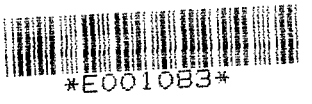
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REGIONAL MEDICAL PROGRAMS - OVERSIGHT

House Committee on

Interstate and Foreign

Commerce Hearings

May 8, 1973

REGIONAL MEDICAL PROGRAMS—OVERSIGHT

Dec 4

HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-THIRD CONGRESS

FIRST SESSION

ON

OVERSIGHT OVER PROGRAMS AUTHORIZED BY TITLE IV OF THE PUBLIC HEALTH SERVICE ACT, COMMONLY KNOWN AS REGIONAL MEDICAL PROGRAMS

MAY 8, 1973

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REGIONAL MEDICAL PROGRAMS—OVERSIGHT

TUESDAY, MAY 8, 1973

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND ENVIRONMENT,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2215, Rayburn House Office Building, Hon. Paul G. Rogers (chairman) presiding.

Mr. ROGERS. The subcommittee will come to order.

This morning the subcommittee is conducting oversight hearings on programs authorized by title IX of the Public Health Service Act, commonly known as regional medical programs. These programs, the product of legislation developed by this subcommittee, were first authorized in 1965. The law has since been amended on two occasions. The amount appropriated for regional medical programs has quadrupled since 1966.

As you know, the fiscal year 1974 budget submitted to the Congress contains the recommendation for termination of the regional medical programs at the end of fiscal year 1973. No new programs are offered to replace the role of RMP's in communities.

The purpose of today's hearings is to explore the administration's rationale for termination of these programs and to explore the effectiveness of regional medical programs during the past 3 years. We will first receive testimony from representatives of the Department of Health, Education, and Welfare; second, a panel of physicians that have become involved with regional medical programs through the practice of medicine or through academic medicine; and finally, from a panel of coordinators of regional medical programs.

Our first witness this morning is Dr. John S. Zapp, HEW Deputy Assistant Secretary for Legislation, accompanied by Dr. Harold Margulies, Director of Regional Medical Programs Service at HSMHA.

We welcome you gentlemen and will be pleased to receive your statement at this time.

STATEMENT OF DR. JOHN S. ZAPP, DEPUTY ASSISTANT SECRETARY FOR LEGISLATION (HEALTH), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DR. HAROLD MARGULIES, DIRECTOR, REGIONAL MEDICAL PROGRAMS SERVICE, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Dr. ZAPP. Thank you, Mr. Chairman, and members of the committee.

I am appearing in response to your request to present the position of the Department with regard to the regional medical programs cur-

rently authorized by title IX of the Public Health Service Act. As you are aware, we have proposed that this authority be permitted to expire at the close of fiscal year 1973 as it does under the current statute with no funding projected for the next fiscal year.

ADMINISTRATION'S HEALTH STRATEGY

The decision to propose termination of the regional medical program must first be considered in light of the overall health strategy of the administration. In the development of the 1974 health budget both HEW and other responsible agencies focused upon several important and unmistakeable problems which had been either prematurely dismissed or inadequately dealt with in the past. In accordance with the President's determination that the administration's budget would not exceed reasonable projections of Federal funding ability without increased taxation, these issues had to be met head on. We had to make realistic assessments of the programs' effectiveness in terms of the Federal funds invested in them. We could not condone funding merely for the sake of keeping a program going for another year. Furthermore, we had to assess the potential for shifting financial responsibility to non-Federal sources, public and private.

We have seen that the infusion of billions of Federal dollars into the American health enterprise has failed to solve some of the problems that have plagued that system for decades and in some cases made matters worse than before.

We believe the path out of this dilemma is not simply more spending, but rather more intelligent use of Federal health dollars.

It is, in our judgment, time to insist that the people of this country receive a better return on the investment in health programs of a sum equal to nearly 10 percent of the entire Federal budget, a return that can be measured in improved health, not just further inflation.

With that objective in mind, we have proposed to terminate a number of Federal assistance programs that either (1) have served their purpose and now should be financed by other permanent sources, or (2) have had no clear and essential purpose to serve.

At the same time, we have proposed increases in other health activities that appear to offer significant opportunities for improving the health of the American people.

Some of these changes are unpopular with those segments of the health enterprise that have become accustomed to steady increases in Federal support. Even before the President submitted his budget to the Congress on January 29 of this year; strenuous protests began to be heard from individuals and organizations interested in the continuation and expansion of one or another Federal health activity. These protests can be expected to reach a crescendo before the end of this fiscal year when many of the affected authorities expire.

We are certainly not indifferent to these protests, nor do we expect the Congress to accept—the proposition that our only choice is to cling to the patterns of he past. Instead, we must clearly define the proper Federal role in health and then begin to measure various individual proposals for Federal intervention against this definition. Only then

can we assign priorities based on actual needs and realistically measure progress in meeting these needs.

Let me define for you briefly our perception of the Department's share in the proper Federal role in health:

First, priority should be placed on reducing financial barriers that limit access to needed health care. This is primarily accomplished now through the medicare and medicaid programs; it will be furthered by enactment of a sound national health insurance program on which we will soon be making our recommendations to the Congress.

There should also be Federal support for health and medical research. The benefits of this activity are national in scope, and high investment costs make ongoing support from the private sector or from State and local government unreliable.

Many preventive health and consumer protection activities are also appropriately Federal concerns in the collective national interest. Controlling the hazards inherent in the use of drugs, preventing and checking food and cosmetics adulteration, and checking the spread of communicable disease, clearly involve a Federal responsibility. Traditional public health concerns such as epidemics across State lines and quarantine requirements fall into this class, although we think the States have a major responsibility here as well.

A more limited Federal role and increased reliance on the capabilities of local public and private sectors are indicated in the following situations:

Start-up funding for demonstration of new facilities or services which should be time-limited and which should incorporate from the outset feasible take-over financing from permanent alternative sources.

The direct provision of health care to segments of the population whose right to such care is recognized in law or whose need is especially acute because of the failure of more traditional means of providing health services.

The education of health manpower which cannot be accomplished through the basic student assistance programs offered by the Office of Education which are essential to meet especially difficult supply problems with respect to certain professions, for example, physicians and dentists, or to assure proper geographic distribution of health personnel or demonstrate the role of new types of health workers.

It is in the context, Mr. Chairman and members of the subcommittee, of this more limited Federal role that the decision was made to permit the authority for regional medical programs to expire at the close of fiscal year 1973 as it does under the current statute.

RMP WEAKNESSES

From the outset, regional medical programs has had great difficulty in defining a clear role for itself in concentrating its efforts and resources on a few, well-selected target areas. It has been unsuccessful in reconciling the conflicting and changing emphasis between categorical disease activities and comprehensive health care problems. As a result, more than $500 million has been expended in many types of diffuse activity rather than achieving a directed approach to the solution of problems in selected major programmatic areas.

Even with its original strong emphasis on regionalization, there is little evidence—and only with regard to kidney disease—that the RMPs have in many areas produced the regionalized systems of health care that the law envisioned.

There is no significant evidence that the RMPs have achieved their goal of getting research advances into regular, large-scale practice. The training programs undertaken are typically of limited scope and duration, and there is no substantiating evidence that these have had a significant impact on actual medical practice or in demonstrating improved quality care.

A major problem with respect to RMP has been the high cost of maintaining the program, or core, staffs in each of the 56 regions. A significant part of the overall RMP effort and funds have gone to pay program staff and the activities performed by them, including administration, consultation, project development and management, and evaluation. Last year, fiscal year 1972, 40 percent of RMP grant funds were for this purpose. And while reasonable men may disagree, Mr. Chairman, exactly how much of that reflects administrative costs, or overhead, strictly defined, it is clear that a very significant fraction of RMP grant funds have been and are being used to support approximately 1,400—full-time equivalents—staff of the 56 regions who are involved in the effort of trying to produce directly certain results, rather than in merely administrative support of specific operational projects and activities which are themselves designed to produce the desired results. RMP grant funds are allocated for both operational projects, which are those activities conducted by outside institutions and organizations, and for what are called program activities, which are those carried out by the salaried RMP staffs themselves.

RMP–CHP RELATIONSHIP

Another continuing problem has been the relationship of regional medical programs to comprehensive health planning. In some areas, RMP's and CHP's have worked closely together in a beneficial way, but often their individual roles have been hard to differentiate. It is difficult to have a CHP agency with responsibility for the health planning for an area while another federally-supported program, an RMP, is implementing activities in that same area based on its own planning and priority setting. What frequently happens, since the RMP had the funds available to carry out operational activities, is that its planning in effect becomes the deciding force of what is done in a given area. Given the narrower provider base of RMP, this is not always consistent with broader community and consumer health needs and interests.

It is expected that the comprehensive health planning agencies will be strengthened during fiscal year 1974, both by increased funding and a major technical assistance effort to be carried out across the country.

The budget request for supporting the planning agencies in 1974 is $38 million. This is $3 million more than in fiscal year 1973, and $12 million more than in fiscal year 1972, and is in keeping with our efforts to confer more responsibility on these organizations.

With a strengthened CHP program, it is expected that the CHP agencies could carry out a variety of planning and data system efforts,

some previously supported by RMP, at both State and areawide levels, as well as joining in regional interstate activities where indicated. It is also expected that the planning done by the consumer-oriented CHP agencies will be more representative of overall community health needs.

ALTERNATIVE SOURCES OF SUPPORT FOR RMP ACTIVITIES

Moreover, in our assessment of the variety of other health programs supported by the Department, it became clear that a variety of ongoing RMP activities are similar to the activities being carried out under other programs or authorities in the Department. A major RMP activity has been the funding of demonstration projects, but many other HEW programs and many other different Federal, State, and local agencies similarly fund demonstration projects, thus adding to the proliferation of separate categorical projects. Some of these can be picked up by the National Center for Health Services Research and Development, disease control programs in heart disease and cancer by NIH and emergency medical service system demonstrations under the authority of section 304 of the PHS act. Much of the RMP effort in the area of developing national capability for transplantation and dialysis is expected to be integrated into the financing system provided through the additional medicare coverage for kidney disease provided by the Social Security Amendments of 1972.

A further example of activities formerly assigned to RMP which are being supported by other components of the Department is in the area of improving the quality of care. Under authority provided by the Social Security Amendments of 1972, the Department is in the process of implementing the section on professional standards review organizations. These organizations will be set up in local areas to assume responsibility for comprehensive and ongoing review of services covered under the medicare and medicaid programs. The PSRO will be responsible for assuring that services are medically necessary and provided in accordance with professional standards. Other quality of care programs, particularly in the area of disease control, will be developed as part of the special NIH cancer and heart disease initiatives.

