DEMONSTRATION PROJECTS

The RMPs continue to have a major impact in serving personal health care needs of consumers. While RMPs do not ordinarily provide direct health services, there are numerous instances where direct — often highly technical services are supported as part of a demonstration project. Examples include: (a) *person screened* in hypertension screening projects, (b) *patients treated* by project staff of a demonstration unit for specialized cancer care, or (c) *patients seen* by a nurse practitioner or a neighborhood clinic staff supported by an RMP. Table I summarizes such direct services recorded in RMP demonstration projects.

TABLE I*

PEOPLE RECEIVING DIRECT HEALTH SERVICES IN RMP DEMONSTRATION PROJECTS: SUMMARY

TYPE OF PROJECT	CALENDAR 1970 *(56 RMPs)*	CALENDAR 1972 *(56 RMPs)*	CALENDAR 1973 *(49 RMPs)*
Primary Care	2,622,000	3,054,000	2,113,000
Emergency Medical Services	466,000	2,443,000	2,624,000
Regionalization of secondary and tertiary care	2,715,000	4,143,000	1,828,000
TOTALS	5,803,000	9,640,000	6,565,000

*a. The comparison cited for 1970 and 1972 was reported by the 56 RMPs then in operation. There currently exist 53 RMPs, 49 of which responded to this survey. While direct comparisons should be made with caution, major trends are considered valid.

b. All numbers are rounded to the nearest thousand.

Table II presents further detail about people directly served in the course of RMP demonstration activities. The numbers of people who received direct health services from RMP projects of a categorical type generally decreased between 1972 and 1973. In part, this decrease was due to Federal directives. A general decrease in people served is due in large measure to the decreased level of financial resources available.

Sharp upward trends in numbers of people served in hypertension projects reflect fulfillment of previous projections.

TABLE II

PEOPLE RECEIVING DIRECT HEALTH SERVICES IN RMP DEMONSTRATION PROJECTS: DETAIL OF REGIONALIZATION OF SECONDARY AND TERTIARY CARE PROJECTS

TYPE OF PROJECT	CALENDAR 1970 *(56 RMPs)*	CALENDAR 1972 *(56 RMPs)*	CALENDAR 1973 *(49 RMPs)*
Heart Disease	1,126,000	1,086,000	318,000
Cancer	413,000	523,000	258,000
Stroke	140,000	348,000	57,000
Kidney	13,000	33,000	107,000
Hypertension	135,000	84,000	256,000
Pulmonary Disease	300,000	307,000	225,000
All Other	588,000	1,762,000	607,000
TOTALS	2,715,000	4,143,000	1,828,000

PEOPLE SERVED BY RMP TRAINED HEALTH PROFESSIONALS

The RMP record is well known in accomplishment of the early mission of "bringing advances in medical knowledge to the bedside of the patient." Many physicians and nurses have been taught new skills for use in coronary care units; many stroke rehabilitation teams have been trained; and large numbers of neighborhood health aides have been trained and placed. As a result of RMP health manpower training activities, substantial numbers of people now have ready access to improved health services not previously available.

Health manpower training activities of RMPs generally have resulted in (a) *new types of health professionals* trained to meet the changing demands for health care services, or in (b) *the acquisition of new skills* by existing health manpower.

New types of health manpower is an RMP program category which includes all persons trained in newly defined categories of health manpower where no widespread, nationally recognized training programs, certification or licensure exist. Examples include nurse practitioners, nurse midwives, community health assistants, and emergency medical technicians.

RMPs have also supported the development of *new skills* in existing health manpower. *New skills* is an RMP program category which includes organized efforts aimed at the acquisition of essentially new skills by persons already educated, licensed or certified. Examples are: (a) a registered nurse who becomes a coronary care unit nurse, and (b) a physician who develops advanced skills as a neonatal intensive care specialist.

Table III summarizes the numbers of people served in the remainder of the year in which training occurred.

Numbers include only persons given direct health services during the time period indicated. For example, a "nurse practitioner" trained in late 1972 may have served a total of 300 patients in the remainder of 1972. In actuality, however, the nurse practitioner may have continued to serve increasing numbers of persons in each year since the completion of training. However, the cumulative total number of persons served is unreported.

TABLE III

PEOPLE SERVED BY RMPs TRAINED HEALTH PROFESSIONALS: SUMMARY

TYPE OF SERVICE	CALENDAR 1970 *(56 RMPs)*	CALENDAR 1972 *(56 RMPs)*	CALENDAR 1973 *(49 RMPs)*
Served by *new types* of health professional manpower	969,000	5,033,000	2,662,000
Served by *new skills* acquired by existing health professionals	19,383,000	25,392,000	11,595,000
TOTALS	20,352,000	30,425,000	14,257,000

Taking into consideration the differences in numbers of RMPs reporting in each of the time periods, the following observations are considered valid:

People served by people trained by RMPs *increased* from about 20 million to over 30 million in the period from 1970 to 1972, an increase of roughly 50%.

People served by people trained by RMPs *decreased* from over 30 million in 1972 to less than 15 million in 1973: a decrease of over 50%.

Figure 1 is a graphic portrayal of the sharp decline and beginning recovery of persons served by health providers using newly acquired skills.

FIGURE 1

PEOPLE SERVED BY VARIOUS HEALTH MANPOWER TRAINED IN NEW SKILLS BY RMPs

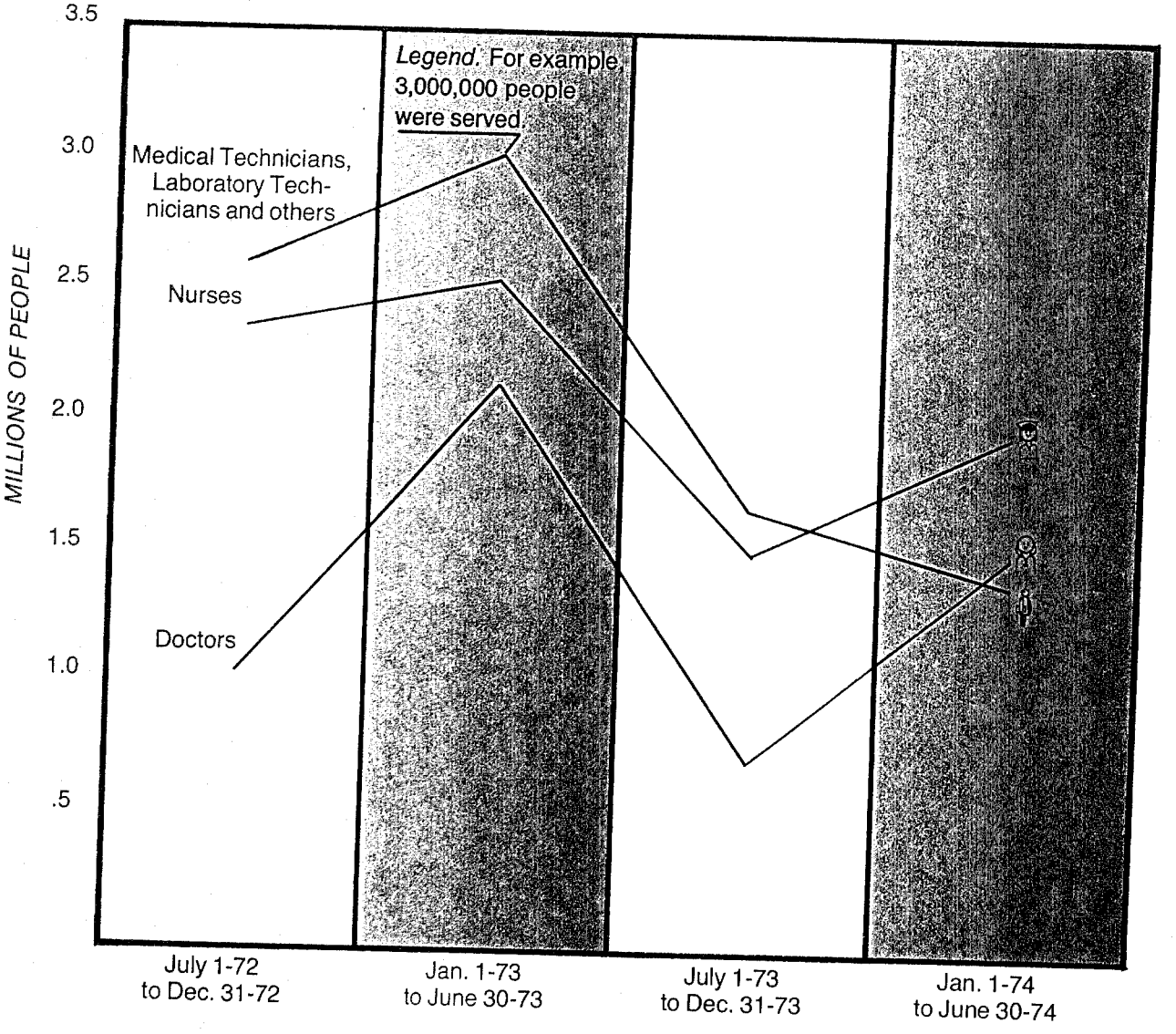
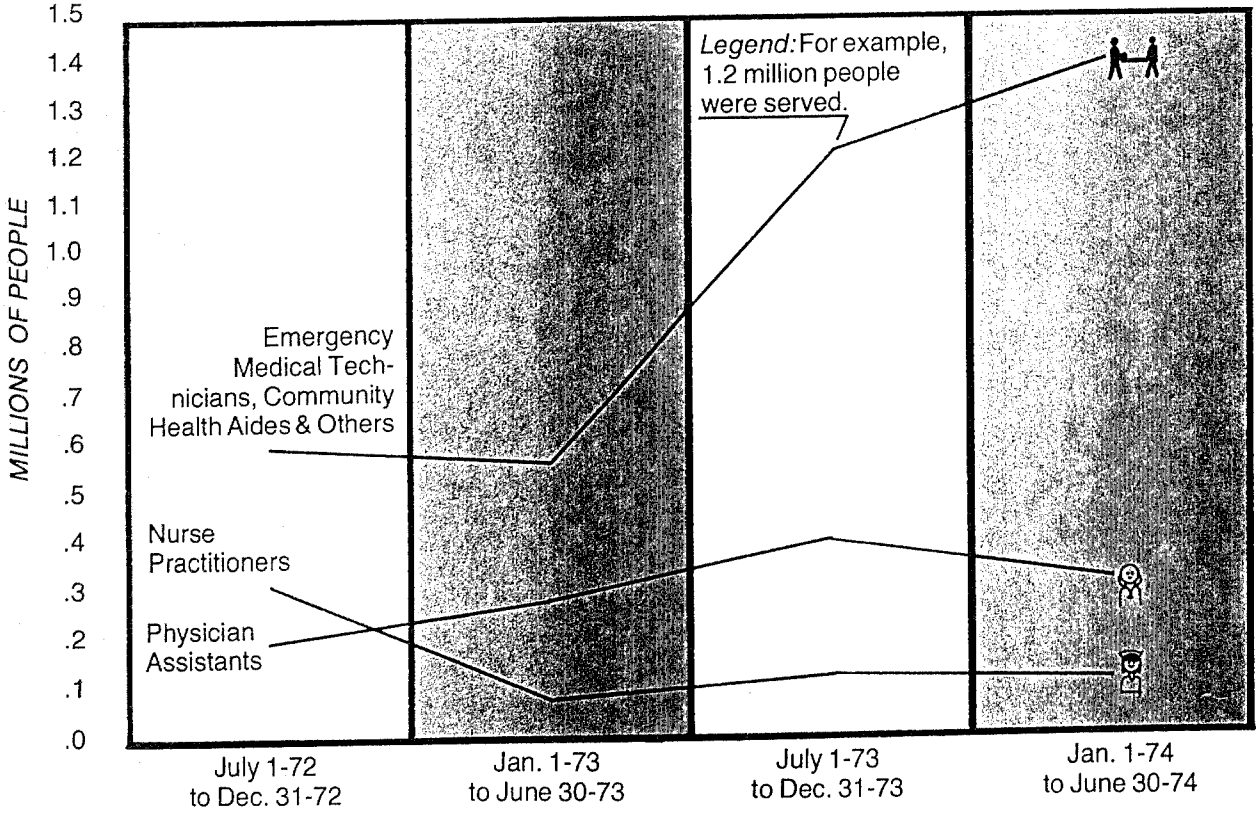


