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Commissioned Officer Policy Task Force - RMP Review  
Dated August 24

Dr. Robert van Hoek  
Associate Administrator for Operations

I appreciate the opportunity to read this document and feel that it basically points out some extremely important features of RMP to which we should devote substantial attention. While at times the conclusions reached concerning either the cause or the necessary remedy may be in need of further refinement and elaboration, nevertheless the issues are well selected.

I do think that a copy of this document should go both to our special consultant group and to the RMP Council and hope you will arrange for this.

In addition it seems to me that there would be some benefit in having a meeting with this group itself and perhaps you and Dr. Margulies could arrange that meeting for me along with any other members of the administrative staff who might like to participate.

/s/ Vernon E. Wilson, M.D.

Vernon E. Wilson, M.D.  
Administrator

cc: Dr. Fred Featherstone  
~~Dr. Harold Margulies~~  
Dr. Marshall Keyes

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE  
PUBLIC HEALTH SERVICE  
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: August 24, 1970

Reply to  
Attn of:

Subject: Commissioned Officer Policy Task Force Report

To: Harold Margulies, M.D.  
Acting Director, Regional Medical Programs Service

The Commissioned Officer Policy Task Force has completed a review of the present structure of Regional Medical Programs Service by focusing specifically on the review process. In doing so we attempted to anticipate the consequences of the FAST Task Force Report, Anniversary Review and potential consequences of new legislation.

In the attached report we attempted to raise the key questions and issues which we believe RMPS must face if it is to be a relevant program. In addition, we raised some of the inherent problems of the past and suggested alternatives and points of leverage to improve the present situation.

We fully realize that this report is not a panacea, but we have suggested future alternatives open to RMPS.

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Attachment

Commissioned Officer Policy Task Force Report

Contents

Introduction -----	1
RMPS Leadership -----	7
"Cooperative Arrangements" as a goal -----	9
Specific RMP Goals -----	11
The Review Process -----	13
Anniversary Review -----	13
FAST Task Force Report -----	14
Points of Leverage -----	18
Core Staff -----	18
Technical Review Group -----	25
Regional Advisory Groups -----	26
Federal Review Panels -----	32
Review Committee -----	32
Site Visits -----	32
Type V Reviews -----	34
Summary -----	37

## INTRODUCTION

It has become common knowledge that America has a national "health crisis." That the crisis is age-old and continuous few dare admit. Although organized medicine and government have now recognized the failures of U.S. health care, little significant action has yet been taken.

The poor have known about the health crisis from birth. Their standard of care has not improved in the last ten years, despite cries about the "health crisis." What has happened is that the incredible rise in costs of glamorous and uncontrolled technology has produced a "medical-industrial complex." This new power bloc, coupled with a rapidly decreasing number of family practitioners and a vast increase in size of major medical centers, has made medical care prohibitively expensive for many people. At the same time, philanthropy and local government have become unable to meet the growing need for expanded health care. The health legislation of the sixties covered the costs of, and indeed opened the floodgates to, an unparalleled inflation. But this inflation has brought almost no increase in service or health personnel and has not alleviated the crisis. Many feel that the health establishment has used the specter of the "health crisis" to further its own ends.

Within organized medicine different interest groups abound -- including the AMA, the AHA, the medical scientists and medical centrists (represented by Dr. DeBakey and Mary Lasker). Within the overall facade and loyalty

of medical professionalism, there are the usual contentions and struggles for control by particular subgroups. The history of the DeBakey Commission illustrates the failure of one of these subgroups--the medical scientist-academician clique--in its bid for control of the bigger pie. PL 89-239 brought RMP under the dominant influence of organized medicine. The struggle between these and other power blocs has determined the shape of RMP today. This report is an attempt to come to grips with the present situation and to consider improvements for the future. To do so, we must look objectively at the past.

One of the more remarkable aspects of the several bills which comprised the health legislation of the mid-sixties was the offering to each subgroup of organized medicine of a piece of the pie: the health scientists and medical university professors had Regional Medical Programs, the AMA and AHA had Medicare, city health and hospital departments had Medicaid, and state and county health departments had Comprehensive Health Programs. In the logrolling and competition that marked the legislative histories of these bills, it was the American Medical Association that fought the hardest and gained the most, along with the voluntary hospitals. RMP directly threatened the primacy of the AMA by creating a federally financed three billion dollar program which was to be controlled by researchers and clinical scientists, the group least susceptible to AMA influence. Of all the legislation of the sixties, RMP suffered the most at the hands of the AMA. In fact, it was the agreement to remove all binding authority from RMP that bought off the AMA's opposition to Medicare. In the words of the then AMA president,

James Z. Appel, "Most medical leaders felt that the establishment of the series of medical complexes initially conceived would have had a more serious long-term effect on medical practice than the recently enacted medicare law." And even after some 20 amendments to the RMP legislation made by the AMA were accepted by the administration, the AMA still refused to support the bill.

The key statement describing the effect of the AMA's stand on the RMP legislation was made by the Committee on Interstate and Foreign Commerce of the House (House Report No. 963) in whose chambers the power struggle for control of the bill had been waged: "The Committee has been very careful to establish machinery in the bill which will insure local control of the programs conducted under the bill. The committee wishes to emphasize that this legislation is intended to be administered in such a way as to make no change whatsoever in the traditional methods of furnishing medical care to patients in the U.S. or to financing such care."