RMP ACHIEVEMENTS—FUTURE OUTLOOK

I would not wish to leave you, Mr. Chairman and other members of the subcommittee, with the impression that regional medical programs had no achievements and accomplishments. Although they have been very uneven in their quality and performance, some RMP's have, for example:

Fostered development of a local decisionmaking and implementing mechanism that constitutes a framework or forum for a broad spectrum of provider interests, institutions and groups to cooperatively address problems. This legacy will, I believe, be helpful to our PSRO effort and very possibly other quality assessment endeavors in the future.

Served as a modest force for institutional reform in the health arena. RMP may have helped, for example, to reduce in some regions the gap between the research-educational focus of medical schools and

the patient service needs of community hospitals and practicing physicians.

Found continuation support, albeit usually at a reduced level, for about one-half of the operational projects initiated with RMP grants.

Contributed to the launching of other Federal health initiatives such as the emergency medical service efforts.

On balance, however, we do not believe regional medical programs has achieved the promise it held when first enacted nearly 8 years ago, nor in our considered judgment have its accomplishmenst been commensurate with the costs, which totaled more than $500 million.

Finally, we feel that those types of activities funded by RMP which appear to have been successful, such as emergency medical services activities and some kidney disease programs, will be carried on by other new and existing programs in the Department more sharply focused on particular objectives.

Mr. Chairman, we appreciate the opportunity to present our views and my colleagues and I would be pleased to try to answer any questions you or other members of the subcommittee may have.

Mr. ROGERS. Thank you very much.

Mr. Nelsen?

Mr. NELSEN. I yield to Dr. Carter.

Mr. ROGERS. Why don't we just go down and you can reserve your time?

Mr. NELSEN. All right.

Mr. ROGERS. Mr. Preyer?

Mr. PREYER. Thank you, Mr. Chairman.

Dr. Zapp, I think we all agree with your statement at the outset that money doesn't necessarily solve our health problems any more than it does many other problems, but I think we have to agree there can't be any solutions without money.

I think what we are looking at is whether it is justified or not. In rationalizing—what you are seeking to do, I gather, is rationalize our medical care system. I gather you were saying discontinuing this program you don't think will really cause us to lose much because the CHP's will take over, a strengthened CHP will take over a lot of the functions of the RMP.

Dr. ZAPP. I think that is right. I really think as far as the department is concerned it is a dollar outlay because our expenses have increased $3 million. We think in some cases the CHP will pick up some of the RMP planning.

The planning has differed from one part of the country to another. We think in some cases the kidney dialysis amendment to Public Law 92-603 will pick up some of the program. We think the cancer and heart disease bill passed by this committee will pick up some of the activities.

We think the authorities of this committee will allow an appropriate reservoir to fund many of the better ones. We find from our standpoint that we can no longer make good use of the Federal dollars.

Where we have multiple programs with overlapping and duplicating purposes, we go through something like this with an expenditure of $500 million. We can't say we have targeted in on a national basis in solving any particular problem. We don't feel this is good use of Federal dollars.

Mr. PREYER. On the strengthening of CHP's, actually your budget for fiscal year 1974 proposes $38 million and that is down, isn't it, from the $42.5 million originally proposed for fiscal 1973? That is not much strengthening, is it?

Dr. ZAPP. It was increased by $3 million for 1974. I would like to point out section 221 of Public Law 92-603 confers authority on planning organizations as designated by the Governor.

In any case, it would require comments by CHP agencies where in existence. As far as comments on capital expenditures in excess of $[illegible], for those activities they are to be reimbursed from the Social Security Trust Fund.

Exactly what this amount will be at this time, Mr. Preyer, we don't know, but it certainly will be a significant amount, depending on the amount of construction that may occur in any particular area.

This is a source of what we consider to be a very reasonable funding in that it gives the CHP's a very targeted activity in an area and a reliable reimbursement mechanism that in that particular case, is related to its workload aside from the project grants the 314 agency makes to them.

Mr. PREYER. On the subject of financing this, since we are dealing with an $80 billion industry, it doesn't seem that $38 million, or whatever it might be, in that general vicinity, is grossly out of line or is a spendthrift program in any sense of the word.

One final question on that, and then I want to leave it, concerns the CHP's, do they cover the entire country?

Dr. ZAPP. No, 73 percent of the country is covered by CHP B agencies; the entire country is covered by A agencies statewide.

Mr. PREYER. On page 10 of your statement you give some credit to what RMP's have accompilshed. You do say they are uneven in the quality of performance, and I suppose that is true. I guess that is true of any program.

In my State, at least I think they have performed very well, and there is considerable concern about destroying all of the momentum that has been built up in the RMP's. Our medical schools have spent a number of years now working with the Cancer Association, the Heart Fund and so forth, building relationships and there is great concern that it is all going down the drain.

In particular, in North Carolina there has been a very substantial volunteer activity, many doctors have volunteered their time. I am afraid the next time they are asked to volunteer for some sort of government activity they are just going to say, "Well, no, thank you. We don't have any faith in the Government's commitment. You get into something of this sort and then you back right out of it."

The comprehensive health planning program, will that be any substitute for RMP in this respect because the CHP does not deal with the providers of health service, does it, like RMP does?

Dr. ZAPP. It deals with providers and consumers. It is a more community representative group, whereas, I think as I pointed out in my statement, RMP's are more provider-oriented. In both cases I think there is overlap.

I would tend to think, Mr. Preyer, in cases where, especially in the North Carolina RMP you mentioned, there have been a large number

of physicians volunteering their time, and they were not doing this because of Federal dollars but because they believed in the project there, that this would continue.

I am not intimately familiar with the individual activities of each of the RMP's on a national basis, but depending on what they were doing, those programs can compete on a large reservoir of residual authoritiesthat this committee and Congress as a whole has conferred upon the Department for similar purposes.

Mr. PREYER. I won't take any more time on questions at the moment. I think we all agree that there are some shortcomings in the programs. The purpose of an oversight hearing is to find out what they are and try to correct them.

It may be we should have some changes in the program and in its relationship with CHP and other health agencies. I am concerned that we might, because of some elements that are not working well, be throwing out the baby with the bathwater and are destroying a good and healthy ongoing relationship in areas where it has worked.

I think it has worked in our area. I am afraid if we destroy it, it will be to irrationalize health services rather than rationalize it. I think this hearing will help us get a better line on where they are working, why they are working and where they are not working and why aren't they.

Dr. ZAPP. We would hope the reverse would be true, that they would build on the relationships fostered rather than destroy them because the Federal dollar in that particular area is no longer available.

Mr. PREYER. Thank you.

Mr. ROGERS. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

How do you define an RMP, Dr. Zapp?

Dr. ZAPP. I will give a broad definition. Dr. Margulies could give a better one. An RMP in this case is one of 56 regional groups which had been formed with Federal funds for a variety of purposes. These purposes being to translate research information and findings to the practice of medicine in heart, cancer, and stroke.

Later amendments gave them broader authority and they have in different parts of the country become involved with utilization of manpower development, education and now in actual delivery of services.

That is something I think we would not have perceived to have been an initial purpose of RMP.

Mr. CARTER. Was that in the bill originally, delivery of services, except in an experimental nature?

Dr. ZAPP. It is in the experimental nature—there is a great flexibility in the RMP's selecting projects for their own particular area. We often times disagree, and I am sure we will in the future, as to what particular joint in time it should be demonstrated, developed, and turned over to the community.

In some cases up to 30 percent of their time is involved in services and I am sure they feel they are demonstrating something in that area.

Mr. CARTER. At the present time, we have 56 RMP's.

Dr. ZAPP. That is correct.

Mr. CARTER. An RMP could be a medical center, a medical school or a private, nonprofit corporation?

Dr. ZAPP. That is correct.

Mr. CARTER. The purpose of that institution was not only to disseminate knowledge, but was to conduct research, is that true?

Dr. ZAPP. I would have to turn to Dr. Margulies. I think we depend on the definition of research, not in the biomedical area, but the research in the utilization of manpower or the relationship between the health and science agencies in the community.

Dr. MARGULIES. I think that is a fair answer. If by research you mean the demonstration of some technique——

Mr. CARTER. We don't mean that. The heart, cancer, and stroke bill, the purpose was to have breakthroughs in these areas and do something about heart, cancer, and stroke, is that true?

Dr. MARGULIES. Yes, the intent was to utilize the products of research such as those established through the National Institutes of Health for the purpose of rapid dissemination of this knowledge to the practicing physician.

Mr. CARTER. That was only one of the purposes.

Dr. MARGULIES. With specific reference to whether RMP was designed for the purpose of doing research, I think in the terms of reference you are using it, the answer is no.

Mr. CARTER. We have an RMP at Vanderbilt University in Tennessee, an excellent one. Do they do research under RMP?

Dr. MARGULIES. No.

Mr. CARTER. They just disseminate such information they may obtain to certain areas, is that right?

Dr. MARGULIES. In terms of biological research, that would be the basic purpose, yes.

Mr. CARTER. Has this been done? Has this been accomplished?

Dr. MARGULIES. There has been, I think, a consistent effort to utilize research knowledge through the RMP's for dissemination to others, yes.

Mr. CARTER. There has been an effort. Has that effort been successful?

Dr. MARGULIES. I think it has had some elements of success and some elements of failure.

Mr. CARTER. How much of your money goes directly to the medical schools, different medical schools in our country and really becomes part of their funds for paying their teachers and for continuing their scholastic work?

Dr. MARGULIES. There are two ways in which medical schools derive funds from the regional medical program, one you already alluded to; that is, when the medical school is the grantee for a regional medical program; that is, it is responsible for handling the Federal grant funds.

From that they derive indirect costs which go into the general accounting office of the medical school. The other way is in a variety of areas in which the regional medical program may support projects conducted in the medical school or share in the support of staff people on the medical school faculty.

They may pay part of a salary for activities which are RMP designated with the school paying the other part. It is not intended the RMP would pay for the medical staff unless they were compensated for RMP activities.

Mr. CARTER. In many cases RMP funds have been used for payment of medical faculty, hasn't it, and there is not a fine line between giv-

ing information out to physicians in the field and the work professors do in the university?