Figure 2 is a graphic pattern of the recent RMP program emphasis in assisting the training and placement of persons in *new types* of primary health care roles. RMPs trained *nurse practitioners* (563) and *physician assistants* (163) who provided direct health services to more than *650,000* patients in 1973. An additional *2,000,000* patients received direct health services in 1973 from other types of new health manpower trained; for example, emergency medical technicians, kidney tissue typing technicians, nurse midwives, and community health assistants.

FIGURE 2

PEOPLE SERVED BY NEW TYPES OF HEALTH MANPOWER



PEOPLE BENEFITED BY RMP INITIATED IMPROVEMENTS IN LOCAL HEALTH CARE SYSTEMS

Many people have gained easier access to higher quality health care services as a result of RMP activities in local communities. RMP activities resulting in improvements in local health care services are reported in the following categories:

1. *Expanded capability* of the Nation's health manpower;
2. Improvement in local health care service through introducing *quality of care, medical audit programs;*
3. *Creation of new health services,* particularly in underserved areas.

Expanded Capability of Health Manpower.

As reported earlier, RMPs' training efforts have added sizable numbers of *new types* of health professionals needed to provide local services. Training efforts also have resulted in *new skills* for large numbers of practicing health professionals. A summary of the numbers of health professionals trained in new skills or in new professional roles is presented in Table IV.

TABLE IV

NUMBERS OF HEALTH PROFESSIONALS TRAINED BY RMPs

TYPE OF TRAINING	CALENDAR 1970 *(56 RMPs)*	CALENDAR 1972 *(56 RMPs)*	CALENDAR 1973 *(49 RMPs)*
"New Skills"	83,361	107,009	114,383
"New Types"	7,526	13,825	12,382
TOTALS	90,887	120,834	126,765

New Skills of Professionals Improve Health Services.

Traditionally, RMPs have provided existing health manpower with opportunities to acquire new skills aimed at providing better quality care to people served. These activities have been well received by the health community and have been of benefit to ever increasing numbers of health services consumers.

A summary of the numbers of local health providers trained in essentially *new skills* is shown on Table V.

The slight increase in numbers of doctors trained result from relative increases in projects concerned with hypertension, kidney disease and other specialized services such as neonatal intensive care.

TABLE V

NUMBERS OF EXISTING HEALTH PROVIDERS TRAINED IN NEW SKILLS BY RMPs

TYPES OF HEALTH MANPOWER	CALENDAR 1970 *(56 RMPs)*	CALENDAR 1972 *(56 RMPs)*	CALENDAR 1973 *(49 RMPs)*
Doctors	13,561	16,164	13,561
Nurses	38,159	42,182	42,182
Others Including Medical, Laboratory and other Technicians	34,641	48,663	48,663
TOTALS	86,361	107,009	104,406

New Types of Health Professionals Increase Access to Needed Services.

Increased access to primary care services has continued to claim RMPs attention and efforts in recent years. The development of new types of health professionals specifically trained to provide primary health care as "mid-level practitioners" working closely with physicians has been an innovative, promising method of increasing access to needed health care services. A summary of the numbers of new types of health professionals trained primarily to increase access to primary care is shown in Table VI.

TABLE VI

NUMBERS OF HEALTH PROFESSIONALS TRAINED IN NEW ROLES BY RMPs

TYPES OF HEALTH MANPOWER	CALENDAR 1970 *(56 RMPs)*	CALENDAR 1972 *(56 RMPs)*	CALENDAR 1973 *(48 RMPs)*
Nurse Practitioners			563
Physician Assistants			163
Community Health Assistants, EMTs and Others			11,656
TOTALS	7,526*	13,825*	12,382

*Information is not available by profession for 1970 and 1972.

Persons Trained in Techniques of Quality of Care Assurance.

RMPs have trained numerous health professionals in techniques to assure high levels of quality care available to patients in local health facilities and clinics. Table VII summarizes the numbers of health professionals trained in quality of care assurance techniques.

The numbers of persons trained in quality assurance techniques increased almost six-fold between 1970 and 1972. RMP program effort in quality assurance techniques is substantial, though it remains less than forecast for 1973.

Improvement in Local Health Care Services by Quality Assurance Programs.

In this report, *quality of care assurance* programs are defined as *systematic* efforts to set standards, determine deficiencies in individual or collective acts of medical care, to develop corrective action, and to implement activities which result in demonstrably improved quality of care.

TABLE VII

NUMBERS OF HEALTH PROFESSIONALS TRAINED IN QUALITY ASSURANCE PROGRAMS

TYPE OF TRAINING	CALENDAR 1970 *(56 RMPs)*	CALENDAR 1972 *(56 RMPs)*	CALENDAR 1973 *(47 RMPs)*
Quality Assurance Program Development	6,872	32,394	27,460

Quality of care assurance activities offer a classic RMP example of an effective, local developmental process which results in sustained change after RMP support is withdrawn.

Program development typically followed a three-stage process.

Stage 1 — A local need is identified and RMP supported professional resource persons are assembled. Table VIII summarizes the numbers of professional resource persons leading RMP program developments in quality assurance in each of four time periods.

TABLE VIII

NUMBERS OF PROFESSIONAL RESOURCE PERSONS INVOLVED IN QUALITY ASSURANCE PROGRAM DEVELOPMENT

	FISCAL YEAR 1973		FISCAL YEAR 1974	
	July-Dec.	Jan.-June	July-Dec.	Jan.-June
Professional resource persons involved as "Trainers/Developers"	818	1,019	934	1,785

A sharp recovery in the last period reflects both Federal priority and local capability to use released funds; however, the increase is not as great as the level the RMPs expected to reach in 1973.

Stage 2 — Representatives of local health care facilities participate in RMP-sponsored "convening/facilitating" activities to begin *exploratory* development, and/or participate in formal projects aimed at developing skills and *implementing* quality assurance mechanisms in their facilities (e.g., medical audit systems). Table IX summarizes numbers of facilities involved in each type of participation.

TABLE IX

HEALTH CARE FACILITIES INVOLVED IN RMPs' QUALITY ASSURANCE PROGRAM DEVELOPMENT

TYPE OF INVOLVEMENT	FISCAL YEAR 1973		FISCAL YEAR 1974	
	July-Dec.	Jan.-June	July-Dec.	Jan.-June
"Exploratory"	524	638	623	2,536
"Implementing"	403	545	496	1,319
TOTALS	927	1,183	1,119	3,855

Stage 3 — As local health care facilities identify specific deficiencies in health care, corrective action is initiated by health care providers involved within the facility. A tabulation of over 5,000 formal *corrective programs* (for example, educational experiences and organizational changes) following specifically identified deficiencies is presented in Table X.