In the end, only one of the 35 recommendations of the DeBakey Commission report remained to constitute the Regional Medical Programs: "Through grants to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, and stroke and related diseases." Cooperative arrangements were therefore to be the means by which "the advances in the diagnosis and treatment of these diseases" would be made available to patients and

the means "to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or the methods of financing of patient care or professional practice, or with the administration of hospitals . . ."

The final draft of the bill provided for advisory group review -- the RAG. By having the advisory group consist of representatives of all the possible shades of persuasion within the health establishment, and by excluding the consumer representations, the bill vested power in the local health bureaucracies, stifled initiative, and insured the status quo. Because this check on program initiative rested at the local level, the value of national leadership was severely undercut.

Passage of the legislation was not greeted with enthusiasm, because by then RMP was nobody's baby. Medical schools and research centers stood to gain little in power or dollars from the Bill. Moreover, they were being asked to forfeit, for dubious benefits, their ivory tower isolationism and circumspection by associating with small hospitals and medical societies from which they had long remained aloof. Besides, their main concern was the fulfillment of their own needs -- finding support for research and faculty and obtaining money for the continuous growth of their staffs and facilities. RMP offered little more than an occasional piece of equipment or partial support for a few faculty on regional core staffs. Even as the long-searched-for base from which to build a medical school - research institute lobby in the Federal government, RMP promised little.



In fact, the only groups that stood to gain anything were precisely those that had most vehemently opposed the original DeBakey Commission report: the private medical practitioner, as represented by the AMA, and the small and resource-poor hospital. At least they could avail themselves of coronary care units or occasional continuing education courses.

The reality of Regional Medical Programs was thus a spineless hodgepodge of 3 billion dollar rhetoric, isolated regional bureaucracies, 50 million dollars (first year) for execution and a system of internal checks and balances that stifled all initiative. It is not necessary to repeat the subsequent history of RMP to recognize its failure. It is necessary to examine its present structure and behavior in the light of the past so that we can pose the questions whose answers will reveal the possibility of future success. And RMP's problems appear to be getting more complex, rather than simpler, with the passage of time. Administration moves to merge RMP with CHP, the growing emphasis on the comprehensive rather than categorical approach to health, and the recent primary defeat of Senator Yarborough all indicate a different future for RMP. The realities of anniversary review and local evaluation and approval of projects as directed by the FAST Task Force could substantially change the relationship between Division and the Programs and result in a lessening of any remaining potential for making RMP an innovative program.

This report can in no sense be taken as a final document. Our contention is that the relevant questions about RMP have rarely been raised. If this document is useful, it is only so because these questions

have been posed, and the beginnings of a methodology for their answers outlined. Bureaucracies move of their own inertia. A delay in the establishment of a new direction while that direction is being sought, is of less consequence than a headlong move on a new tack without benefit of some guidance system. It is our intention to scrupulously raise the issues that lead to that strategy, and where possible, to explore some alternatives open to RMPS. Finally, to be honest in our analysis and not rob it of its potency, we cannot rule out the possibility that RMP may not be the vehicle for achieving needed change. . . that new wine just does not fit into old bottles.

RMPS LEADERSHIP

If RMP is to become a more relevant program then leadership must be exerted from some source to guide the Programs into new directions. And yet, from the historical background just outlined, it is clear that the obvious source for that leadership - RMPS and its Director - has been blocked from exerting effective leadership. In addition, there is ample evidence that the Division has not exerted the maximum degree of leadership possible even within the constraints of the legislation. Now, at a time when renewed effort must be made to strengthen that leadership, to get around old impediments, RMP is faced with a new dilemma - decentralization. Will the decentralization of responsibility and authority from the Division to the Programs, as inherent in the FAST Task Force Report and Anniversary Review, strengthen or weaken the Division's hand in ensuring that Programs improve the quality and relevancy of their activities?

It is a basic tenet of the RMP legislation that there is a virtue in decentralized, non-federal organizations developing regional programs. We share both that theoretical assumption and the fear of an unwieldy centralized bureaucracy attempting to impose a rigid "blueprint" on every section of the country. We believe that there is at least as much talent, motivation and good will in the Programs as in the Division. But at the same time, we believe that the central agency (The Division) has a clear and urgent role in setting basic standards and directions for the various Programs.

To some extent, a "hands-off" approach by the Division may have been required to overcome initial fear and hostility in the early

stages of regional development . However, it was a mistake to place so much emphasis on projects -- which could be submitted at any time, in any form, and without reference to any regional plan -- and so little emphasis on first developing adequate regional plans. Although there are some Programs who feel the Division is already too directive and intrusive, many more Programs are calling for more direction, clearer Guidelines, and professional assistance. The permissive attitude that may have helped initiate the Programs will not help sustain them.

Yet, at the same time more central direction seems to be required, we are in the process of decentralizing authority. How can the two be reconciled? The centralization-decentralization controversy is hardly new to government or to business. Many management studies and doctoral theses have been devoted to this issue. It is perhaps the central issue of government today: How can the government develop a sense of identity and responsibility in local communities and take advantage of local knowledge and initiative, while at the same time developing a cohesive, equitable and efficient national program?

There is much confusion surrounding this issue. Surely, President Nixon and the parents in the Ocean Hill-Brownsville School District are not thinking of the same thing when they laud the merits of decentralized authority. Surely, those who are "closest to the problems" of a community are also most exposed to corrosive local pressures. It was not through the efforts of local authorities "closest to the problem" that there are nine times more black voters in Mississippi today than there were in 1965.