Dr. MARGULIES. I think that is a fair statement. If someone designates 20 percent of his time to RMP and the rest to the medical school, it is difficult to break that time down.

Mr. CARTER. A lot of funds have gone to the medical schools?

Dr. MARGULIES. I think significant funds have, yes.

Mr. CARTER. I would like to know how much went to the University of Kentucky.

Dr. MARGULIES. I don't have those figures with me.

Mr. CARTER. I would like that for the University of Kentucky and Vanderbilt.

[The following information was received for the record:]

RMP SUPPORT TO THE UNIVERSITY OF KENTUCKY AND VANDERBILT UNIVERSITY

	Direct costs	Indirect costs	Total
Ohio Valley RMP: Support to University Kentucky Research Foundation:			
1968	$14, 279	$6, 530	$20, 809
1969	59, 490	2, 698	81, 188
1970	96, 567	40, 000	136, 567
1971	110, 774	44, 921	155, 695
1972–73	275, 640	104, 459	380, 099
Total	556, 750	217, 608	774, 358
Tennessee Mid-South RMP: Support to Vanderbilt University-Grantee:			
February 1968 to January 1969	577, 028	79, 422	656, 450
February 1969 to January 1970	889, 406	182, 454	1, 071, 860
February 1970 to January 1971	1, 032, 438	269, 043	1, 301, 481
February 1970 to December 1971	907, 314	208, 737	1, 116, 051
January 1972 to February 1974	1, 932, 398	380, 106	2, 312, 504
Total	5, 338, 584	1, 119, 762	6, 458, 346

Mr. CARTER. Have RMP's stayed within the limitations of the legislation?

Dr. MARGULIES. I would say they really have, although on one particular issue it is a matter of definition. In the original and subsequent legislation there is an injunction against doing anything which will interfere with the practice of medicine.

When you have an RMP which is helping to develop a new program someplace, it is difficult to say absolutely that this is not altering the practice of medicine in that area. That particular proscription was an important one.

I think they were more concerned in the early days of RMP's relationship with the practice of medicine with reference to setting fees or providing direct services, something of that kind. Basically RMP's have stayed within the limits of the legislation.

Mr. CARTER. Is it true some RMP's are getting into HMO's?

Dr. MARGULIES. They have had involvement with HMO's in providing assistance for those interested in developing an HMO.

Mr. CARTER. Where do they get the authorization?

Dr. MARGULIES. They do that as a professional activity, which I think is a reasonable thing to do.

Mr. CARTER. Their primary responsibility is in the field of heart, cancer, stroke, and kidney diseases, isn't it?

Dr. MARGULIES. Also to improve delivery of health services. Local providers have come to them for advice on how to develop professional standards of an HMO or how to go through the process of organizing an HMO.

Mr. CARTER. Can you show me in the legislation where they have this right?

Dr. MARGULIES. Section 910 of the PHS Act is fairly broad legislation.

Mr. CARTER. I believe that is an interpretation you placed on it. We write legislation and sometimes it is interpreted quite differently than the intent.

Actually, I am afraid in many cases different departments and agencies interpret legislation differently. I think it is quite obvious they do.

Mr. HASTINGS. If you are pursuing the question of the HMO and RMP involvement, I think we might go to the legislation for HMO's.

Thank you for yielding.

Mr. CARTER. How do RMP's actually relate to section 314(b) agencies?

Dr. ZAPP. Within a State, I would say, except for the fact that the 1970 amendment that Dr. Margulies mentioned a minute ago, the added requirement of review of RMP applications by the areawide planning agencies, that was part of the Health Services Improvement Act of 1970.

The arrangements have generally been based on the strengths and interest of the various CHP people within their areas. The only statutory requirement comes from the 1970 amendments.

Mr. CARTER. Has the continuing educational function of RMP been effective?

Dr. MARGULIES. It is difficult to judge the effectiveness of an educational program. I would have to respond. I think more as a——

Mr. ROGERS. You have had this program for 8 years. Surely you should know whether it is effective or not.

Dr. MARGULIES. In my judgment, it has not been effective.

Mr. ROGERS. That is what I wanted to know. Do you have any hard data on this?

Dr. MARGULIES. No.

Mr. CARTER. Do you ever evaluate these programs, have someone outside the house evaluate it? If you have in-house evaluations, they are rarely good. Have you had GAO go over these?

Dr. MARGULIES. We have had evaluations over the past 3 years that have addressed this question, but I am not satisfied with our evaluations.

Mr. CARTER. Have RMP's been doing much of their own planning?

Dr. MARGULIES. Well, in the sense that they are obligated to lay out a plan for 1 to 3 years, yes. They planned for the activities in the regional medical programs in all cases.

Mr. CARTER. How similar are the plans submitted by the 56 different agencies?

Dr. MARGULIES. They are highly varied.

Mr. CARTER. Just a hodgepodge, they are not directed, they lack direction, is that not true, really as much from the national level as anywhere else?

Dr. MARGULIES. I think from the national level the variety is very striking. On the other hand, within certain kinds of regional medical programs, there is a higher level of consistency. You would not expect to get the same kinds of activity in Maine as in Metropolitan New York, and those differences are striking.

There are similarities between relatively rural States and relatively urban States in what they propose to do.

Mr. CARTER. What are the consistencies which tend to occur in RMP's?

Dr. MARGULIES. I think a fair number of the programs in rural areas have been concerned with the improvement of cardiovascular medical care and use of manpower and placed higher emphasis on that, for example, coronary units or better utilization of hospital facilities.

Mr. CARTER. Would you give me some example of the training and teaching in cardiac care, emergency cardiac care?

Dr. MARGULIES. There have been several approaches to that. The regional medical program certainly in the first few years sponsored the development of coronary care units in a great range of hospitals around the country.

That was a fairly consistent pattern which had a kind of flowering, and then a settling down period. There have been a variety of services, which include attention to people with cardiovascular diseases. These have had some consistency around the country.

Mr. CARTER. Do you have any data about people with heart disease, how many people have been treated or any data to show the effectiveness of this program over 8 years?

Dr. MARGULIES. We have some data on the effectiveness of the coronary care units.

Mr. CARTER. How much has heart disease diminished in the last 8 years as a result of this program?

Dr. MARGULIES. I think it would not be possible to find any effect on heart disease as a result of this program.

Mr. CARTER. RMP's have really been doing much of their own planning. Each has its own plan. Is that correct?

Dr. MARGULIES. Yes.

Mr. CARTER. Goes its own way. Are some or all RMP's bound by community health planning?

Dr. MARGULIES. There is a requirement that the plan of the regional medical program go to the CHP B agency for its review and comment.

Mr. CARTER. Do RMP's plan better than CHP's?

Dr. MARGULIES. No. RMP's can plan for specific kinds of provider-oriented activities which are within the range of that experience, but they are not designed for nor competent to look at the total health picture as a CHP agency would. In all fairness, the regional medical programs have not involved all the provider structure within a State or region.

They have had a heavy concentration of people with categorical or academic interests and have not involved hospitals and hospital associations as they should.

Mr. CARTER. How much of the RMP funds are spent for administration of the programs?

Dr. MARGULIES. It was indicated outside our structure in the Regional Medical Program Service that that runs about 40 percent for support of staff and associated activities.

Mr. CARTER. About 40 percent. Do you have hard data on this?

Dr. MARGULIES. Yes.

Mr. CARTER. Are some programs spending less on administration than others?

Dr. MARGULIES. Yes.

Mr. CARTER. Do you have any information available?

Dr. MARGULIES. Yes.

Mr. CARTER. What are the compensations and salaries of core staff on an average?

Dr. MARGULIES. They range considerably. Each regional medical program has a chief executive officer who is known either as a coordinator or some similar name, and then they have professionals, sometimes physicians and sometimes nonphysicians as evaluators. So, sometimes the salary range is considerable, but I think it parallels closely a similar salary structure in an academic institution with which they might be affiliated.

Mr. CARTER. What might that be?

Dr. MARGULIES. Salary ranges for coordinators run as high as $40,000 or $45,000 a year, and other costs run well below that.

Mr. CARTER. How many in these core positions would draw salaries of $40,000 or $45,000 in a region?

Dr. MARGULIES. No one but the chief executive officer.

Mr. CARTER. How many more close to that range would you get?

Dr. MARGULIES. How many coordinators?

Mr. CARTER. How many close to that. How many employees in a region would have salaries close to that level?

Dr. MARGULIES. I think none.

Mr. CARTER. Is it true, as some claim, that RMP's are too closely tied to medical schools?

Dr. MARGULIES. In some instances, yes. In many areas where they were, I think that relationship has become less binding.

Mr. CARTER. Does such a tie help or hurt?

Dr. MARGULIES. If it is overly zealous on the part of the medical school, which sees the RMP as a mechanism for getting things it cannot otherwise get, I think it is harmful.

Mr. CARTER. Really, I had great hopes on this bill, and I feel in some cases it has been extremely helpful, but we have had such diverse programs and so little lack of direction that the program has sort of lost its way.

We have 56 different groups that have lost their purpose. Some are providing services, and some are in ambulatory care. As you said, they have forgotten that they were originated to disseminate information about heart, cancer, stroke, and later on kidney; isn't that true?

Dr. MARGULIES. I think that is a fair assessment. In the last few weeks, I have been going over all the activities of the regional medical programs very intensively, and it is a really tremendous activity, small projects, large activities, all going in different directions.

If I tried to recapitulate or describe it, it would be impossible.

Mr. CARTER. How much did we spend on this program last year?

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Dr. MARGULIES. In 1972 the grant activities were around $110 million.

Mr. CARTER. Around $110 million. Some matching funds were used by States?

Dr. MARGULIES. No. This is full Federal support.

Mr. CARTER. Thank you, Mr. Chairman.

Mr. ROGERS. Dr. Roy?

Mr. ROY. I want to thank Dr. Zapp and Dr. Margulies for being with us.

Is it true that you, Dr. Margulies, said in January 1972 that RMP was the best of all Federal programs? Is that a proper phrasing of what you said?

Dr. MARGULIES. It is possible that is what I said.

Mr. ROY. What happened between January of 1972 and January of 1973?

Dr. MARGULIES. Dr. Roy, let me go back and give you as candid an answer as I can. Before I joined Regional Medical Programs, I had great doubts about it. I thought it was a so-so program, and my interest was modest.