TABLE X

FORMAL CORRECTIVE PROGRAMS WITHIN LOCAL HEALTH CARE FACILITIES PARTICIPATING IN RMP QUALITY ASSURANCE PROGRAMS

	FISCAL YEAR 1973		FISCAL YEAR 1974	
	July-Dec.	Jan.-June	July-Dec.	Jan.-June
Formal Corrective Programs Initiated by Local Facilities	1,307	1,383	1,338	3,933

Increased Access to Care: Initiation of Needed Health Services.

As a consequence of RMP *demonstration projects* and substantial technical assistance by program staffs, major impetus to the creation of new health service units needed in local communities has been provided. Since July 1, 1971, RMPs have assisted local communities to implement more than 1,800 new health service units needed locally to provide services to people. Included, for example, are neighborhood health clinics, rural health stations for primary emergency care, formal agreements for *cooperative sharing of specialized* services, and ambulatory out-patient clinics in hospitals in underserved urban areas.

New health services organizations in whose establishment RMPs participated, continue to provide needed services without continuing RMP technical or financial assistance. Table XI summarizes the types of new health services created in the course of RMP projects and program staff efforts.

TABLE XI

NEW HEALTH SERVICES CREATED
(Since July 1, 1971)

Type of New Health Services	Numbers of New Health Services Established
Primary Care (including Emergency Medical Services)	1,250
Specialized Services (Secondary and Tertiary Care)	579
TOTAL	1,829

ALLOCATIONS OF RMP RESOURCES IN PEOPLE SERVICES PROGRAMS

The RMPs have allocated their operating funds into four major program areas. Total direct costs awards to RMPs are categorized for three calendar years in the following program areas.

More Effective Use of Manpower is an RMP program category which includes new skill development, new types of manpower development, efforts to implement arrangements for shared training and service resources in underserved areas, and efforts to bring about improved utilization and relevance of health manpower training programs.

Improved Accessibility and Availability of Primary Medical Care includes development of new or improved health care services such as family health centers, free clinics, hospital-based ambulatory care centers, primary and emergency care centers, and improvements in minority group access to services.

Regionalization of secondary and tertiary (specialized) care includes RMP efforts to facilitate general institutional sharing of scarce resources such as radiation facilities, shared services such as joint purchasing, and development of needed services for specialized care of heart disease, cancer, stroke and other patients.

Quality of Care Assurance programs are an RMP program category which includes efforts to assist local hospitals, out-patient departments, and physicians in private practice to perform audits of care and efforts to foster development of standards or other mechanisms needed to improve care provided.

Relative investments of RMP resources in the four program areas along with remaining administrative costs is shown for three years in Figure 3.

FIGURE 3
ALLOCATIONS OF RMP RESOURCES TO PEOPLE SERVICE PROGRAMS
(Selected Calendar Years)

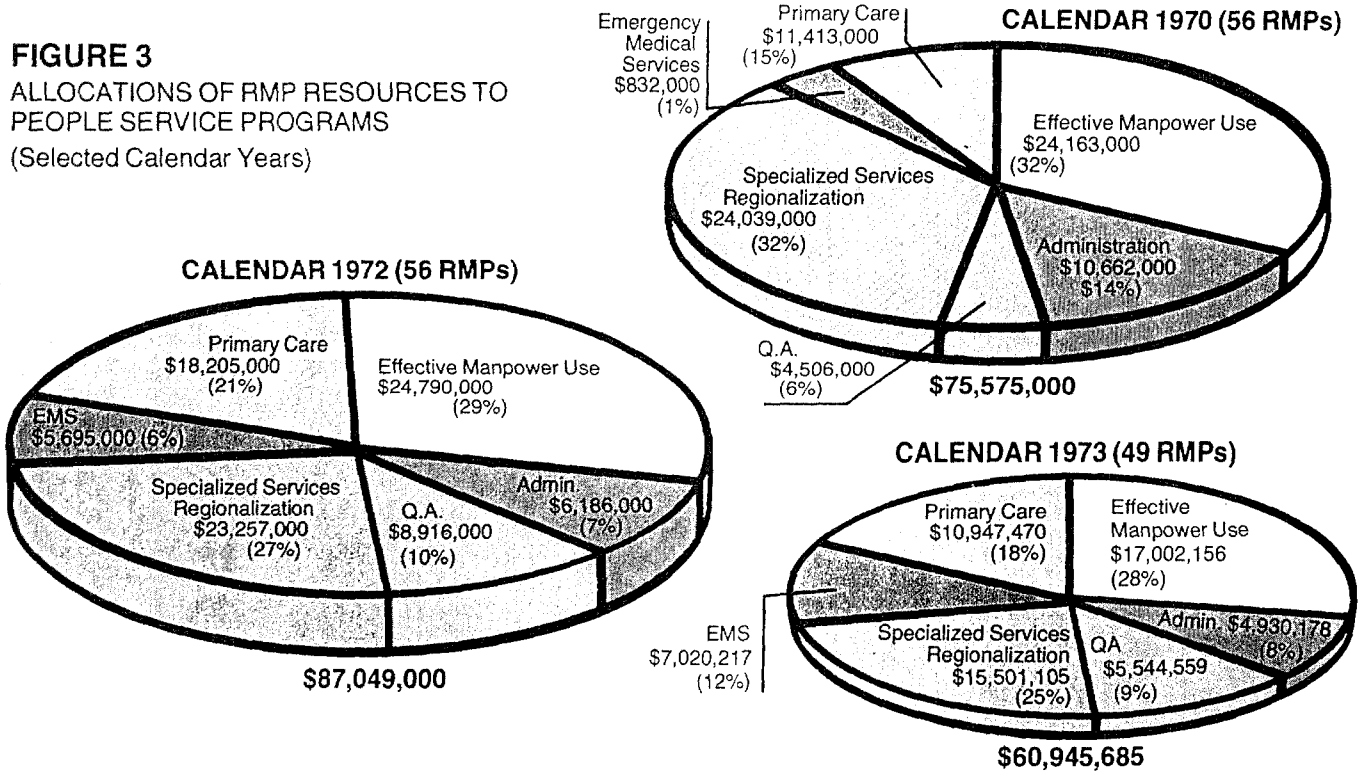


Figure 3 also reflects the overall decrease in resources available in 1973. However, relative investments have remained essentially stable in the three years with the following exceptions:

1. The investment in assisting the development of emergency medical services has increased, due in part to Federal budgetary actions.

2. Administrative costs have decreased from an estimated 14% in 1970 to 8% in 1973, in part due to increased efficiency of local operations.

COMMENT

Despite Federal administration vagaries of financing and program direction, the evidence reported indicates that the Nation's RMPs have continued to assist in the implementation of locally needed health service programs for people. The RMPs remain a major National resource capable of prudently and effectively assisting local communities to implement expanded health services for people.

SECTION II
THE REGIONAL MEDICAL PROGRAMS: IMPLEMENTING LOCAL HEALTH SERVICES

The Nation's RMPs constitute a major resource for implementing professional responses to locally identified health needs within the broad framework of national health policy. As currently constituted, RMPs offer an effective model of an implementing agency which functions at the local level "to convene, coordinate and correlate federal, state and local government efforts with private provider efforts and with others toward improving health care services."[2]

Section II of this special progress report from the Nation's RMPs focuses primarily on accomplishments in local health care systems development. RMP accomplishments summarized are those which are directly related to the unique role of the RMPs as a community-based, federally supported implementing agency.

RMPs' impact on development of needed health services for people is well known and is documented elsewhere. Improved services for people result from operational efforts in the areas of access to primary and emergency health care, the development of quality of care assurance programs in local health care facilities, development of new skills in existing health manpower, development of new types of manpower and innovative demonstration clinics and patient care projects. This impact has been uniquely effective and uniquely far reaching.

Less widely known are results growing out of the RMP process of working with a wide array of local health agencies and organizations. Original legislation creating the RMPs provided a broad mandate to act as an implementing agency to develop innovative changes through a community-based, locally controlled process involving cooperative arrangements among local health professionals and organizations. That process, the community structures and effective working relationships painstakingly developed constitute a major strength of RMPs; they are important reasons for RMP accomplishments summarized as follows:

A COMMUNITY BASED PROCESS

There are two major components of the community based RMP process:

(1) an effective blend of local boards of directors, volunteer committees and professional staffs;

(2) a locally determined pattern of expenditures which includes demonstration projects and community development activities.

Local Structure: Regional Advisory Groups, Volunteer Committees and Professional Staffs.

.. RMPs are federally supported implementing agencies which are largely locally controlled. Regional Advisory Groups act as boards of directors to study and act upon health problems in a way that is best suited to local situations. Volunteers serve long hours, often at considerable personal financial sacrifice.

The financial value alone of time donated by volunteers in integrating the activities of the RMPs into health care systems in local areas is truly impressive. For example, a detailed analysis conducted by an RMP in the South conservatively estimated the value of the "man-hours" contributed by the Regional Advisory Groups volunteers during federal fiscal year 1973 as $450,000.

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[2]"A Report from the Coordinators of the Nation's Regional Medical Programs" (mimeographed August 6, 1973).

In addition to Regional Advisory Groups, RMPs make use of numerous important volunteer committees for purposes such as technical review and project development. Table XII displays current membership of RMP Regional Advisory Groups and of major committees whose members had volunteered at least one day of service in the preceding six months.