There is less confusion about what decentralization means for RMP. The outlines of Anniversary Review and the FAST Task Force report are fairly clear. We will attempt to consider the implications of decentralization and show how stronger central leadership can, nevertheless, be exerted.

First, however, we must examine the goals of RMP. In keeping with the spirit of the legislation, the independence of the Programs was considered paramount. Not wishing to be overly directive, neither the National Advisory Council nor the previous directors established specific goals. Under the guise of "cooperative arrangements," RMPs were free to develop programs and projects of their own choosing.

It has now become apparent that the desirability of cooperative arrangements and the absence of specific RMP goals must be re-evaluated.

#### Cooperative Arrangements as a Goal

PL 89-239 described the goal of the Regional Medical Programs as the establishment of "regional cooperative arrangements." Theoretically, the CORE staff is always working to establish such arrangements. Acting as "brokers" they may encourage different elements of the health community to work together. Each operational project is supposed to include and promote such arrangements.

Programs may develop a project proposal specifically because it promoted a "cooperative arrangement." More often, projects attempt to "involve" a powerful local institution. In these cases, the "cooperative arrangement" is often concocted as an afterthought to make the project more acceptable to RAG's and to the National Advisory Council.

Cooperative arrangements have rarely been bought. The use of seed

money to buy cooperation has usually bought names rather than genuine commitment to RMP. Where lack of cooperation exists, there are definite reasons, and dissolution of the obstacles requires more than a facilitating RMP effort. Often even money is not enough to encourage cooperation (e.g., Medicare, Medicaid opposition by the AMA).

There have been two major difficulties in connection with the creation of "cooperative arrangements." First, the Law, the Guidelines, the DRMP staff and the National Advisory Council have never defined such an arrangement: Adequate descriptions of these arrangements have not been required by DRMP nor supplied by the Programs. Consequently, federal reviewers and the Director are hard-pressed to determine the value of such arrangements in a project proposal. Secondly, even if the arrangement effectively coordinates the activities of several institutions, it is the resulting activity which must be evaluated. Put another way, if the coordinated effort is not directed toward solving the region's most urgent needs, it is not worth supporting.

This introduces a more basic question: Are "regional cooperative arrangements" a goal in themselves or are they merely a method by which goals can be achieved? We believe that "cooperative arrangements" should not be a goal. Rather, once goals have been set, cooperative arrangements become a methodology -- or part of a methodology -- for reaching those goals. There is no need to define a successful or unsuccessful cooperative arrangement. There is need only to define success or failure in reaching a specific, predetermined RMP goal. Only in this context, as a methodology for achieving a predetermined goal, can cooperative arrangements be accepted as a function of RMP.

Specific RMP Goals

From its inception RMP has been characterized by global, unrealistic objectives. Its original goal, nationwide improvement of health care in heart disease, cancer and stroke through voluntary cooperative arrangements, could not be achieved under the legislation.

The time has come for the establishment of specific goals. We feel it is both politically and ethically necessary for RMP to address itself to more pressing specific problems. Selecting high priority goals will hardly destroy local initiative. It is the Programs which must develop the projects and determine who will be involved and how the activity will be carried out. In addition, available funds are limited and if impact is to be achieved, funds must be concentrated in fewer activities.

The establishment of specific national goals would represent a change in the relationship of the Director and National Advisory Council towards the Programs. The Director and the Council must consider carefully how directive they wish to be. Notwithstanding past regional independence and future decentralization, we believe that there can be no excuse for continued failure to define specific RMP goals and provide substantial Federal direction.

In developing these goals one must consider two basic approaches. One is to set a number of very specific goals to which all Programs must adhere. The other is to set a number of broader priorities within which Programs must work. We believe the latter to be a more acceptable alternative, as it would allow the Programs more freedom in selecting priorities and methods for program and project development.

In the development of criteria for the selection of these goals, the following should be considered:

- a. Goals should be in keeping with the priorities outlined in the HEW five-year plan.
- b. Goals chosen by the Division or the local Program should be those in which RMP can realistically expect to exert influence and affect change.
- c. Goals should ideally be areas in which innovative but proven solutions to problems exist and are not widely employed. RMP should avoid activities which require extensive research and development.
- d. Goals and activities should be such that they have more than local potential and can be used in many places.

As some possible goals we suggest:

1. Training and expanded utilization of the nurse-practitioner.
2. Training and expanded utilization of the community health aid.
3. Expansion of automated health testing multiphasic screening in the context of comprehensive care.
4. Widespread implementation of the Weed Problem-Oriented Medical Information System.

These activities represent proven methods for the improvement and expansion of health services. They offer immense potential for improving the quality and quantity of health care provided to many people. Other similar activities could be proposed which would be appropriate, high-priority goals for RMP. Development of a list of such activities would be one possible task for commissioned officers.



THE REVIEW PROCESS

The most important factor in implementing new RMP goals is the review process. We will now examine the review process in light of the impending realities of Anniversary Review and the Recommendations of the FAST Task Force. The strictness of judgements made at all levels of review will determine how definitely RMP is able to move in new directions. Through judicious use of its points of leverage, RMPS and its Director can maximize the strength of central leadership.

Anniversary Review

We should be clear about what Anniversary Review does and does not do. Anniversary Review alone (without the developmental component) does not offer new responsibility and authority to a Program; in fact, it reduces a Program's flexibility in charting new directions through the submission of new project proposals. Furthermore, Anniversary Review does not guarantee that regional planning will improve or that project proposals will relate more closely to that plan or to the relevant health needs of the region.