When I became Director of the program, it was in great trouble, but I entered it enthusiastically. I pursued it as vigorously as I could. I could not have been in it and remained objective about it and when I worked for it. I worked for it with all my heart. When I said strong, warm things about it, it was partly because I wanted to transfer my enthusiasm and support to what is really a remarkable group of people, the coordinators of the RMP's, as much as I could.

If I exaggerated in the process, I feel no uneasiness about it. It is the thing I needed to do. Placing the program in the total context and with the range of the issues Dr. Zapp has laid out, I have had to be more objective, more withdrawn, and take a view within a larger setting.

Nothing remarkable happened except as I had to look at this program in what I think is a much wiser frame of reference with a total look at the health delivery system and a more cautious use of funds to get the job done.

Mr. ROGERS. You are telling us that your prior statements are now inoperative?

Dr. MARGULIES. Should I respond further?

Mr. ROGERS. No. I think we have the picture.

Dr. ZAPP. Would you allow a response? I think that something happened there besides the points that Dr. Margulies indicated. There are some in which Congress had a major part: that is, the passage of legislation in cancer, and heart and lung, the professional standards review, part of H.R. 1, kidney dialysis, all these areas had a significant impact on a dollar basis.

Mr. ROGERS. If the gentleman would permit, they are administered in the same manner. You are now telling us the man with the responsibility for administering this program for 3 years has allowed things to disintegrate in such a drastic way.

I am not sure we can count on any programs being properly administered by HEW.

Dr. ZAPP. I do not think that is a fair assessment.

Mr. ROGERS. It is a factual assessment.

Dr. ZAPP. I do not think we can agree. The legislation gives us this type of choice within the area of review of the area planning agencies.

Mr. ROGERS. You do not have to make the grants unless they come up to proper standards. That is why we left that authority with you. I won't pursue that now.

Excuse me, go ahead.

Mr. ROY. I am interested in the interrelationship between RMP and CMP, or the lack thereof. Has this been a satisfactory relationship. Dr. Margulies?

Dr. MARGULIES. There are really two answers, if I may. I think the RMP's and CHP's at the local level have, on an individual, personal basis, worked reasonably well together, but the capacity of the RMP's to move rapidly in the direction they choose and the vigor of the RMP's has weakened the potential of CHP to do what it was supposed to do, which was to represent the community in a real planning process.

Because of their early and more aggressive start, RMP's have attracted much more of the interest of the community including the volunteers which were spoken of earlier. So, they rather usurped the field at the local community and State level.

Mr. ROY. Why have they been able to do so?

Dr. MARGULIES. I think in large part because they had full Federal funding and the backing of people already organized, the medical groups and the medical schools to which they were earlier attached.

Mr. ROY. Did it have anything to do with the fact they had more money and could get better people?

Dr. MARGULIES. I am sure that had something to do with it.

Mr. ROY. With RMP's out of the way, do you think CHP's will do better.

Dr. ZAPP. We are saying, hopefully on two fronts the planning will be more targeted, and also because there is not the competition.

Mr. ROY. We know what H.R. 1 provides, but we do not know who will make the decisions unless it is the CHP agencies. You are speaking of $100,000 in capital expenditure?

Dr. ZAPP. Yes.

Mr. ROY. Who will make the decision?

Dr. ZAPP. It depends on who the Governor designates.

Mr. ROY. What alternative does he have?

Dr. ZAPP. He would be allowed, I suppose, a variety of alternatives. If there are CHP (B) agencies in existence, they may not have the, so to speak, review and approval authority, but would have review and comment. I think the earlier indication of designations by the Governors have been that about 70 percent—I would not want to be held to that figure—of the CHP's have been designated by the Governors for section 221 implementation.

Mr. ROY. Do you think they will do that?

Dr. ZAPP. Yes, I do.

Mr. ROY. With $3 million?

Dr. ZAPP. There is reimbursement of the trust funds.

Mr. ROY. In what amount?

Dr. ZAPP. It is an amount that I am simply unable to say at this point. We do not know. We are developing regulations for the implementation of section 221. The fact is, they will be reimbursed, and it

will give them a specific target which CHP's have not had up to this point.

We think that with the fact of having a broad mandate in the project grant that will begin to have them focus in certain areas and be more effective. I think the fact they are not competing with groups in the area such as RMP's that pay higher salaries, they will be able to attract some of the people that might be more helpful.

Mr. Roy. Do you think people in the RMP's will go on State salaries to work in CHP's?

Dr. Zapp. At your professional level, the coordinators or people having portions of salaries paid by medical schools——

Mr. Roy. The professional level?

Dr. Zapp. Those people won't be attracted to CHP's. Generally, those people in many cases, portions of their salaries are paid by RMP's, and they have a faculty appointment or other involvement that constitutes probably a principal amount of that salary.

They will not be drawn into a CHP, but many of the people working for them, that have salaries probably closer to what CHP's could pay, we would hope they would be picked up.

Mr. Roy. So, your feeling is that if CHP gets an increase from $35 million to $38 million, then all things that RMP's have done in assisting CHP's, the CHP's will be able to do themselves?

Dr. Zapp. We think the CHP's, on a statewide basis, are ready, as a result of having additional financing mechanisms, to do better in areas like facilities review, and program cost effectiveness, and developing core expertise, in these areas in which they will and probably should expand.

I think one of our problems is that all of us, the administration included, have expected much more from essentially a community of centrally based CHP's than they could deliver.

Mr. Roy. Isn't $38 million an insignificant amount in this area?

Dr. Zapp. If it was not supplemented by additional trust funds, and they were to maintain their broad mandate, I think it would be difficult.

Mr. Roy. How do you plan on narrowing the CHP mandate?

Dr. Zapp. I think the Social Security Amendments of 1972 to a degree will begin to have them focus principally on facility review on an initial basis.

Mr. Rogers. If the gentleman will permit.

Mr. Roy. I yield.

Mr. Rogers. How many people are covered by social security health care?

Dr. Zapp. Medicaid and medicare?

Mr. Rogers. How many people?

Dr. Zapp. I think it is more than the people.

Mr. Rogers. Just answer my question.

Dr. Zapp. Mr. Chairman, I do not have the figures in front of me.

Mr. Rogers. Approximately how many people are covered?

Dr. Zapp. I would say perhaps 80 percent of the facilities if not more. We are reviewing facilities, not beneficiaries.

Mr. Rogers. Aren't about 40 million people covered?

Dr. Zapp. Approximately.

Mr. ROGERS. We are talking here about the rest of the people in the Nation. We don't expect Comprehensive Health Planning to deal with just the 40 million people covered by medicare or medicaid?

Dr. ZAPP. I understand that, Mr. Chairman.

Mr. ROGERS. I am not sure we want you to rewrite Comprehensive Health Planning.

Dr. ZAPP. We have a proposal before the Ways and Means Committee for extension of our proposal.

Mr. ROGERS. We have to be careful on guidelines, and I think this committee would be interested in any guidelines that change the thrust of our law. This committee wrote the law, not Ways and Means.

Dr. ZAPP. I would like to point out that out of those 40 million, the medicare and medicaid beneficiaries, it is the institution providing care to them, and they are speaking of 80 or 90 percent of the institutions with medicaid and medicare patients.

It is those institutions in excess of $100,000 that will have review.

Mr. ROGERS. I am not sure that we want Comprehensive Health Planning to be restricted to whatever medicaid and medicare may require.

Dr. ZAPP. I understand that.

Mr. ROGERS. I think we should have a clear understanding of that.

Mr. ROY. Your recommendation to extend CHP will not take care of the salary problem of the section 314 agencies, is that correct?

Dr. ZAPP. Will it increase the salary of the individual members?

Mr. ROY. Yes. Will it increase their ability to go into the marketplace and get more competent people?

Dr. ZAPP. It would increase total salaries, rather than the individual salaries. Without knowing how much money will flow into CHP's, I do not know.

Mr. ROY. It is not the amount of money flowing in——

Dr. ZAPP. You are talking of A agencies, and I am talking of the B agencies.

Mr. ROY. Yes. I am talking of A's.

Dr. ZAPP. That is true on A's.

Mr. ROY. The B agencies cover what percentage of the population?

Dr. ZAPP. About 73 percent.

Mr. ROY. Geographically, what percentage in the Nation?

Dr. ZAPP. I frankly do not know.

Mr. ROY. You really have no plans to increase the number of B agencies, is that correct? Your plan is to beef up those presently in existence?

Dr. ZAPP. I think essentially that is what we are proposing. We would propose to discuss with the committee when the extension of the CHP is before it.

Mr. ROY. Let me ask, what went wrong as far as RMP? You say training programs were of limited scope and duration. You say there is no substantiating evidence that these had significant impact on actual medical practice and improvement of health care.

Why weren't you able to advance and bring the knowledge to the local level? I hope we have learned something from RMP over 8 years.

If you were not able to do it, how can we do it through the alternative programs that Dr. Zapp mentions?

Dr. MARGULIES. I would like to respond to that fairly fully, if I may. When we began the educational activities in RMP, it was an extension of past exercises which had never been much more than rather pedestrian training programs where a physician on his day off attends meetings, hearings, lectures and goes home.

Whether the teaching was relevant or pertinent to his practice problems was never certain. There is a likelihood with the development of activities such as those envisaged under PSRO with a better kind of quality review that the deficiencies that exist can be identified and there can be designed a program to meet those deficiences.

Mr. ROY. You didn't identify these deficiencies.

Dr. MARGULIES. I think not.

Mr. ROY. Why not?

Dr. MARGULIES. I don't think the skill of the continuing education activities had reached that point. Let me just use as a reference, if I may, the State of Kansas, which has been involved in continuing education for many years.

At its best, it designed continuing education around what the teachers thought learners ought to learn rather than identifying with learners' needs to know.

Mr. ROY. I object to that statement. They have gone to the people year after year in Colbey, Great Bend and elsewhere and said, "What do you need? What information are you not getting?" They went to Great Bend trying to teach more about stroke. I think you are simplifying and perhaps distorting it by that statement.

Dr. MARGULIES. I disagree on this basis. I don't agree with that method of asking people, "What do you need to know?" gets at their deficiencies because they are not aware of their needs in practice.

Mr. ROY. That was not the only method, they tried all ways to get this information out.

Dr. MARGULIES. In the absence of organizing medical records and objective review of them, those deficiencies are a matter of guesswork. I have often attended the meetings in Kansas. I know how they are.

I know who went and who didn't go and I don't think RMP's are any more successful in involving people in learning activities or any better than anyone else, no matter how designed.