Together, the voluntary groups and RMP professional staffs provide a local mechanism which constitutes the wide range of skills, training and experience necessary to assist communities to develop workable solutions to complex health problems.

Table XIII shows the current composition of RMP program staffs and staffs of externally operated RMP demonstration projects.

TABLE XII

CURRENT RMP VOLUNTEER STRUCTURE (As of February 1, 1974) (49 RMPs)

TYPE OF VOLUNTEER ACTIVITY	NUMBER OF VOLUNTEERS
REGIONAL ADVISORY GROUPS:	
Doctors (e.g., MDs, DOs, DDS)	851
RNs, Allied Health	249
Health Administrators	438
Members of the Public	547
TOTAL	2085
MAJOR COMMITTEES:	
Doctors (e.g., MDs, DOs, DDS)	2175
RNs, Allied Health	1004
Health Administrators	905
Members of the Public	1012
Others — Not Classified	278
TOTAL	5374

TABLE XIII

CURRENT RMP STAFF STRUCTURE (As of February 1, 1974) (49 RMPs)

TYPE OF STAFF	STAFF	
	NUMBER	FTE*
RMP PROGRAM STAFFS:		
Doctors (e.g., MDs, DOs, DDS)	72	56
RNs, Allied Health	48	42
Social and Behavioral Scientists (e.g., educators, administrators)	398	378
Support Staff (secretarial & clerical)	295	278
TOTALS	813	754
STAFFS OF RMP DEMONSTRATION PROJECTS:		
Doctors (e.g., MDs, DOs, DDS)	326	141
RNs, Allied Health	642	465
Social and Behavioral Scientists (e.g., educators, administrators)	750	507
Support Staff (secretarial & clerical)	799	583
TOTALS	2517	1696

*FTE's are full time equivalent staffs, rounded to nearest whole number.

The effect of a Presidential message and subsequent DHEW directives to "phase-out" RMPs had drastic repercussions on the numbers of volunteers participating in RMP major committees and on both program and project staff of RMPs.

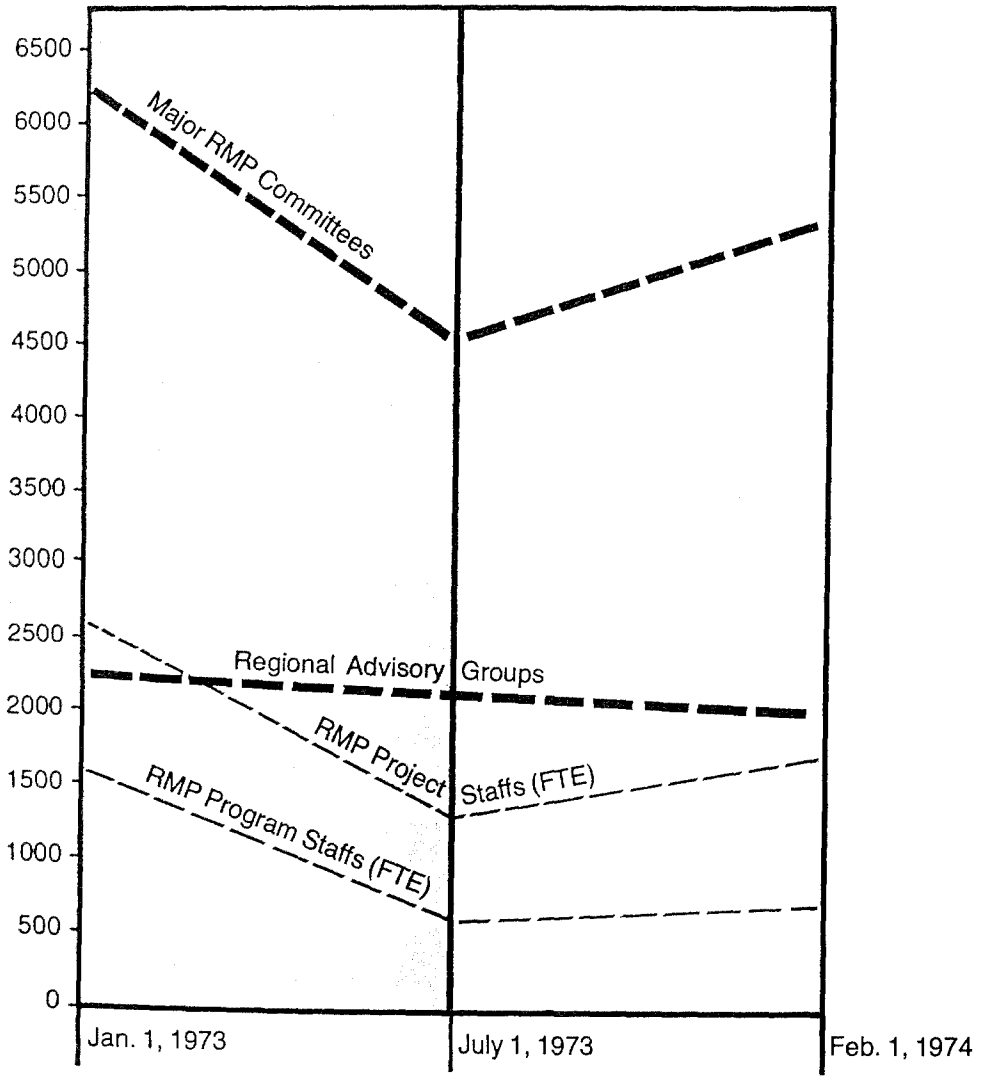
Figure 4 graphically shows the dramatic drop in membership of committee volunteers and staffs. The Regional Advisory Groups, however, maintained considerable membership stability.

By February 1, 1974, both the numbers of committee volunteers and the numbers of project and program staffs had increased, however numbers were still at lower levels than they had been prior to the phase-out orders.

The recovery of RMP volunteer structures and staffs toward pre-phaseout levels strongly argues that the general health community maintains a continuing commitment to the RMP mission as well as a belief in RMPs' important implementation role in local health care services system.

FIGURE 4

RMP ADVISORY STRUCTURES AND STAFFS: EFFECTS OF FEDERAL ADMINISTRATION PHASE-OUT ORDERS



RMP Process Components: Relative Investments

Funds[3] available for use by local RMPs constitute a valuable community resource for assisting and accelerating improvements in local health care service systems. The RMP processes for investing locally controlled funds are an important aspect of that resource.

RMPs invest their program resources[4] in two basic process components:

(1) *initiation of demonstration projects,* and

(2) non-project related *community development* activities, primarily by local professional staffs.

There are two kinds of *demonstration projects* in RMPs:

(a) *Pilot projects* include trial efforts or feasibility studies aimed at evaluating the potential of the project objectives prior to implementing a more substantial project.

(b) *Operating projects* are usually larger scale, externally operated demonstration projects based on the direct or indirect outcomes of pilot projects. Funds to support operating projects are awarded by Regional Advisory Groups to local health organizations to achieve specifically defined objectives; often projects are co-funded by other local, state and Federal agencies. Local RMP professional staffs maintain significant, frequent contact with operating projects in activities such as inter-project coordination, monitoring, evaluating, seeking continuation funding, and recommending (to Regional Advisory Groups) modification of objectives and rebudgeting of project funds which are not being expended at expected rates.

RMPs also provide other non-project related community development functions. The primary components of *non-project related community development* activities are:

(a) *Technical Assistance* activities include consultant and program staff time and costs used to fulfill requests by local agencies for assistance, for example, developing grant applications for new Federal initiatives. Technical assistance essentially is the sharing of RMPs staff and volunteer expertise with all other elements in the health services system;

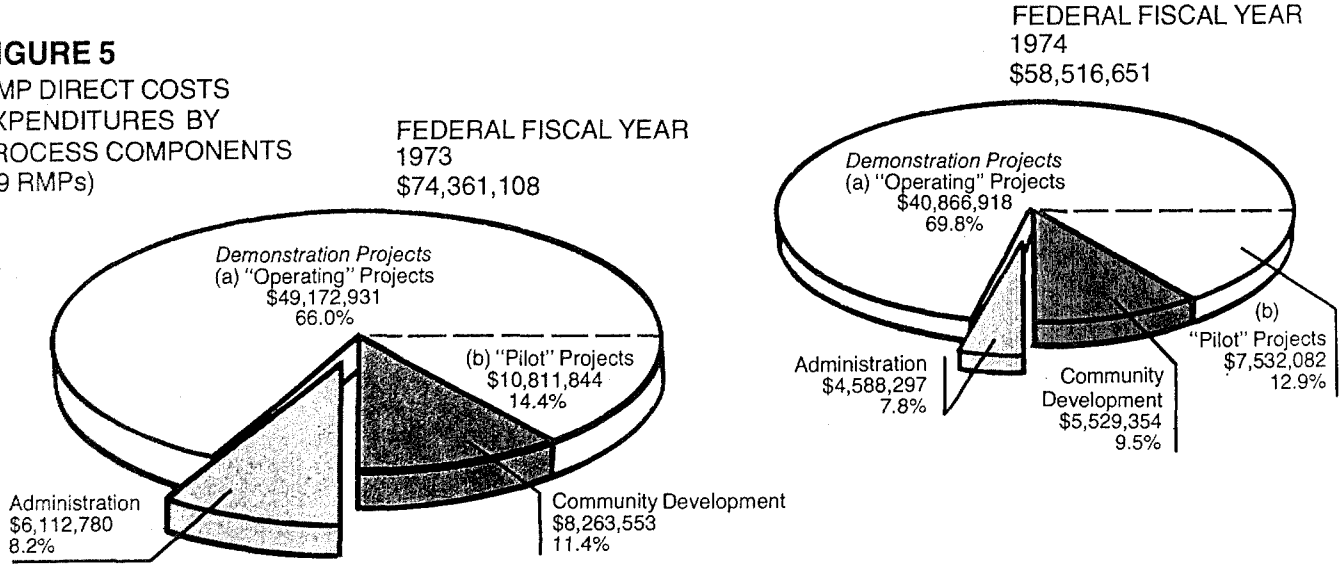
(b) *Convening/Facilitating*[5] activities include RMP efforts to assist local groups, agencies and others to form ad hoc and persisting cooperative arrangements or agreements and to develop a common local understanding of the implications of new Federal programs.