Anniversary Review does structure the review process in a more rational way by insisting that overall program plans and individual project proposals be considered together. Anniversary Review will improve RMP only if the Core staffs improve program planning and project relevance and only if federal reviewers take advantage of the more rational review process to insure regional cooperation towards pre-determined goals.

It is the developmental component and not the Anniversary Review process itself, which allows Programs significantly more authority and responsibility. The Program would be given a pot of money which it could use with great latitude, informing the Division after the fact. This flexibility more than offsets the restrictions placed on Programs by Anniversary Review. The Developmental Award is a potent tool for any Program which gets one. It can allow for the kind of rapid action not possible in most bureaucracies and yet so often necessary for effective, relevant action. Or it can become a "license to steal" -- a pot of money which the local power blocs begin to vie for. The acceptance of a Developmental Award poses significant problems for Coordinators and Regional Advisory Groups as it will subject them to more pressure than ever.

Because of this potential for significant benefit or harm, the handling of the developmental component becomes particularly important for the Division. How can the Director and the Council monitor the use of these funds? We will discuss this question later.

#### FAST Task Force Report

The major change which the FAST Task Force will impose on RMP is the prohibition of project review at the federal level. The requirements that projects be seen by CHP and the HEW Regional Offices are not significant changes in themselves, although they represent the potential for significant change. It is the diminished federal role in reviewing project proposals which has significant implications for quality control.

Do we need federal review of individual projects to assure their

technical quality? The FAST Task Force argues that since the RAGs approve only about 60% of the proposals, and that since this is approximately the approval rate of other "reputable" review bodies -- such as NIH study sections -- this is adequate proof that project quality does not require further assessment at the federal level. We feel that this is an untenable assumption. Our panels and the Review Committee, are occasionally unanimous in feeling that a project proposal which has passed the RAG is of unacceptable quality. Their unanimity suggests that more is involved than a simple difference of opinion between federal and local reviewers. At the same time, the Review Committee and Council themselves often approve projects which are admittedly of poor quality on the grounds that "they nevertheless foster regionalization." In so doing, the federal review bodies are making the same error often made by local review bodies.

We might generally concur that the federal review process, as it has been working, has not filtered out significantly more poor quality projects than have been filtered out at the regional level. This does not mean, of course, that the federal review process could not become more critical. Nonetheless, it appears as if we are dealing with a fait accompli and federal review of individual projects will be largely discontinued as standard practice.

There is a more important question regarding the federal review of individual projects, however. Projects must be considered not only for their technical quality but also for their role in describing and

developing the overall regional program.

This distinction between "project" and "program" -- or between "product" and "process" in the A.D. Little terminology -- is an important one, but is in danger of becoming a glib shibboleth. It is now "in" to emphasize program rather than projects and RMP is seldom considered just another organization for project grant funds.

But what does this all mean? Surely, projects can not be disregarded. They constitute approximately 60% of RMP grant monies. A few Coordinators have stated that their Programs could do without project grants, since the meaningful work being done in their region was the "broker" function of the Core staff. But most Coordinators for various reasons, place great stock in project grants. Some undoubtedly can not shake the NIH concept of individual grants for individual activities, or the attendant prestige of having "a grant" for a given activity. Others believe that the planning and brokerage functions are important but they feel that planning without subsequent "action" (i. e. projects) is sterile. They feel that serving only as a broker casts them in the role of the impotent guy who always has advice for others but never accomplishes much himself.

We agree that project grants are important and that greater emphasis should be placed on approving projects which relate to, and develop, the overall regional plan. Thus, it becomes crucially important that Anniversary Review consider projects in this light.

Several very major problems arise at this point:

How do the federal reviewers and the local Programs determine what constitutes an adequate regional plan into which projects can fit?

The absence of standards has led to bewildering inconsistency. Whether a Program was deemed to have an adequate plan or effective cooperative arrangements has depended on who the primary reviewer was and how late in the day the review took place.

The Division has hesitated in determining these standards for fear of appearing arbitrary, and because the task is so difficult. Of course the setting of standards is difficult, and to some degree arbitrary. But in the absence of such standards, Anniversary Review will become useless and the Regional Medical Programs will become moribund.

If such standards can be developed, then the federal reviewers can meaningfully consider individual projects and their relationship to an overall program. That is, the federal reviewers can do this once every three years when an in-depth program review occurs. The FAST recommendations allow for project review to this extent. But what about the intervening years?

This is a tricky question. As we understand it, a Program on Anniversary Review but without a developmental award would be unable to begin new projects -- whether or not additional funding was provided -- unless Council approved them. A Program could come to Council for approval of new projects only once a year. But the FAST report states that Council should not perform project review in the intervening years. What does this mean, practically? Could a Program begin a project which had been approved by its RAG, using unexpended monies from other activities rather than new money, without Council approval? FAST seems to say yes, while the Anniversary Review guidelines clearly say no.

What about Programs which have a developmental award? Here the Anniversary Review guidelines and FAST recommendations correspond better. The Program with a developmental award could begin new projects without Council approval.

In either case, it will be harder for the Division to assure that projects are either technically sound or relevant to the Program's overall plan. How will it be possible for the Director, Division staff, or the federal reviewers to help assure that this new decentralized responsibility is used appropriately?

#### Points of Leverage

There are several points of leverage which the Director and the Council can use to exert leadership and assure improved project and program quality while at the same time allowing for a decentralization of authority. These will be discussed in the following sections on Core Staff, Technical Review Groups, Regional Advisory Groups, Federal Review Panels, Review Committee, Site Visits and Type V Reviews.