The people who are not going to learn and remain in the background practicing out-dated medicine were not reached. I don't know how to involve them unless it is with the PSRO approach. It requires a more formidible structure than we have had.

You don't need to teach the chairman of a department of medicine and his colleagues at a university. It is the people out of circulation that need it, and we didn't get to them.

Mr. ROY. We are going into whether the PSRO's are going to be able to identify the deficiencies.

Dr. MARGULIES. It is my hope.

Mr. ROGERS. Will the gentleman yield?

Mr. ROY. Certainly, Mr. Chairman.

Mr. ROGERS. I know some of the programs have not run too well, but I don't want to leak the impression in the record that one derives from your statement. The following statement, from an HEW publica-

tion referring to fiscal years 1971 and 1972 states, "In North Carolina a comprehensive stroke program was initiated which included among its range of activities, the publication of guidelines for community stroke programs, educational activities such as training programs for nurses, annual stroke workshops and stroke consultation services for physicians through the cooperation of the neurological staffs of three medical centers.

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

I would say that is a rather favorable comment coming from HEW on an RMP.

Mr. ROY. Can you differentiate consultation from project development and management, or administration from project management?

Dr. MARGULIES. I think it is difficult. You have to apply arbitrary standards and try to allocate costs.

Mr. ROY. Can anyone in HEW do this, Dr. Zapp. Can they tell the difference between consultation and administration?

Dr. ZAPP. You can set up definitions, but you have to realize we are talking abut how much time each individual would be involved in these activities—how much time spent on consultation, how much time on project review and management.

It is difficult. We know the bulk is about 40 percent of these funds: in other words, the program activities. We have made what I consider to be the best breakout we can base on the information we had.

Mr. ROY. Have you separated administration from consultation?

Dr. ZAPP We have program direction and administration at 10.8 percent of the overall: project development review and management, 8.8 percent: professional consultation, community relations and liaison, 10.4 percent: planning studies and inventories, 4.4 percent: feasibility studies, 2.8 percent: regional and other services, 2.8 percent, for a total of 40 percent of the funds.

Mr. ROY. Do you feel those are pretty good figures?

Dr. MARGULIES. Yes.

Mr. ROY. Do you think they are better rather than the blanket statement that RMP's are spending 40 percent on administration. Weren't you a little insulted by this comment?

Dr. MARGULIES. No; as a matter of fact, I thought the figure could have gone a little further. It is interesting the Department didn't point out the administrative costs in running the RMP Service, which is not included in this activity.

It did not identify some of the indirect costs for a variety of affiliated institutions which run extraordinarily high. I thought it was a reasonable statement and, if you wanted, it could be made even more damaging.

Mr. ROGERS. You permitted this imbalance you are now criticizing?

Dr. MARGULIES. Yes, sir.

Mr. ROGERS. Why?

Dr. MARGULIES It was one way a program designed in this way could be managed. The comment you made earlier regarding the way this program was conducted is worth looking at.

Mr. ROGERS. That is what we are going to do.

Dr. MARGULIES. If you want to design a program as this one has been designed, so it is decentralized, as you wrote the legislation——

Mr. ROGERS. I am not sure it has been administered as we wrote it.

Dr. MARGULIES. I think it has. It was written to be decentralized with regional medical programs having a regional advisory group and to be operated as a federally supported private institution. That meant the decisions should be made locally. The more they were made locally, the more it seemed to me it was consistent with the purpose of the legislation.

Mr. ROGERS. This seems to me to be the whole thrust of what HEW is attempting to do by turning everything over locally. Now you are saying that is not a good philosophy.

Dr. MARGULIES. It is a philosophy that will work in the right structure. I think placing the responsibility in the hands of a limited number of people for provider care has not the same effect as decentralization that goes to a State government. I think you would have difficulty in finding the same situation.

Mr. ROY. Are you telling me State governments are not affected by these decisions, when these interests have skewered RMP programs?

Dr. MARGULIES. No; but I am saying the health interests of a region can be identified and pursued by a portion of the providers of medical care in that State, but that does not provide a reasonable test of decentralization.

You can examine in your State, if you wish, Mr. Rogers, the makeup of the people involved in the RMP and find major segments of the provider group totally uninvolved. Or, you can check on participation of nurses, many classes of physicians, hospital administrators, nursing home directors, and so forth.

A limited number of people are making most of the decisions. There was no way to expand that because of the way the program was established.

Mr. ROY. Isn't it true you really said with this whole program we will go to the grassroots, find out their needs and develop from their needs? This is the way I understand RMP. You didn't really try to do this.

Mr. ROGERS. He just said the reason they haven't had good, continuing education was because they didn't go to the grassroots level and find out what was wanted. Now you are saying don't do it. I don't know what you want.

Mr. CARTER. If the chairman will yield, this is just a little sheep that has gone astray. They are not following the concepts we presented in the legislation. It has never been followed.

It has not been administered correctly. In some cases it has been very good. In some cases they have very good programs, and in other areas very poor.

Mr. ROY. What is the opposite of decentralization?

Dr. MARGULIES. Central control.

Mr. ROY. This is the way we should go. This has been the single greatest effort in Government health programs to decentralize, and you say it has not worked?

Dr. MARGULIES. I think decentralization to a limited portion of the community is ill advised.

Mr. ROY. You go along with our continuing CHP 314B agencies that are going to do wonderful things but have to get matching funds from providers. Do you go along with that?

Dr. MARGULIES. I think the basic concept of comprehensive health planning is a good one and deserves strong support.

Mr. ROY. Including matching funds from providers for 314B.

Dr. MARGULIES. There has to be matching funds. I am not sure of the requirements. I have not been dealing that closely with their responsibilities.

Mr. ROY. If I told you they come generally from providers, would you agree with this temporarily?

Dr. MARGULIES. I think so. When it comes from a limited number of providers, it provides an opportunity for the individuals to run the affairs of a B agency. I would prefer to see a broader base of funds from the community.

Mr. ROY. Decentralization has not worked in RMP's because it has been captured by local providers?

Dr. MARGULIES. I think it has not worked partly because of the purposes of the program as laid out were so multiple, and there were so many interests the group needed to respond to, and they have not been able to keep a centralized purpose consistently throughout the program as has been evident here.

Mr. ROY. Is it fair to paraphrase your testimony that the core staff costs a lot of money because you decentralized into 56 units?

Dr. MARGULIES. I think that is necessary if you have a freestanding institution operating with Federal funds. I see no way to reduce the overhead costs.

Mr. ROY. I have other questions, but I have taken far too much time. I would like to ask a couple of questions later on as to what I think is called the administration's health strategy.

Dr. ZAPP. Quite certainly.

Mr. ROGERS. Mr. Hastings?

Mr. HASTINGS. I yield to Dr. Carter.

Mr. CARTER. No; I have nothing right now.

Mr. HASTINGS. Dr. Margulies, you stated—I do not want to be repetitious, but in December 1971, not January 1972, you said that RMP's, between Government and the private sector, would provide a test package and distribute new health concepts.

You may have changed your view, but I have not. I think we have to, on a regional basis, do precisely that. In the same article in "Medical World News," again quoting yourself, you said:

> Contrary to popular belief, today's national RMP does have teeth. The National Board grades all programs numerically like students in a classroom, to establish relative rankings with lagging programs.
>
> An RMP can be put on probation for 6 months, limiting funding to that period rather than 3 years, which forces involvement in the community, recruits skilled managers, which make our people more of a political, social and economic instrument.

If you don't feel today RMP's are involved in the community, the oversight procedures you cited here simply did not work. They were not in existence. You do have that National Advisory Board with some responsibility in RMP's, do you not?

Dr. MARGULIES. Right; the RMP's, within a limited scope as described here, and as said in the opening statement, have achieved some useful purposes. It is essential, in fact probably one of the most critical elements of a strategy, whether on that side of the table or on this one, for improving health services that there be created an effective relationship between government at any level and professional people involved in the delivery of services.

Whether in this country or others I have studied, that relationships is an important one, without which programs to improve medical services will not develop. What I was talking about represents a kind of linkage which was serving a purpose for a limited number of activities, but it was too limited in scope.

Government-professional coordination is necessary in any kind of health strategy based on the kind of things Dr. Zapp laid out on a broader base with a more consistent and lasting mechanism——

Mr. HASTINGS. Where is the device to deliver these services you talked about? I have not seen a proposal saying, as a substitute for an RMP, this is what will go in place and deliver the same thing to the community. What are we talking about?

Dr. ZAPP. I do not think in any case we have said there will be in each area a mechanism to duplicate the RMP activities. The RMP activities were different in each area. What we are saying is that we have residual authorities that fit into these major components. I would be pleased to provide them for the record, because they break down into categories that are easy and ones that are familiar to the committee.

They are all authorities which this committee and the committee on the Senate side have given the authority.

[See "Residual authorities available for RMP-type activities," p. 142.]

Mr. HASTINGS. You are saying the good parts will continue except under existing authorities, they won't be put all together but under existing authorities you now have in HEW?

Dr. ZAPP. Yes.

Mr. HASTINGS. What is wrong with considering the suggestion I made before about taking the best parts of RMP's—we admit parts have not been productive, and there is no argument on that. The RMP people do not argue that point. But take the CHP, which you advocated continuance of, you are calling for renewal with no changes in CHP.

Take into consideration a combination of these agencies, still with regionalization, which I believe in. I do not think in my rural part of New York State that you can design a program that will be good in Minneapolis or San Francisco. I think they have to be different.

Dr. ZAPP. We would agree with that.

Mr. HASTINGS. I do not think HEW, frankly, and this subcommittee are as far apart as some may think. I think a little bending on both sides perhaps could bring us to a point where we could take the most effective parts of RMP's, take the CHP's which we all indicate we

want to continue, and put them together, try to develop some national health policy, which I think we are lacking today, and come up with some organizational structure that can deliver these services.

Is that really too much to ask?

Dr. ZAPP. I think from your standpoint, it is a good statement, Mr. Hastings. We could go down the line of all the good programs that we would like to do, but obviously we cannot fund them all.

I can only reiterate what I said before and look forward to the opportunity when we can come before the committee to testify for CHP's.

Mr. HASTINGS. I will get to a question relevant today. Why can we not extent RMP's with a simple extension for 1 year to give us the necessary months to work on the type of proposal we are talking about. That is essential to the question we are considering today, of course, and we all know it. For that reason, I think it is necessary that the subcommittee have the time to do precisely what we are talking about and what I think HEW is talking about, except you would rather meld in on the successful part of your broad authorities.