Convening/Facilitating efforts are directed toward specific results; e.g., continuation funding of RMP initiated projects or implementing locally suitable versions of new, Federal initiatives.

Direct costs associated with community development activities include both project related and non-project related activities. Figure 5 shows the relative costs of project activities and of non-project community development activities for each of the last two fiscal years. Direct costs used for local administration remain minimal, an indication of RMPs' organizational efficiency.

FIGURE 5

RMP DIRECT COSTS EXPENDITURES BY PROCESS COMPONENTS (49 RMPs)



[3]All dollar figures in this report are based on actual expenditures where figures were available or budget allocations where such figures were not available.

[4]Relative investments of RMP resources in local administration and in four major program areas (e.g., primary care, regionalization) are described in Section I.

[5]One description of RMP "Convening/Facilitating" functions is provided in an A. D. Little report, "Evaluation of Facilitation in the Regional Medical Program," May, 1973.

Additional RMP dollars ("indirect costs") are awarded to RMP grantees to support administrative expenses of operating in conformance with Federal guidelines. Indirect costs are reimbursed by DHEW to grantees on the basis of negotiated rates; RMPs have no direct control over indirect costs. For the 49 RMPs, grantee indirect costs were $7 million in Federal Fiscal Year 1973 and $4.2 million in 1974.

DEMONSTRATION PROJECTS: JOINT FUNDING AND CONTINUATION

Extensive community involvement frequently lends two unique strengths to RMP initiated projects:

(1) dollar costs of projects are shared by other organizations, allowing an enhanced level of operation; and (2) worthwhile project activities are continued through other financing mechanisms after RMP funding is completed, allowing reinvestment of scarce RMP funds in other needed health services improvements.

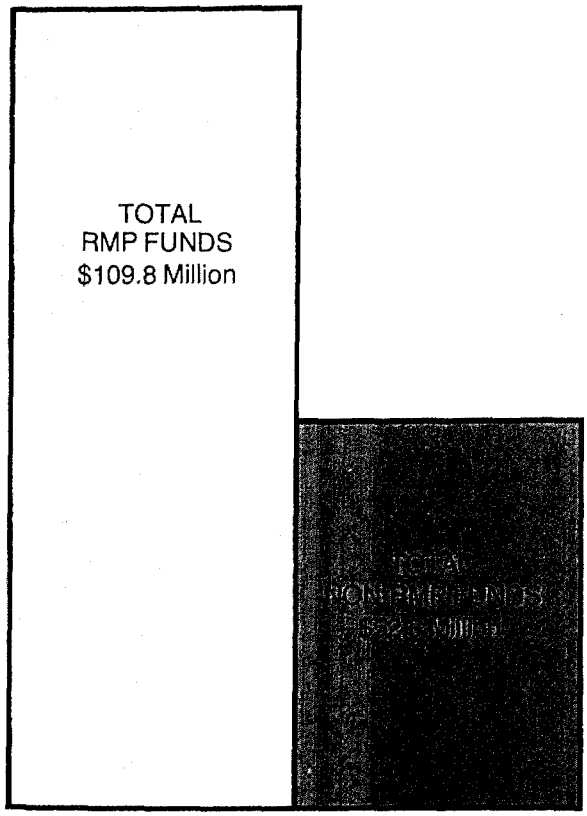
Joint Funding

Since July 1, 1971, RMPs have initiated and supported 1936 major demonstration projects. Demonstration projects result from extensive but relatively rapid local development and review; they are developed in response to community needs which are objectively verifiable. One indication of community commitment and participation in RMP demonstration projects is the number of other health orgainzations and agencies participating as co-sponsors and co-funders of projects. Joint funding serves not only to secure active involvement and financial commitment of the other agencies to RMP projects, but also allows an enhanced project operation *during* the time of RMP support. Joint funding often insures continuation of the project *after* RMP funding support is discontinued.

Since July 1, 1971, the 49 RMPs developed a total of $52.8 million of joint funding support for RMP initiated projects. Amounts of support by various joint funding sources are summarized in Figure 6.

FIGURE 6

TOTAL INVESTMENT IN RMP INITIATED PROJECTS — RMP AND NON-RMP FUNDING
(1936 Projects Since July 1, 1971)
(49 RMPs)

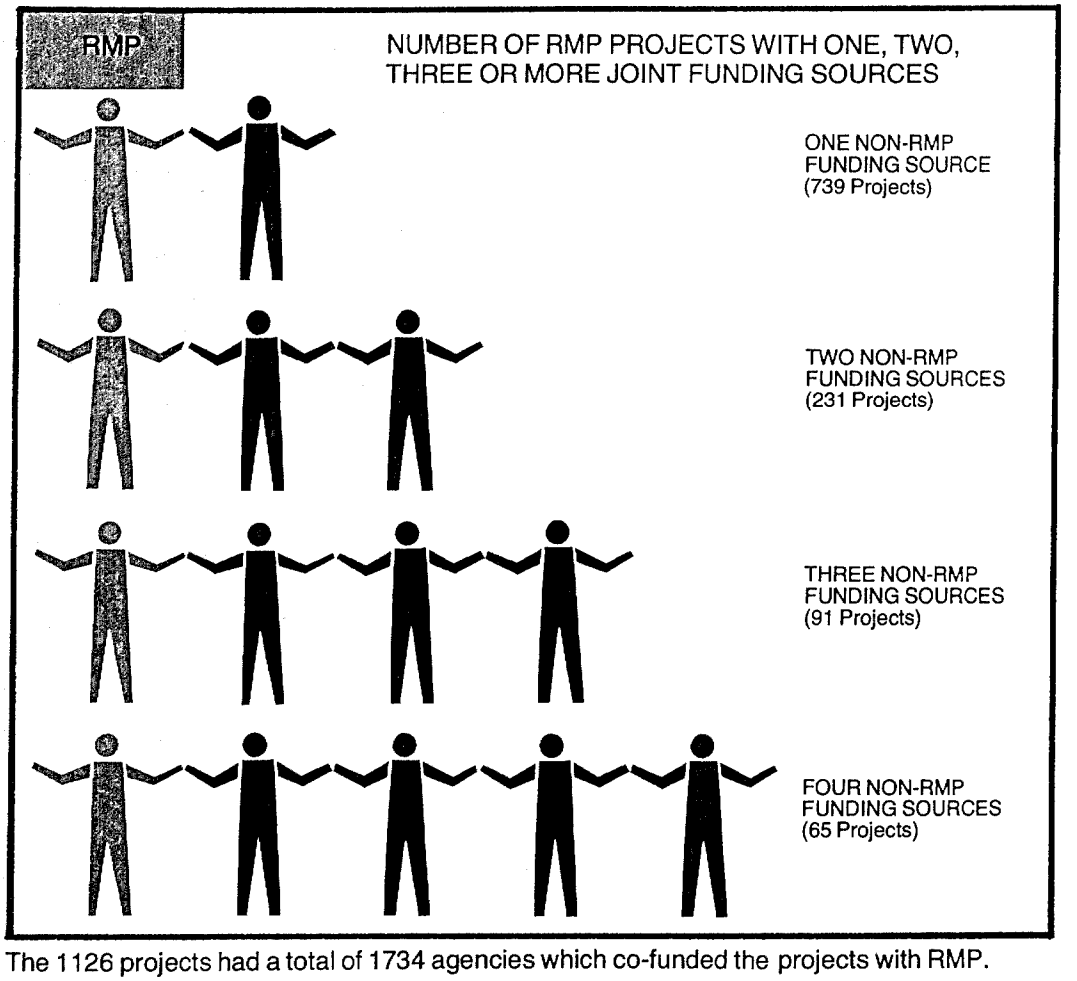


Participation by other agencies and organizations in sharing the dollar costs of RMP projects is substantial. Of the 1936 major demonstration projects initiated by RMPs since July 1, 1971, a total of 1126 projects were characterized by participation of one, two, or as many as four other community agencies.

Figure 7 shows the total number of sponsors which, singly or in concert, co-funded RMP projects.

FIGURE 7

DISTRIBUTION OF JOINT FUNDING SOURCES OF RMP INITIATED PROJECTS
(Since July 1, 1971) (49 RMPs)



The 1126 projects had a total of 1734 agencies which co-funded the projects with RMP.

Figure 8 shows both the numbers of co-funded RMP projects and the sources of funds used by the co-sponsoring agencies.