#### Core staff

The Division and Council should begin looking more closely and systematically at Core staffs. There can not be any blueprint for an "ideal" Core staff, yet there are clearly certain types of people who should be on Core staffs or available for substantial consultation: clinical specialists, educators, epidemiologists, community health planners, and allied health professionals, in particular.

At the present time (1-1-70) the core staffs of the Regional Medical Programs include 1,363 persons (full-time equivalents). This includes 218 physicians, 66 RN's, 50 allied health and hospital administrators.

61 other health related professionals, 42 education specialists, 131 administrative and fiscal agents, 277 technical professionals and 518 secretarial and clerical employees.

The staffs within the program vary in size from a low of 2 and 12 to a high of about 135 in California, including clerical staff. The average core staff has 23 full-time equivalent employees. About one-third of the regions have less than 20 people for the core, while another one-fifth of the regions have over 40 people. In addition, about 70% of the staff are full-time and 30% are part-time. About 72% of the staffs are located in the central RMP office, 21% are institutionally based in medical schools, hospitals councils, etc....and 7% serve as field or subregional staffs. All but one Program (Susquehanna Valley) has a physician on its core staff. While most physicians serve on a part-time basis, most of the other professionals such as nurses, hospital administrators, and education specialists, serve on a full-time basis. At this juncture, it is difficult to determine what the staffing pattern should be for each Program; but we know that 13 Programs have no RN's on their core staff, 30 have no hospital administrator, 24 have no education specialists, and 34 have no allied health persons.

We reject any formula that states how large a Program's Core staff should be, whether in relation to the region's population, size, or funding level. But the norms for these variables should be determined, and Council should look closely at those Programs whose Core staff size falls clearly outside the norm. And, after the determination of core function is established, it should be possible to set minimal guidelines to aid Programs in developing their staffing pattern.

A major problem in some Core staffs is the productivity of part-time people. This is particularly true with part-time staff who are primarily medical center faculty. Such part-time support is worthwhile when RMP is subsidizing the efforts of a university medical center to become meaningfully involved in carrying out an acceptable regional plan. But too often RMP seems to be "buying the support and involvement of the University" by finding money for University faculty who have no real interest in contributing to RMP. This has been particularly true in some of the large metropolitan area, multi-medical school programs. RMP will ultimately help neither the medical schools nor itself by this kind of assistance to medical schools in a period of fiscal stringency.

To alleviate this problem, we recommend that the Core staff be predominately full-time personnel or part-time employees with allegiance to the Program. In regions where there is a scarcity of professional resources, the Program should have the flexibility to use available manpower. However, there should be some assurance that in exercising this option, the Program is fully utilizing the part-time professional. We can no longer tolerate large part-time staffs which only "foster" cooperation by paying someone's salary. The in-depth program and the "Type V" review by staff ought to develop methods for getting a clear picture of the contribution to RMP, in time and effort, of every Core staff professional, particularly part-time employees.

Currently, approximately 43% of RMP funds are devoted to the support of Core activities. If Core staff activity is viewed purely as administrative management or overhead costs of operating the Regional Medical



Program, then it is no wonder that Congress questions the effectiveness of such a program. However, at the present time there is no definitive way of separating Core activity among the 55 Programs. An activity that may fall within the Core budget of one Program, will be classified as a project in another. Many regions have deliberately played this "switches" game with Core activities just to be where the money is. For instance, public information and communications is generally accepted to be a Core budget item. However, the Division has also funded this as an individual project in the past. In addition some Programs have classified central regional services such as registries, data banks, and regional blood banks as projects while others consider this a Core activity. Such manipulation is done in many cases to make the program look good to its RAG members who cannot understand that Core includes more than mere administration and overhead. In other instances, the Program has heard that the Division is cutting down on Core funds and that they would be wise to change the activity into a project or vice versa.

Thus, we concur with the FAST Task Force recommendation that core staff funds be clearly differentiated between administrative management and core staff support for other program functions. Into the former category might go the Coordinator, the fiscal director, the staff person who coordinates the program evaluation and the public information director.

Into the latter category might go the health planners, epidemiologists, educators, and clinical specialists -- those people responsible for developing an overall plan, individual projects, feasibility studies, and performing the broker function. Given the variety of Core staffs, it

will be difficult to develop an overall outline of Core activities. However, RMPS could develop several large categories of activities common to all programs which would allow the Programs some freedom to separate Core staff in this fashion, and yet not be so arbitrary as to let each Program decide these categories itself. Having done this, the Division will be better prepared to defend itself against charges of having an unusually high overhead. We also will probably discover that, in some cases, the overhead is high.

While 50% of RMP funds for Core may be justified in some regions based on the fact that they are relatively new organizations, the new emphasis on program planning would necessitate greater emphasis on core staff responsibility towards defining true management abilities. Functionally, Core responsibilities include the administrative and professional activities relative to planning, decision-making, program development and support of the overall program.

The Core staff should have the capacity to assess the needs of the area that it serves. This function might well be coordinated with the CHP(b) agency in the area, the Department of Health, the HEW Regional Office, other state agencies such as Hill-Burton and the Welfare Department, and third party payers. It appears that most of the above agencies must perform some data collection to assess their needs, and coordination and collaboration between them would serve to eliminate duplication and to reduce costs. In the event that the Core staff does not have the ability to assess its local needs, or falters in this process, RMPS should provide the Program with the necessary methodology and inform them where such resources do exist. For the most part, these resources

should be drawn from the other Regional Medical Programs on a consultation basis.