We would like to bring it together in a statute that defines what we would like to do in delivery of health care, research and education, and point at it and say, have we lived up to the intent of the law or not.

I do not think we are that far apart .I would once again plead with you that we have the opportunity to discuss that type of question before not just this subcommittee but all intersted parties throughout this country, who are in fact interested in improving our heath delivery system.

I think that is what we are talking about. Again because of the time limitations, I won't pursue my questions further.

Mr. ROY. Will you yield?

Mr. HASTINGS. Dr. Carter asked first.

Mr. CARTER. I know you said that you grade the 56 regional programs. Do you have the results of that here?

Dr. MARGULIES. I do not have them here, no.

Mr. CARTER. Would you bring them around so we can see them, how the different ones are rated and the basis for so rating them?

Dr. MARGULIES. Yes.

[Testimony resumes on p. 31].

[The following information was received for the record:]

REVIEW CRITERIA AND RATING SYSTEM—REGIONAL MEDICAL PROGRAMS

The Regional Medical Programs Service utilizes a rating system based on specified review criteria in evaluating the grant applications of the 56 individual Regional Medical Programs. A copy of ratings as of January 31, 1973, the Criteria themselves, and the Scoring Sheet used by reviewers is attached.

USES OF THE CRITERIA

The development of review criteria was necessitated in part by the decision to assess the RMP's from the national level in terms of their overall progress and program, rather than in terms of the technical adequacy of individual projects or discrete, singular activities.

As part of the effort to promote regional decision-making and responsibility, project review and funding authority were decentralized to the 56 RMP's in mid-1971. Regions have the authority, if their own review processes meet defined minimum standards, to make the final decisions regarding (1) the technical adequacy

of proposed operational projects and (2) which proposed activities are to be funded within the total amount available to them.

This change from project to overall regional program review at the national level necessitated the development of program review criteria, aimed at assessing a Region's (1) performance to date, (2) the process and organization that had been established, and (3) its proposal for future activities. After using these criteria and the corollary scoring system on a trial basis, they were found to be operationally satisfactory, and were incorporated as an integral part of the national review process.

Each region is rated annually. Regions requesting three-year approval are rated by the RMP's Review Committee. Applicants for recommended second or third year support of a three-year grant already approved by the National Advisory Council are rated by a Staff Anniversary Review Panel. In either case, the National Advisory Council considers and may at its discretion change the ratings assigned by the Review Committee or the Staff Panel.

The Criteria are used to provide a relative ranking of RMP's on the basis of numerical scores. As a result, Regions are ranked and then grouped in terms of quality—(A) Those which have demonstrated the greatest maturity and potential. (B) those which are generally satisfactory in their performance and progress, and (C) those which are below average.

About a third of the Regions are reviewed at each review cycle. Therefore, the relative standing of an individual Region may change on completion of any cycle, based on the ratings for the Regions then under consideration.

The scores represent the subjective opinions of reviewers at a given time and are only one of a number of factors considered by the staff and Director of RMP's in determining an approved level of support.

THE CRITERIA

The Criteria are divided into three groups: (1) "Performance." (2) "Process." and (3) "Program Proposal." Each criterion is assigned a relative weight. Weights were originally developed on a subjective basis modified after a trial period and approved by the Review Committee and Council. In addition, a series of questions appear under each criterion. The questions are not criteria themselves, but are used to illustrate and amplify the kinds of things covered by the individual criteria. Copies of the Criteria are furnished to the reviewers at each Staff Panel and Review Committee meeting.

THE SCORING SHEET

The Scoring Sheet is used by individual reviewers to provide their ratings. Each column is used to record the reviewer's ratings for an individual Region. The Criteria and the weights for each are shown in the left hand column. Space is also also provided on the Scoring Sheet for an overall assessment of the Region (line D), a recommendation for a Developmental Component, if requested (line E), and finally for recording the basis for the reviewer's evaluation (lines F, 1–7). The latter is used by RMPS for monitoring and evaluating the rating system itself. The "Basis for Evaluation" lines are the RMPS use only and do not affect the numerical scores.

Each reviewer rates each region on a 1–5 scale for each criterion. The reviewers do not sign the sheets. At the end of the meeting, the Scoring Sheets are collected and a computerized composite score for each Region is generated almost immediately through the RMPS Managament Information System. The overall numerical ratings for each Region are made available to the Council which may, at its discretion, modify any rating.

OFFICE OF SYSTEMS MANAGEMENT, REVISED RANKING OF RMP REGIONS (53 REGIONS RANKED), JAN. 31, 1973

Region	Prior cycle, score and date	January/February 1973 review cycle	
		SARP, December 1972	Rev. Comm. January 1973
"A" regions (326 and above):			
New Jersey	413 S December 1971	400	
Georgia	366 S September 1972		
Illinois	375 R January 1972	361	
Iowa	342 R October 1971	357	
California	355 S September 1972		
Washington/Alaska	330 S September 1971		345
Florida	354 R January 1972	342	
Ohio Valley	323 R October 1971	338	
West Virginia	336 R October 1972		
Wisconsin	336 S September 1972		
Maine	335 S September 1972		
Western Pennsylvania	330 S April 1972		
Puerto Rico	326 R May 1972		
"B" regions (251–325):			
Northlands	317 S December 1971	325	
Arkansas	341 R October 1971	324	
North Carolina	324 S April 1972		
Oregon	321 R May 1972		
Nassau/Suffolk	319 R May 1972		
Texas	314 R October 1972		
Mountain States	314 S April 1972		
Hawaii	309 R October 1972		
Louisiana	241 R January 1972		306
Connecticut	312 R October 1971		305
Albany	303 R October 1972		
Alabama	292 S December 1971	298	
Tennessee/Midsouth	298 S September 1971	294	
New Mexico	294 R October 1972		
Colorado/Wyoming	290 S September 1972		
Michigan	290 S September 1972		
Nebraska	288 R May 1972		
Mississippi	288 R October 1972		
Virginia	287 R October 1972		
Tristate	343 S September 1971	292	
Northern New England	282 R October 1972		
Memphis	281 R October 1972		
North Dakota	183 S September 1971		280
Lakes area	277 R January 1972		
Intermountain	298 S December 1971		275
Arizona	287 R October 1971		274
Rochester	269 R October 1972		
Kansas	264 S April 1972		
"C" regions (250 and under):			
Bistate	247 R October 1972		
Susquehanna Valley	244 S December 1971		
South Carolina	240 S April 1972		
Central New York	239 R October 1972		
Indiana	222 R October 1972		
New York Metropolitan	324 S September 1971		216
Greater Delaware Valley	213 R January 1972		
Maryland	245 R January 1972		193
Metropolitan District of Columbia	207 R January 1972	176	189
Missouri	188 R May 1972		
Oklahoma	184 R May 1972		
Northeast Ohio	133 R May 1972		
Regions without a score:			
Delaware			
Ohio			
South Dakota			

DECEMBER 28, 1971.

RMP REVIEW CRITERIA

A. PERFORMANCE (40)

1. Goals, objectives, and priorities (8)

(a) Have these been developed and explicitly stated?
(b) Are they understood and accepted by the health providers and institutions of the Region?
(c) Where appropriate, were community and consumer groups also consulted in their formulation?
(d) Have they generally been followed in the funding of operational activities?
(e) Do they reflect short-term, specific objectives and priorities as well as long-range goals?
(f) Do they reflect regional needs and problems and realistically take into account available resources?

2. Accomplishments and implementation (15)

(a) Have core activities resulted in substantive program accomplishments and stimulated worthwhile activities?
(b) Have successful activities been replicated and extended throughout the Region?
(c) Have any original and unique ideas, programs or techniques been generated?
(d) Have activities led to a wider application of new knowledge and techniques?
(e) Have they had any demonstrable effect on moderating costs?
(f) Have they resulted in any material increase in the availability and accessibility of care through better utilization of manpower and the like?
(g) Have they significantly improved the quality of care?
(h) Are other health groups aware of and using the data, expertise, etc., available through RMP?
(i) Do physicians and other provider groups and institutions look to RMP for technical and professional assistance, consultation and information?
(j) If so, does or will such assistance be concerned with quality of care standards, peer review mechanisms, and the like?

3. Continued support (10)

(a) Is there a policy, actively pursued, aimed at developing other sources of funding for successful RMP activities?
(b) Have successful activities in fact been continued within the regular health care financing system after the withdrawal of RMP support?

4. Minority interests (7)

(a) Do the goals, objectives, and priorities specifically deal with improving health care delivery for underserved minorities?
(b) How have the RMP activities contributed to significantly increasing the accessibility of primary health care services to underserved minorities in urban and rural areas?
(c) How have the RMP activities significantly improved the quality of primary and specialized health services delivered to minority populations; and, have these services been developed with appropriate linkages and referrals among inpatient, out-patient, extended care, and home health services?
(d) Have any RMP-supported activities resulted in attracing and training members of minority groups in health occupations? Is this area included in next year's activities?
(e) What steps have been taken by the RMP to assure that minority patients and professionals have equal access to RMP-supported activities?
(f) Are minority providers and consumers adequately represented on the Regional Advisory Group and corollary committee structure; and do they actively participate in the deliberations?
(g) Does the core staff include minority professional and supportive employees and does it reflect an adequate consideration of Equal Employment Opportunity?

(h) Do organizations, community groups, and institutions which deal primarily with improving health services for minority populations work closely with the RMP core staff? Do they actively participate in RMP activities?

(i) What surveys and studies have been done to assess the health needs, problems, and utilization of services of minority groups?

B. PROCESS (35)

1. Coordinator (10)

(a) Has the coordinator provided strong leadership?

(b) Has he developed program direction and cohesion and established an effectively functioning core staff?

(c) Does he relate and work well with the RAG?

(d) Does he have an effective deputy in name or fact?

2. Core staff (3)

(a) Does core staff reflect a broad range of professional and discipline competence and posses adequate administrative and management capability?

(b) Are most core staff essentially full-time?

(c) Is there an adequate central core staff (as opposed to institutional components)?

3. Regional advisory group (5)

(a) Are all key health interests, institutions, and groups within the region adequately represented on the RAG (and corollary planning committee structure)?

(b) Does the RAG meet as a whole at least 3 or 4 times annually?

(c) Are meetings well attended?