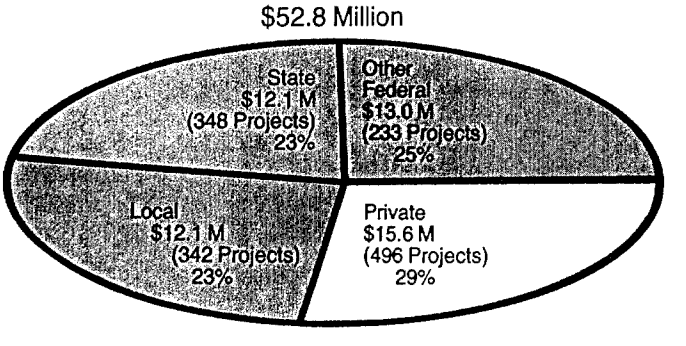


FIGURE 8

RMP PROJECT FUNDING BY TYPE OF JOINT FUNDING SOURCE
(Since July 1, 1971) (49 RMPs)

Continuation

"... to be maximally effective requires that most RMP supported endeavors make adequate provisions for continuation support once initial Regional Medical Programs grant support is terminated; that is, there generally must be assurance that future operating costs can be absorbed within the regular health care financing system within a reasonable and agreed upon period." *RMP Mission Statement* of June, 1971.

The willingness of other agencies and organizations to invest their own funds to continue services when RMP financial support has been completed is an important, concrete measure of the long-term worth of newly developed, expanded, or improved health services. As in the development of joint funding resources, the RMP record in this regard is impressive.

Over the past three years, RMP funding was terminated for 1732 demonstration projects, of which 557 were originally planned as "one-time" activities. Nine hundred seventy-four, or over 83 per cent, of the remaining 1175 projects initiated with the help of RMP funds, were continued with other funds following termination of RMP support.

FIGURE 9
NUMBER OF DEMONSTRATION PROJECTS
RMP SUPPORT TERMINATED
(Since July 1, 1971)

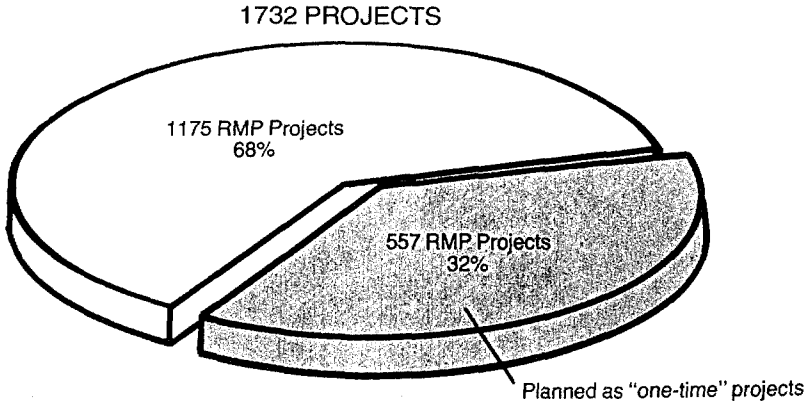


FIGURE 10
NUMBER OF DEMONSTRATION PROJECTS: CONTINUATION SUPPORT SOUGHT AND OBTAINED
(Since July 1, 1971)

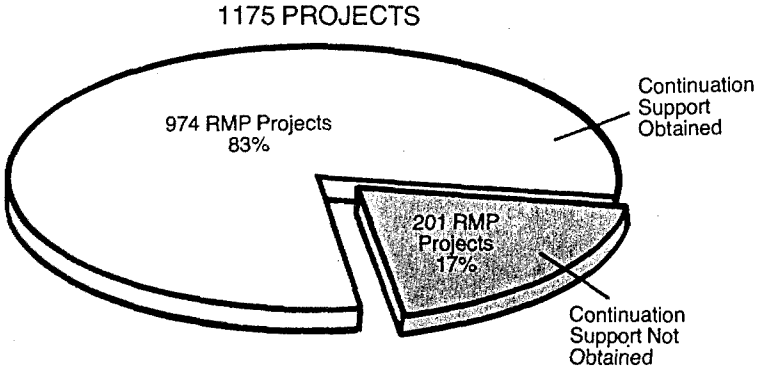
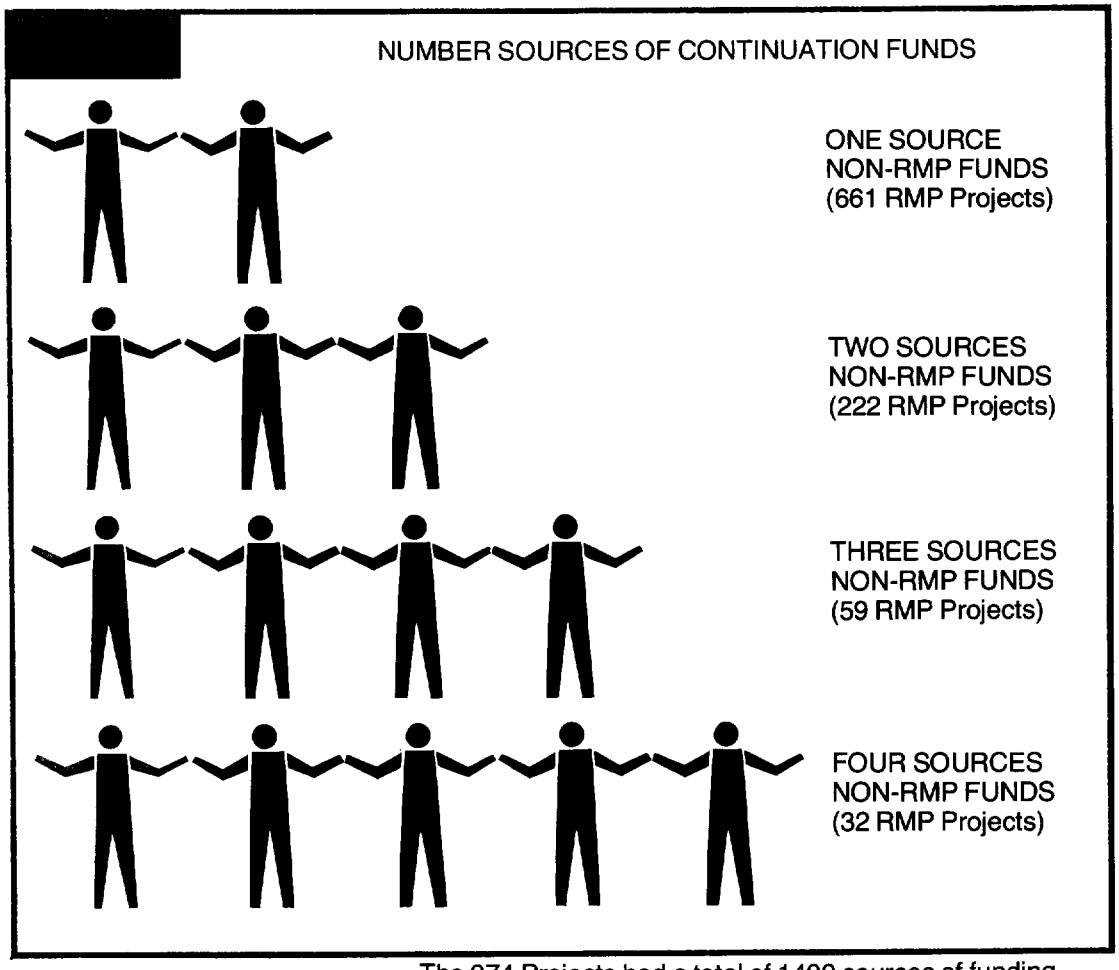


Figure 11 summarizes the number of single or multiple sources of one year continuation funding of projects.

FIGURE 11

NUMBER OF SOURCES PROVIDING CONTINUATION FUNDS FOR RMP TERMINATED PROJECTS
(Since July 1, 1971)



The 974 Projects had a total of 1400 sources of funding.

In a real sense, local communities and agencies have frequently "voted" with their dollars for the maintenance of worthwhile activities of RMP initiated projects. Continuation funds are supplied by State and local governments, other Federal agencies or programs, and private sources, including fee-for-services reimbursements by insurance companies and individuals. Approximately *one-third* of the 974 projects continued after termination of RMP funding *involved several sources of support.*

FIGURE 12

RMP PROJECTS AFTER RMP FINANCING COMPLETED: FIRST YEAR CONTINUATION FUNDING AMOUNTS AND SOURCES
(974 Projects Since July 1, 1971)

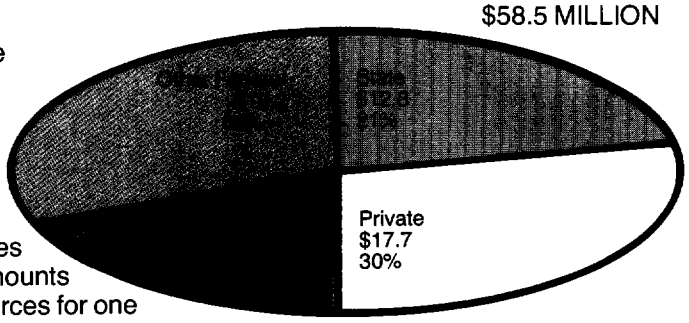


Figure 12 summarizes the relative dollar amounts from sponsoring sources for one year continuation funding of projects.

The success of RMPs in developing continuation support for improved services initiated as demonstration projects is due in part to the efforts of local RMP program staffs in planning for, and specifically building into projects those features that increase the likelihood of continuation support. In addition to rebudgeting surplus project funds as a result of effective fiscal monitoring, limiting the period of the RMP support, (usually to a maximum of three years) enables local Regional Advisory Groups to reinvest available funds to accelerate development of other activities and projects needed to improve local health services for people.