Inasmuch as RMP is provider-oriented, the local advisory groups that several Programs have established should be consumer-oriented and should serve the Core staff in developing a list of needs for the region among its other functions. In some cases, the RMP's have developed new groups to serve as LAG's, while others have used the 314(b) agencies for these tasks.

Given the priorities of HEW and newly developed, more specific RMPS Goals, the Core staff should then be able to develop a list of the region's priorities, considering their needs in relation to these federal priorities. This would constitute the framework within which an overall program for the region could be established. Although almost all of the Programs are presently operational, and such an exercise would appear to be characteristic of the planning phase, experience has shown that very few Programs have this conceptual framework. This framework would also appear to be mandatory in light of Anniversary Review. Furthermore, it is only within such a framework that the Programs could help develop projects to meet their needs.

Since many regions have neither the talent nor the inclination to make their programs responsive to a plan based on objective data and priorities, RMPS can be most helpful by preparing a document outlining basic steps which are essential for relevant health planning. Preparation of such guidelines could be the responsibility of RMPS staff and consultants. These guidelines would then not only assist the regions in developing relevant program objectives, but would also provide a uniform

standard for local evaluation and national review.

The Core staff as a body should be objective in developing the program and should serve as a check on the RAG, whose members may have self-interests in the development of certain projects. Core staff should help in the development of projects which fit into the overall framework of the Program. This should eliminate the fragmentation which presently exists and foster cooperation among project coordinators in meeting the Program's goals.

In order to meet these goals a staff must be maintained whose primary task is to assist prospective sponsors with the development of project applications. In some cases, Core staff should suggest subject areas which fit into the overall program to possible applicants. On the other hand, project proposals submitted by interested sponsors would be carefully reviewed to assure that it is really needed by the region and not just needed by the applicant and the sponsoring agency. A case in point is the way coronary care units and coronary care training programs have sprung up in recent years without significant planning. It may well be suspected that these projects were submitted to meet the institution's needs, rather than the region's needs.

Thus, each Program must include a comprehensive review system to ensure that projects submitted to the Regional Medical Programs Service for final approval will enhance their program goals and be of relevance to local needs. For the most part, this review process should be handled primarily by the Core staff with the support of the Regional Advisory Group and other voluntary committees and panels.

Technical Review Groups

Since technical review at the Federal level will diminish, the need for good technical review at the local level is important. Most Programs now have adequate resources to draw upon. Several Programs are now bringing in reviewers from outside their region, and conducting their own "pre-site visits." These steps should be encouraged.

It should be the function of these panels to evaluate each project for:

1. scientific and technical quality
2. adherence to policy of TAG and federal guidelines
3. regional impact, effect, and outreach

In order to insure standardized, high-quality evaluation, all panels should be required to use guidelines prepared by the Division. At least two separate sets of guidelines will probably be necessary, one for continuing education projects (one now exists), and one for health services delivery projects. Because of the different competencies involved, two separate technical panels might be required to serve a region.

Panels composed of experts from outside a region as well as local experts would tend to insure the political neutrality of these groups. No one person or group should choose all of the members of the panel. Perhaps of an eight-man panel, two should be selected by the regional director, two by the RAG, two by the Core staff and two by division staff. At least one-third of the members of the panel should come from outside the region. Final approval of the Director of RMPS or the National Advisory Council should be needed for all such panels.

Because of potentially high expense and duplication of effort, panels

which can serve multiple Programs should be considered. Conceivably, the HEW Regions could be used as focal points for multi-Program panels in continuing education and health services delivery.

The function of the technical review panels should be to insure that RAG and Core approve and administer only projects of the highest quality. By strengthening the review panels, division staff and the Programs can insure a higher quality of projects. But the panels cannot insure the submission of quality projects. It is the function of the Core staff to solicit, initiate and develop quality projects in keeping with the directive of the regional director, the RAG and the federal guidelines.

#### Regional Advisory Groups

Like Core staffs, there is no blueprint for the ideal Advisory Group, beyond the language of the current (and likely subsequent) legislation.

P.L. 89-239 requires that each Regional Medical Program establish an advisory group "to advise the applicant and the institutions and agencies participating in the...Program in formulating and carrying out the plan for the establishment and operation of the Regional Medical Programs." The RAG must include "practicing physicians, medical center officials, hospital administrators, representatives of other organizations and institutions and agencies concerned with activities of the kind to be carried out under the Program and members of the public familiar with need for the services provided under the Program."

The Regional Advisory Groups established by the 55 Regional Medical Programs vary considerably in size, makeup and conception of their role.

As of January, 1970, there were a total of 2,463 members on the 55 RAGs, with a range in size from 12 to 229 members and an average size of 45.

Groups differing in size of membership have been equally effective (or ineffective) in different Programs. What is clear is that the RAG cannot become the captive of any single health faction and hope to remain viable.

By profession 46% of the Advisory Group members are physicians, 13% are from business or managerial background, 9% are hospital or nursing home administrators, 6% are registered nurses, 7% are from other health fields and 19% are from non-health occupations. From an affiliation standpoint consumer representation accounts for 18% of the RAG composition, 14% by health practitioners, 12% hospitals and other health interests, 9% medical societies, 9% voluntary health agencies, 8% public and other health agencies, 8% medical schools, 5% affiliated hospitals and 17% others.