(d) Are consumers adequately represented on the RAG and corollary committee structure? Do they actively participate in the deliberations?

(e) Is the RAG playing an active role in setting program policies, establishing objectives and priorities, and providing overall guidance and direction of core staff activities?

(f) Does the RAG have an executive committee to provide more frequent administrative program guidance to the coordinator and core staff?

(g) Is that committee also fairly representative?

4. Grantee organization (2)

(a) Does the grantee organization provide adequate administrative and other support to the RMP?

(b) Does it permit sufficient freedom and flexibility, especially insofar as the RAG's policy-making role is concerned?

5. Participation (3)

(a) Are the key health interests, institutions, and groups actively participating in the program?

(b) Does it appear to have been captured or co-opted by a major interest?

(c) Is the Region's political and economic power complex involved?

6. Local planning (3)

(a) Has RMP in conjunction with CHP helped develop effective local planning groups?

(b) Is there early involvement of these local planning groups in the development of program proposals?

(c) Are there adequate mechanisms for obtaining substantive CHP review and comment?

7. Assessment of needs and resources (3)

(a) Is there a systematic, continuing identification of needs, problems, and resources?

(b) Does this involve an assessment and analysis based on data?

(c) Are identified needs and problems being translated into the Region's evolving plans and priorities?

(d) Are they also reflected in the scope and nature of its emerging core and operational activities?

8. Management (3)

(a) Are core activities well coordinated?

(b) Is there regular, systematic and adequate monitoring of projects, contracts, and other activities by specifically assigned core staff?

(c) Are periodic progress and financial reports required?

9. Evaluation (3)

(a) Is there a full-time evaluation director and staff?

(b) Does evaluation consist of more than mere progress reporting?

(c) Is there feedback on progress and evaluation results to program management, RAG, and other appropriate groups?

(d) Have negative or unsatisfactory results been converted into program decisions and modifications; specifically have unsuccessful or ineffective activities been promptly phased out?

C. PROGRAM PROPOSAL (25)

1. Action plan (5)

(a) Have priorities been established?

(b) Are they congruent with national goals and objectives, including strengthening of services to underserved areas?

(c) Do the activities proposed by the Region relate to its stated priorities, objectives and needs?

(d) Are the plan and the proposed activities realistic in view of resources available and Region's past performance?

(e) Can the intended results be quantified to any significant degree?

(f) Have methods for reporting accomplishments and assessing results been proposed?

(g) Are priorities periodically reviewed and updated?

2. Dissemination of knowledge (2)

(a) Have provider groups or institutions that will benefit been targeted?

(b) Have the knowledge, skills, and techniques to be disseminated been identified; are they ready for widespread implementation?

(c) Are the health education and research institutions of the Region actively involved?

(d) Is better care to more people likely to result?

(e) Are they likely to moderate the costs of care?

(f) Are they directed to widely applicable and currently practical techniques rather than care or rare conditions of highly specialized, low volume services?

3. Utilization manpower and facilities (4)

(a) Will existing community health facilities be more fully or effectively utilized?

(b) It is likely productivity of physicians and other health manpower will be increased?

(c) Is utilization of allied health personnel, either new kinds or combinations of existing kinds, anticipated?

(d) Is this an identified priority area; if so, is it proportionately reflected in this aspect of their overall program?

(e) Will presently underserved areas or populations benefit significantly as a result?

4. Improvement of care (4)

(a) Have RMP or other studies (1) indicated the extent to which ambulatory care might be expanded or (2) identified problem areas (e.g., geographic, institutional) in this regard?

(b) Will current or proposed activities expand it?

(c) Are communications, transportation services and the like being exploited so that diagnosis and treatment on an outpatient basis is possible?

(d) Have problems of access to care and continuity of care been identified by RMP or others?

(e) Will current or proposed activities strengthen primary care and relationships between specialized and primary care?

(f) Will they lead to improved access to primary care and health services for persons residing in areas presently underserved?

(g) Are health maintenance and disease prevention components included in current or proposed activities?

(h) If so, are they realistic in view of present knowledge, state-of-the-art, and other factors?

5. Short-term payoff (3)

(a) Is it reasonable to expect that the operational activities proposed will increase the availability of and access to services, enhance the quality of care and or moderate its costs, within the next 2–3 years?

(b) Is the feedback needed to document actual or prospective pay-offs provided?

(c) Is it reasonable to expect that RMP support can be withdrawn successfully within 3 years?

6. Regionalization (4)

(a) Are the plan and activities proposed aimed at assisting multiple provider groups and institutions (as opposed to groups or institutions singly)?

(b) Is greater sharing of facilities, manpower and other resources envisaged?

(c) Will existing resources and services that are especially scarce and/or expensive, be extended and made available to a larger area and population than presently?

(d) Will new linkages be established (or existing ones strengthened) among health providers and institutions?

(e) Is the concept of progressive patient care (e.g., OP clinics, hospitals, ECF's home health services) reflected?

7. Other funding (3)

(a) Is there evidence the Region has or will attract funds other than RMP?

(b) If not, has it attempted to do so?

(c) Will other funds, (private, local, state, or Federal) be available for the activities proposed?

(d) Conversely, will the activities contribute financially or otherwise to other significant Federally-funded or locally-supported health programs?

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ADMINISTRATIVELY CONFIDENTIAL SCORING SHEET AND INSTRUCTIONS: _____
(Date and group)

Region

Criteria
Date of most recent site visit
A. Performance, 40:
1. Goals, objectives and priorities
2. Accomplishments and implementation
3. Continued support
4. Minority interests
B. Process, 35:
1. Coordinator
2. Core staff
3. Regional advisory group
4. Grantee organization
5. Participation
6. Local planning
7. Assessment of needs and resources
8. Management
9. Evaluation
C. Program proposal, 25:
1. Action plan
2. Dissemination of knowledge
3. Utilizing manpower and facilities
4. Improvement of care
5. Short-term payoff
6. Regionalization
7. Other funding
D. Overall assessment
E. Developmental component (If yes, check)
F. Basis for evaluation (Check all applicable):
1. Current site visit
2. Previous site visit
3. Application
4. Committee discussion
5. Other
6. Primary reviewer
7. Secondary reviewer

Note: Using a 1 through 5 scoring scale (5, outstanding; 4, good; 3, satisfactory; 2, fair; 1, poor), rate the region in accordance with the criteria set forth below. Reviewers are reminded to consult the *RMP review criteria* document (dated Dec. 28, 1971) which includes subcriteria or elements in the form of questions designed to make these broad, general criteria more specific and understandable. These are intended to be of help to the reviewer in assigning a score to each of the criteria. Multiplication of scores by the assigned weights and the necessary addition will be done by staff; reviewers need not make those computations. Reviewers should provide their overall subjective assessment of the region and its application by rating on a 1-to-5 basis in item D, overall assessment. Feel free in making your overall assessments to use decimal scores (e.g., 3.5). Use a check ($) in item E, developmental component, if in your best judgment this region has achieved sufficient program, maturity and status to warrant award of a developmental component. In item F, basis for evaluation indicate for each region the basis for your evaluation. When appropriate, more than one item in item F may be checked for each region.

Mr. ROY. Mr. Hastings, I want to identify myself with your statement. I believe regionalization is the correct way to go to it. It hurts me to hear Dr. Zapp criticize it so fully as he has. Second, I want to identify myself with your concept of bringing together the present authorities in order to do a better job than in the past.

Mr. HASTINGS. Thank you.

Thank you, Mr. Chairman.

Mr. ROGERS. Mr. Kyros?

Mr. KYROS. No questions.

Mr. ROGERS. Mr. Heinz?

Mr. HEINZ. First, Dr. Zapp, let me sincerely commend you for, I think, setting a new record, perhaps for any witness. I received your tesitmony last night in advance of your appearance here today, and I want to sincerely commend you for having made that possible.

I think a lot of the questions I had intended to ask have been touched on one way or another. There is one area I would like briefly to get into, because I do not think it has been specifically touched on. That is, where CHP's or, for that matter, RMP's fit in with certificate-of-need legislation.

Dr. ZAPP. In approximately 20 States, where they have certificate-of-need legislation. it varies considerably as to how the CHP's fit in, as to whether they are the body where the State requires review and comment, or they actually give them review and approval.

I would be pleased to provide that for you. but I do not have that with me today, the chronology or analysis of the certificate of needs that are in effect.

[Testimony resumes on p. 138.]

[The following material was received for the record:]

Note: article and legislative report on certificate of need legislation not photocopied

Mr. HEINZ. Do we mandate the development of certificate of need legislation?

Dr. ZAPP. No, that has been a State responsibility. I think we have always said from the standpoint of the Department that where it exists, we will honor it.

As an example, we will not go around and overrule an individual State where there has been certificate-of-need legislation.

Mr. HEINZ. Does the agency have review and approval?

Dr. ZAPP. We have review and comment. Most public health service acts provide for review and comment, not approval.

Mr. HEINZ. One thing concerns me greatly about the Pittsburgh area health planning agency, which is a B agency established back in 1969 as a review-and-comment agency. Clearly there is a tremendous amount of work to be done in furthering the delivery and planning of medical service. Yet it is now 1973, going on 1974, and they do little if any planning.

What they do is they simply make comment upon proposals that other people bring to them. Their comment can never be framed within the constraint of some kind of master plan, because there is no master plan. I was wondering if you had found this to be a problem in other CHP type B agencies around the country?

Dr. ZAPP. I think essentially you could say that of most CHP (B) agencies. Their interests differ from area to area as RMP's do. It is true in most cases the planning, if it exists, has not gotten beyond the facilities or manpower stage, but the interphases in relation to the delivery of services and provider facilities is a step beyond what the CHP B agencies have gone to.

Mr. HEINZ. The reason I bring that subject up, of course, is because the effectiveness of CHP's is a central issue, if, as you propose we are going to phase out RMP's.

I have here a miniaturized computer printout of some expenditures which my local RMP in the southwestern Pennsylvania region has produced. It is a statement of RMP funds requested. Two of the items, are item 0000 core and item 0001 core professional training and education.

Would you consider those administrative cost items in the budget? I suppose that question should be directed to Dr. Margulies.

Dr. MARGULIES. I think they were in the figures Dr. Zapp presented.

Mr. HEINZ. That would be presented in the figures on page 7 or 8 of your statement?

Dr. ZAPP. That is correct.

Mr. HEINZ. For the record, in western Pennsylvania RMP, the core RMP funds requested were $778,000. The core professional training and education funds requested were $438,000, and all the other funds requested, another 10 components, were $574,000.