NEW HEALTH ORGANIZATIONS AND FORMAL COOPERATIVE ARRANGEMENTS

Creation of needed new health organizations or formal cooperative arrangements is a frequent outcome of RMP demonstration projects or technical assistance processes.

The RMPs (47) reported a total of over 6,000 occasions since July 1, 1971, where demonstration projects or substantial assistance resulted in the creation of "new health organizations" or "new formal cooperative arrangements" between elements in local health services sytems.

New health organizations include currently continuing clinics, rural health stations, medical care foundations, areawide planning agencies and expansion of services to underserved areas. *New formal cooperative arrangements* include additional needed health manpower training programs, shared services agreements and similar cooperative efforts to achieve greater efficiency of local health care systems.

Major occasions in which substantial RMP assistance was provided to create new health organizations or cooperative arrangements at the local level are described below.

Establishment of New Health Services includes occasions where the arrangements or organizations created resulted in the provision of health services not previously available on a continuing, permanent basis; e.g., rural health stations, neighborhood health centers, health screening stations, out-patient clinics, pre-paid health service plans.

Specific examples include:

. . . a Northeast RMP has established 6 new ambulatory outpatient clinics in a medically underserved metropolitan area where the population per square mile is almost 50,000 people; nearly 45,713 patient visits have been recorded since the first unit was opened on November 7, 1972. As a direct result of these ambulatory clinics, utilization of hospital emergency rooms as the place of primary care has decreased by fifty per cent.

. . . a medically underserved area, which has only *eight* physicians serving a population of almost *19,000* was given a boost by a Western RMP in establishing a clinic, the *Centro de Salud,* which has served 2,400 people since its August, 1973, opening;

. . . another Western RMP supported training and placement of 13 family nurse practitioners who have served 9100 isolated rural patients since completing training.

New Health Organizations Created includes creation of new local organizations and cooperative arrangements for health planning, manpower, and health service development. Examples include "area-wide comprehensive health planning agencies", Experimental Health Service and Delivery Systems, manpower training consortia, and quality assurance organizations.

. . . an RMP in the South Central United States supported the development of six health planning agencies with dollars, staff and facilitating efforts; all six are currently approved CHP (b) agencies. Four other CHP agencies are currently in advanced stages of development and will complete comprehensive health planning coverage of the entire state.

. . . RMPs in the Pacific Northwest and in the South acted in primary leadership roles to create statewide consortia of private and public health interests to implement coordinated, statewide comprehensive cancer control programs.

Formalization of Sharing of Existing Resources includes occasions when two or more local health care facilities formalize agreements to jointly support staff or related services, common purchasing and billing arrangements, or regionalization of specialized health services.

. . . a Midwest RMP fostered the development of ten distinct "Cooperative Resource Sharing Groups" primarily to cooperate in the provision of in-service education programs. Sixty-eight institutions, comprised of 60 of the state's 110 hospitals and 8 nursing homes, are currently participating in the program. The estimated savings due to sharing of audio-visual resources and in-service instruction time amounts to $171,200. In addition, spin-offs due to this cooperative effort have had a unifying effect on other areas including shared purchasing, services and personnel.

. . . an RMP in the Northeast developed agreements among 23 of 50 hospitals in the Region to support a coordinated tumor registry for an investment of $184,975 (through December of 1973) and modest amounts of staff time. The goal of this project is to serve cancer patients by stimulating continuity of care and to promote continuing physician education and train medical records personnel in a specialized form of record keeping to improve patient followup.

Establishment of New Training Programs includes assistance to educational institutions, health organizations and facilities in the development of new health manpower training programs needed and supported financially at the local level.

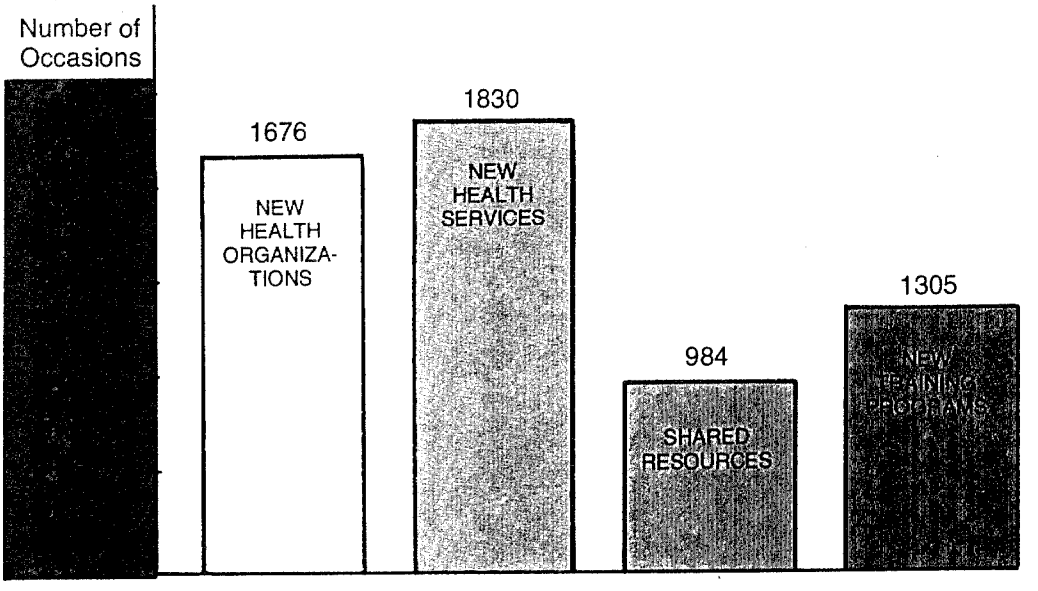
. . . an RMP in the West created a statewide corporation representing all health professions to provide needed continuing education on a self-supporting basis. Since its creation, the organization has provided planned continuing education experiences for over 9000 health professionals who are essentially isolated from large medical centers or other resources for assistance in maintaining current competence and developing new skills.

. . . an RMP in New England was instrumental in creating and guiding the development of a statewide manpower training consortium. Since its inception, the consortium has installed 3 needed "mid-level" practitioner training programs, graduated 60 needed health professionals, and moved effectively toward the establishment of a continuing university-based, integrated training effort of these types of personnel.

Figure 13 summarizes the occasions that RMPs provided substantial assistance to local communities in creating new health services or supportive organizations and formal cooperative arrangements described above.

FIGURE 13

NEW ORGANIZATIONS OR FORMAL COOPERATIVE ARRANGEMENTS CREATED: RMP TECHNICAL ASSISTANCE OCCASIONS
(Since July 1, 1971)
(47 RMPs)



RMPs described several specific methods and activities used in providing assistance in creating new organizations and formal agreements. Included are:

— Provision of direct RMP financial assistance;

— Assistance in securing non-RMP financial support;

— Assistance by "loaning" or "detailing" RMP program staff for a short period of time;

— Provision of specialized staff technical expertise and/or external consultants;

— Assuming leadership in providing the initiative to convene interested and necessary principals.

— Securing the cooperation and support of others.

The numbers of occasions RMPs used these specific methods while assisting in the creation of four kinds of new health organizations and cooperative arrangements are summarized in Table XIV.

TABLE XIV

USE OF TYPES OF RMP ASSISTANCE IN CREATING NEW HEALTH ORGANIZATIONS & FORMAL COOPERATIVE ARRANGEMENTS
(Since July 1, 1971)
(47 RMPs)

TYPES OF ASSISTANCE	New Health Organizations	Totals
Prof/Tech Assistance Consultation	2765	5713
Convening Necessary Principals	1755	3282
Helping Secure Cooperation	1600	3024
Direct Financial Assistance	481	1827
Help in Securing Funds	407	1105
Detail or Loan of RMP Staff	243	851

RMPs assisted a wide array of local agencies and professional associations in joint efforts to develop new health organizations, services and agreements.

The number of occasions other local agencies received substantial assistance in developing such resources are summarized in Table XV.

TABLE XV

OCCASIONS OF TECHNICAL ASSISTANCE PROVIDED OTHER AGENCIES IN DEVELOPING NEW ORGANIZATIONS AND FORMAL ARRANGEMENTS

(Since July 1, 1971)
(47 RMPs)

AGENCIES ASSISTED	New Health Organizations	New Health Services	Sharing Resources	New Training Programs	Totals
State and Local Medical Societies	306	278	109	178	871
Other Professional Associations	246	209	137	250	842
Volunteer Health Associations	238	319	287	204	1048
State and Local Health Departments	306	552	403	196	1457
Comprehensive Health Planning Agencies (A and b)	308	289	151	159	907
Educational Institutions	370	298	261	545	1474
All Others	371	544	852	424	2191