The issue of consumer representation on the RAGs is a difficult one. For one thing, there is no clear definition of a "consumer." Some people believe that a "consumer" is anyone who is not a health professional. Others believe that it is anyone whose livelihood does not derive from the health field. Others use the term "consumer" as a euphemism for the poor.

The RAGs have, in fact, an impressively heavy representation of "affluent consumers" -- e.g., businessmen and non-health professionals. These people constitute the largest single category of membership on RAGs. As a general rule, it is members of and spokesmen for the poor.

communities who are not represented on the RAGs.

Should they be? Some people argue that RMP is essentially and unalterably a program of, by, and for the "providers" -- or the "establishment," when the involvement of high-level consumers is considered. We agree. They further argue that CHP really represents the "consumer"; they maintain that RMP and CHP were created as separate entities so that providers and consumers could develop their interests and sense of involvement separately, before facing the threat of dealing with each other; they maintain that as RMP and CHP work more closely together, providers and consumers will be drawn into common effort; finally, they state that, since this is the case, there is no need to push for "disadvantaged consumer" representation on RAGs.

On this point, we disagree. RMP and CHP were not created as separate agencies in order to eventually bring together providers and consumers; their separate births were for other reasons. Furthermore, it is not even true that CHP sufficiently represents "disadvantaged consumers." Nor is it a foregone conclusion that RMPs and CHP agencies will be brought meaningfully together.

We feel that the Director and Council should require "disadvantaged consumer" representation of RAGs. This representation should be proportional to the size of the disadvantaged community in the region. The "disadvantaged consumers" should reside in census tracts whose average income is at or below the poverty level. We recognize that such precise requirements do not guarantee that the poor will be adequately represented. Any requirements can be circumvented by people of bad faith. We also recognize that, even if these requirements are met, RMP will still be,



and should still be, basically a "provider program." But we feel that this action would be tolerated by the "providers" on the RAGs. We feel it will more likely lead to the necessary redirection of RMPs than will some hypothetical future coordination with CHP.

We believe that the Director and Council ought to require every RAG to have by-laws. We feel that these by-laws should outline a system of appointing members to the RAG which avoids any possibility that RAG membership will be determined by any one health faction such as the medical school or medical society. Currently, this is not the case. Certainly, the deans of the medical schools in the New York Metropolitan RMP want a piece of any action involving money for their institutions, but so do the residents of Harlem since they are even more "...familiar with the need for the services, provided under the program." However, ask the man in the street about "RMP" or even "Regional Medical Programs" and you run up against a blank wall. Perhaps the Local Advisory Groups are supposed to bridge this knowledge gap, but in most cases the persons best capable (yet not knowledgeable) of making an input are not included on the RAGs. A review of the 55 RAGs would show that there is at least one representative organization which has the most to gain by participating with RMP and generally does, i.e., the medical societies and medical schools. Although politics is the name of the game, we should strive to have RAG members with less of a vested interest. Some Programs even use appointments to the RAG as a means of enhancing their image or placating critical agencies.

We recognize that membership listings, bylaws, organizational structure and work flow charts submitted to RMPS seldom indicate or reflect the actual functionings of the RAG or the real power relationships with the RMP. Although the 55 RAGs are used to review projects and the overall grant application, many decisions are made by the Program Coordinator, core staff, in the medical schools or by the categorical and other planning committees and are only ratified by the RAG.

Thus, the FAST Task Force finding that "as of January, 1970, slightly less than two-thirds of the proposed operational projects or activities presented to Regional Advisory Groups have been approved by them -- 1021 out of a total of 1553 -- provides evidence that the technical and peer review procedure is being exercised in a critical, rather than mere rubber-stamp fashion" appears to be fallacious.

In many instances, both RAG members and RAGs as a whole, have differing conceptions of their functions and power.

Although some people are saying that we must wait to see the new legislation before restructuring the Regional Advisory Groups, both the House Bill and the Senate Bill will have the same basic effect on the RAG. Both Bills (H.R. 17570 and S. 3355) add the requirement that the Regional Advisory Groups include representatives from official health and planning agencies (CHP agencies) and public members familiar with the financing of, as well as the need for services, and that such public members be sufficient in number to insure adequate community orientation of RMP. In addition, the Senate Bill would add

a representative of the Veterans' Administration, if there is such an institution in the RMP area, as an ex officio member.

We believe that the Director and Council must make it clear to RAGs that their primary concern is with program, rather than project, development. RAGs must take a greater hand in monitoring the functioning of Core staffs and developing overall plans. With the assistance of core staff, the RAG must analyze the health needs of the region and set priorities. The RAGs are in a much better position than Division staff or federal reviewers to see that part-time Core staff members are effective, for instance. What the RAGs have lacked in the past was not the will to exert leadership, but a clear statement from Washington describing the extent of their responsibilities.

The nature and quality of the planning and decision-making process within a RMP must be clarified, and guidelines adopted. As defined in the legislation, the RAG should have a general advisory function in program planning, policy development and the evaluation of progress. In our experience, when they have been assured of their broad responsibilities, they have taken up the challenge and greatly strengthened the Program.

Thus, the RAGs will have significantly expanded responsibilities as decentralization of authority proceeds. The Division staff must spend more time with RAGs, letting them know that we will accept their invitation to attend RAG meetings. Division staff needs to expand its contact with RAGs even more than with Core staffs. We feel that it is with the RAGs, even more than the Core staffs, that RMP will succeed or fail.

### Federal Review Panels

Presumably, these panels will be disbanded as a consequence of the FAST report. We feel that this is a shame, for the panels have provided the most effective federal review of project quality. As mentioned in a previous section, however, their function can be replaced by local or multi-regional panels with similar functions.

### Review Committee

The Review Committee membership has been determined in the past primarily with regard to expertise in the categorical disease areas. With Review Committee, rather than Council, likely to have the primary role in program review from now on (as per the FAST report), it is absolutely essential that the Review Committee membership include primarily people with expertise in community medicine, manpower, economics, advanced medical technology, and related disciplines more appropriate to RMP's new directions. The Director has many vacant positions on the Committee to fill.

The Review Committee should continue to be heavily involved in developing specific standards by which the quality and relevancy of RMPs can be measured.

### Site Visits

Under Anniversary Review, the site visit will take on even more significance than it has in the past. The Division has already conducted

a few successful "program site visits" -- as compared with the project site visits in the NIH mold. The prerequisites for a successful program site visit seem to include:

- 1) A full statement of the Program's plan, and how its operational activities manifest and develop that plan. The Division staff (here the C.O. Task Force could help), Committee and Council need to develop a checklist of questions which should be answered in any such document. This checklist should be distributed to the Programs.
- 2) A full statement of the precise activities of each professional member of the Core staff, complete with an organization diagram.
- 3) A statement about the "broker" function of the Core staff, and other "spin-off" benefits resulting from Core staff activities. Again, examples of these should be chosen by Division staff, Committee and Council, and distributed to the Programs.
- 4) Staff should prepare the site visitors in advance with a Regional Profile, a complete funding picture (including how the Program's funding compares with that of other Programs in terms of population size, geographical size, years of operational activity, etc.), and an "issue paper" containing a summary of the questions which have been raised by staff and previous reviewers about the Program.
- 5) The site visit should visit different parts (such as sub-regional offices) of the Program if appropriate.
- 6) The site visitors should meet with all key members of the Core staff, RAG, subsidiary advisory or review groups, and spokesmen

for the key health factions -- medical society, hospital association, allied health representatives, state health department, CHP, schools of public health, etc. The site visitors should also meet with "consumers" representing all areas of society.

7) The site visitors should ask the Programs to invite certain key members of the health community who are not involved in RMP, and whom the local RMP would not have invited. A site visit inevitably tends to give a picture determined by the Program; this provision adds an important dimension to site visits.

8) The site visit is perhaps the most powerful potential constructive force which the Division can bring to bear on a Program, because of the prestige and caliber of people involved, and the desire of the Program to please the visitors. The site visitors should be encouraged not just to judge in silence, but to offer as much feedback as they can, recognizing that some of their specific feelings and recommendations may be reversed by Committee, Council, or the Director.

#### Type V Reviews

We have pointed out that Anniversary Review and the FAST report allow for a thorough evaluation of a Program, but only once every three years. This obviously places great responsibility on the Type V review of continuation applications. Unless this review is critical, the Council will have no assurance that its recommendations have been carried out, and the Director will have little ability to influence the direction of RMP.

It is obvious that the staff reviewers, like the federal reviewers, must have a better idea of what the direction of RMP should be, and what standards (as discussed previously) have been developed to evaluate a Program. It is also obvious that the effectiveness of the Type V review hinges on the caliber of staff participating in the review. Representatives of the Regional Development Branch, RMP representatives in HEW Regional Offices, Grants Management Branch, and Grants Review Branch must be included because of their familiarity with the Program. Other Division staff who have had special contact with the Program -- such as the ORSA Branch, C.E. Branch or P&E Office should also be included.

A representative of the new Clinical Services Branch should be included. This branch represents an opportunity to bring to RMPS expertise now lacking in preventive medicine, ambulatory services, urban planning, and business administration.

In addition to the above people, each application should be reviewed by an independent group who are not familiar with the Program, but who can ask objective and pertinent questions. We feel that this is an ideal role for the two-year Commissioned Officers.

No group of reviewers, no matter how intelligent, informed, or objective can adequately review a Program if there is not some consistent format to the application. We have not had such a format in the past, although the Anniversary Review format is a step in the right direction. The key element in any such format is a precise, measurable (if possible) statement of objectives in the original application, followed by a progress report -- objective by objective - -

stating the degree to which each objective has been achieved, reasons for success or failure, plans for the next grant period, and reasons for believing that these plans can be carried out.

There is no more justification for allowing a Program to submit a grant application in any form that it chooses than there is for allowing a hospital record to include or exclude any information, in any order. This single factor, along with the failure to develop standards of the type discussed previously, has severely impaired the review process, whether by staff or by Committee and Council.

We believe that few things are more urgent than the development of such standards, checklists and formats, and we believe that the C.O. Task Force can assist in their development.



SUMMARY

In the past, the Division and the Council have abdicated important leadership roles in the name of "independence and flexibility for the Regions." This has been merely a rhetorical excuse for intellectual and moral laziness. Of course, no one knew what an ideal Program would be. No blueprint could be imposed. The Programs have at least as much to teach Washington as Washington has to teach the Programs. There is strength in diversity. But there is no strength in aimlessness and confusion.

There is a new Administration push for decentralization. There is a new Administrator of HSMHA, a new Director of RMP, some new health leadership in the Senate and impending new legislation. Most of all, there is a new urgency for change in the health field. Now is the time for clear central leadership from RMPS. With such leadership, decentralization will be meaningful and the Programs will flourish. Without such leadership, we will merely decentralize chaos and the Programs upon whom all of us must place our hopes for RMP, will die.