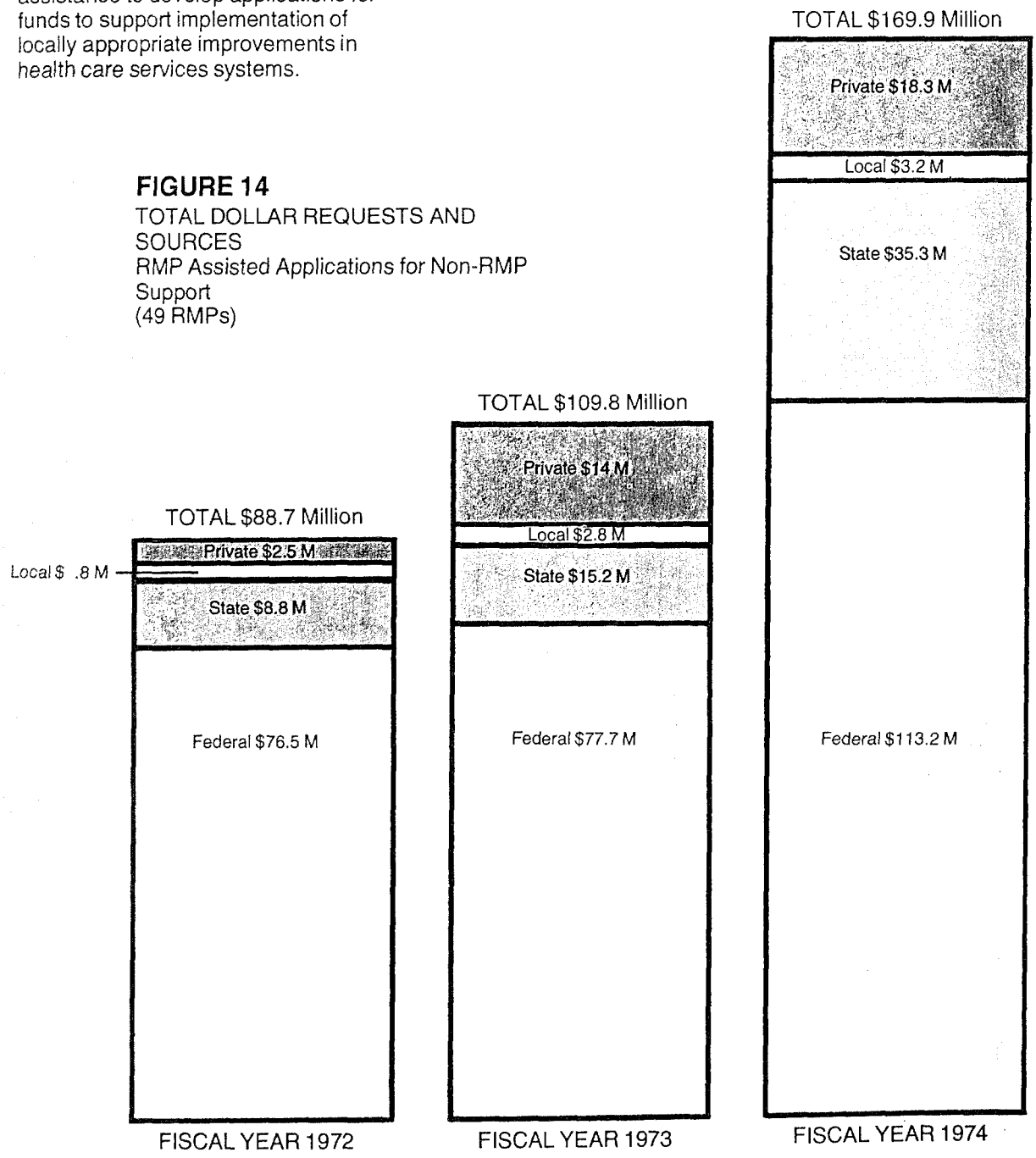
DEVELOPMENT OF RESOURCES FOR LOCAL SERVICES IMPROVEMENTS

Another major outgrowth of RMPs' community-based process has sometimes been described as a "broker" role. RMPs' carefully constructed, effective working relationships with major segments of the private and public sectors provide a basis of confidence which underlies numerous requests for technical assistance to develop applications for funds to support implementation of locally appropriate improvements in health care services systems.

RMPs provided substantial technical assistance in preparation of applications for non-RMP funds to a wide array of local agencies and organizations. From July 1, 1971, to January, 1974, the RMPs assisted local agencies and organizations in preparing a total of 1,135 applications for funds for health services improvements from (non-RMP) Federal, State, local and private funding sources.

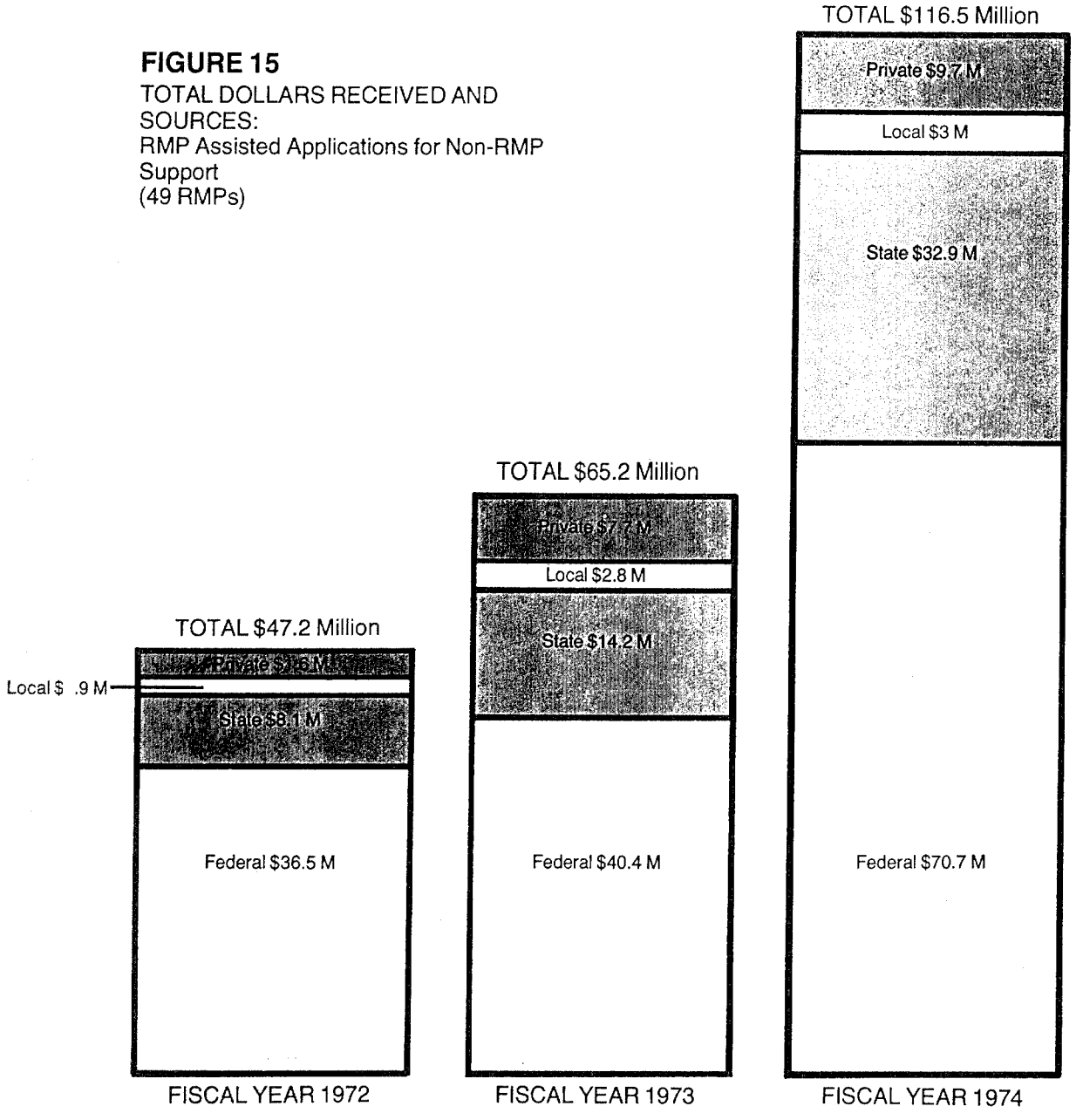
Application requests totaled over $368 million, a sum whose magnitude is indicative of a major development effort. Figure 14 summarizes the amounts requested from each non-RMP funding source.

FIGURE 14
TOTAL DOLLAR REQUESTS AND SOURCES
RMP Assisted Applications for Non-RMP Support
(49 RMPs)



One indirect measure of the worth of RMP technical assistance is the dollar amount of the non-RMP awards actually made to local agencies and organizations assisted in the preparation of applications. Figure 15 is a summary of the total dollars in non-RMP awards received by local health organizations in cases when RMPs provided substantial technical assistance in developing the application.

FIGURE 15
TOTAL DOLLARS RECEIVED AND SOURCES:
RMP Assisted Applications for Non-RMP Support
(49 RMPs)



While the specific purposes for which non-RMP funding was sought have not been enumerated, in many cases, applications were for funds to support continuation of RMP projects or for the creation of new local health care services organizations or formal cooperative agreements previously described.

Total dollar volume of applications does not, in itself, adequately describe RMP assisted improvements in local health care services or the RMPs community development role. However, inferences about the dollar volume may be drawn from three perspectives:

(1) *The community perspective:* RMPs have provided substantial assistance in effective project planning and review, and have successfully played a major role in developing needed additional fincancial resources for local health improvements.

(2) *The Federal perspective:* The necessity has been reduced significantly for creating new bureaucracies to implement new programs in a locally acceptable and valid manner.

(3) *The RMP perspective:* Provision of technical assistance to develop applications for other agencies insures the continuation of RMP initiated improvements, enhances RMP program operations through coordinated community efforts and establishes a mechanism for maintaining effective working relationships with the widest array of local health interests.

COMMENT

In addition to improving services to people the RMPs have developed a community-based process which is an effectively functioning model of a federally supported, largely locally controlled implementing agency which has major impact on local health care services systems.

The RMPs remain a major National resource capable of prudently and effectively assisting local communities to implement expanded health services for people.

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