This example would tend to support your figure that a high proportion does go into administrative costs, and perhaps your number is low. I do not know, based on this one particular item. It might well be.

I must say, from talking with my regional medical people, I have been impressed with their efforts to develop something HEW has not provided much help with, and that is a mission in the planning and

implementation of an RMP concept, and they have done some good things.

I must say the discussion here today has indicated to me that HEW, I think, could have done more to encourage RMP's to define their missions earlier on in the game, because there is no doubt that the activities lacked focus over a period of 1 or more years and that we have, therefore, wasted a considerable amount of money.

In many instances, I gather they still do. Thank you.

Mr. ROGERS. Mr. Symington?

Mr. SYMINGTON. Thank you, Mr. Chairman.

Did the Department send phaseout instructions to all of the RMP's, and is the information available on the dates of those notices?

Dr. ZAPP. Notices went out to RMP's on February 1 with a followup on February 22. I am sure there have been numerous communications between the RMP service and the Department and the individuals since that time. The initial ones went out right after the President's submission of his budget.

Mr. SYMINGTON. What was the statutory authority for that decision?

Dr. ZAPP. There is no statutory authority that says per se that you may. What we were saying—I would have to back up to January 29—is that we have made a legislative proposal using the President's 1974 budget as a vehicle, and that the regional medical programs be allowed to terminate.

In other words, the authority would be allowed to expire on June 30, 1973, as it currently does. In fairness to the people involved in the program, we prepared for an orderly transition. This is a proposal that has been before Congress for an excess of 3 months.

Mr. SYMINGTON. Your general testimony indicates that RMP's were not cost effective and that would take some study to determine, and one of the things we would like to know is, how many people were served by RMP's? Do you have figures of that kind?

Dr. ZAPP. I would not have—approximately 30 percent is used for the delivery of service. I would have to refer to Dr. Margulies, and see if they have the figures on the number of patients served.

Dr. MARGULIES. Actually the number directly served, for example, by demonstration projects, would be relatively small because these are usually confined activities. I do not have a specific figure.

Mr. SYMINGTON. In your ranking system you gave high marks to certain States, I think, Florida, Maine, western Pennsylvania. What were the criteria you used in giving them high grades? Is it the people served, the manner served, the structure of the organization?

Dr. MARGULIES. We used 20 criteria which were applied through a variety of methods which included site visits, consultants, a national review committee, a national advisory council.

These were designed pretty much around the way in which you judge the effectiveness of an institutional process to achieve a goal. We were concerned with how well the regional advisory group operated, whether the RMP set a goal for itself and established projects to meet that goal.

I felt very strongly about the ways in which RMP's addressed the problems of equal employment opportunities. We took a look at the quality of the coordinator, the way the evaluation was carried out, a whole series of issues, addressed and examined it the best we could.

Mr. SYMINGTON. Perhaps you could supply for the record a résumé on that approach.

Dr. MARGULIES. We would be glad to.

[See "Review Criteria and Rating System—Regional Medical Programs," p. 23.]

Mr. SYMINGTON. Do you know how many doctors and nurses received continuing education through the RMP's?

Dr. MARGULIES. Not offhand.

Mr. SYMINGTON. Would you supply that?

Dr. MARGULIES. Yes.

[The following information was received for the record:]

COURSE REGISTRATIONS IN RMP-SPONSORED EDUCATION ACTIVITIES FISCAL YEAR 1972 (LISTED BY TYPE OF TRAINING RECEIVED AND DISCIPLINE OF RECIPIENT)

Discipline	Continuing education[1]	New skills for existing personnel[2]	New personnel[3]	Total	
				Number	Percent
Physicians (MD/DO)	46,328	10,140		56,468	29
Dentists	1,442	197		1,639	1
Nursing personnel	36,301	25,072	146	61,519	32
Allied health personnel	23,011	12,362	1,205	36,578	19
Hospital/nursing home personnel	10,414	694		11,108	6
Medical, dental and nursing students	6,106	1,139		7,245	4
Other	8,582	9,579	1,046	19,225	10
Total	132,184	59,183	2,415	193,782	100

[1] Continuing education—courses aimed at maintaining or improving the level of practice of the health professional.
[2] New skills for existing personnel—training aimed at enabling the person trained to assume new responsibilities in the already chosen career field or adding skills in a different but related health field (e.g., coronary care training for nurses, career mobility for licensed practical nurses).
[3] New personnel—development of training programs for such new categories of personnel as physicians' assistants, nurse practitioners, and community health workers.

Mr. SYMINGTON. If nurses were receiving continuing education, perhaps then they need to seek other forms of support, and I wonder if provision was made to help them continue?

Dr. MARGULIES. I think most continuing education of nurses took place in a hospital setting and added to what they would ordinarily get. I believe that kind of institutional support will still be available and can be expanded for that purpose.

Mr. SYMINGTON. Mr. Chairman, I think I can submit the rest of my questions.

Mr. ROGERS. No, go ahead.

Mr. SYMINGTON. One question would be that RMP review criteria were first developed on December 28, 1971, is that true, that is the date?

Dr. MARGULIES. Yes, sir.

Mr. SYMINGTON. Then there was a $60,000 contract awarded to validate the criteria?

Dr. MARGULIES. Yes, we are studying the effectiveness of those review criteria.

Mr. SYMINGTON. In other words, you are studying the effectiveness of the criteria after the decision to terminate, or did the validation of the criteria occur before the criteria were issued?

Dr. MARGULIES. We set that activity in motion at a time when the program was in full operation. In any case, I think it is a useful kind of technique which needs to be studied under any circumstances.

Mr. SYMINGTON. Do you know if any of the review criteria were changed?

Dr. MARGULIES. No, we kept them constant so we could carry out an effective analysis. If we changed them very much, it would be difficult to analyze their meaning.

Mr. SYMINGTON. Is the analysis complete?

Dr. MARGULIES. Not yet.

Mr. SYMINGTON. But sufficiently complete, together with other considerations, to justify in your mind terminating the idea as it is a part of the input in the decision?

Dr. MARGULIES. The use of review criteria has continued but, in the phaseout activity, we had other kinds of considerations which were inapplicable to this kind of technique.

Mr. SYMINGTON. Thank you, Mr. Chairman.

Mr. ROGERS. Let me ask a few quick questions. I won't take long. You did rate all the RMP's by these criteria.

Dr. MARGULIES. Yes, sir.

Mr. ROGERS. How did you grade them?

Dr. MARGULIES. They were given a numerical grade.

Mr. ROGERS. Did you use A, B, or C?

Dr. MARGULIES. They were listed in three groups: A, B, and C.

Mr. CARTER. What would a grade of 323 mean?

Dr. MARGULIES. Offhand, I don't recall. Probably the B level. I am not sure at this moment.

Mr. ROGERS. Well, how many were good or excellent? How many were not?

Dr. MARGULIES. I think the last time we evaluated it, there were about 14 rated "C."

Mr. ROGERS. Otherwise, the B and A would signify they were good or excellent.

Dr. MARGULIES. Yes, sir.

Mr. ROGERS. I will submit this for the record. Here is your rating of them which was made January 31, 1973. Out of 56 only 14 are rated as less than good, the others good or excellent. What did you use as a basis for saying the program should be phased out after this appraisal on January 31, 1973? That was just a few months ago.

Dr. ZAPP. I think we are talking of separate things. I think my statement pointed out——

Mr. ROGERS. I want to know what was the basis for the decision to terminate a program where you have just rated the vast majority of the component programs as good or excellent?

Dr. ZAPP. I am anxious to answer that question. I would think you have a program that is performing well or a significant number of those are performing well but that does not necessarily mean the Federal Government should continue 100 percent funding of that program. There can be a variety of reasons why that program—in this case you are talking of a variety of programs on a national basis—should not receive further support. We are saying, from the standpoint of expenditures and Federal purposes, it is not justified to continue that type of national program.

Many of the components in those programs should be continued. We think Congress has responded in the last couple of years to many of those same purposes that they have in the regional centers, for

example, kidney dialysis, PSRO's, the cancer control programs and health manpower. It is not just because the programs have performed miserably—we are not making that case—some of them have, but many have not.

Mr. ROGERS. That would not seem to be the thrust of the testimony today.

Mr. CARTER. Would you yield?

Mr. ROGERS. Certainly.

Mr. CARTER. I wonder how, in the heart, cancer, stroke, and kidney bill we can have the organization and the physician assistants, patient followup, emergency service and coordination of regional resources, how does that apply to heart, cancer, and stroke? Those are the purposes, avowed purposes of a particular program.

Dr. ZAPP. Dr. Carter, I would be pleased to read or provide for the record, time allowing, a 2½-page document which breaks down by groups the various thrust of IMP's starting with patient care and innovation of health care programs. A through H are residual authorities proposed for continuation within the Department.

Mr. ROGERS. By residual, do you mean a broad general authority?

Dr. ZAPP. No, they are authorities we are proposing for extension on which would continue. In other words, an authority that would expire on June 30, which we are proposing for continuation.

Mr. ROGERS. I think it would be well to have that for the record. I think it would be well for you to designate components which will continue action to determine the level of funding and the funding authority. Could you let us have that?

Dr. ZAPP. Yes, we would be pleased to do that. I think we have that all prepared.

[The following information was received for the record:]

RESIDUAL AUTHORITIES AVAILABLE FOR RMP-TYPE ACTIVITIES

Provided below is a list of the major types of RMP activities, including patient care demonstrations, quality of care assessment and assurance, manpower training and utilization, continuing education, health services research and development, and program staff activity. These are followed in each case by other continuing authorities available to fund similar activities. In addition, other RMP activities may be assumed by the efforts of State and local governments and local voluntary agencies.

I. PATIENT CARE DEMONSTRATIONS AND INNOVATIONS IN HEALTH CARE SYSTEMS

A. *National Center for Health Services Research and Development*—Section 304 PHS Act—A range of pilot experiments and demonstrations in terms of new patterns of delivery and patient management can be supported by NCHSR&D. A strong emphasis is on improving productivity through different methods of organizing health care delivery systems.

B. *Heart Disease Control Programs*—Section 414—Programs of prevention diagnosis and treatment of heart and pulmonary diseases similar to activities supported by Regional Medical Programs in the past.

C. *National Research and Demonstration Centers for Heart Disease*—Section 415—Aimed at clinical research, training, and demonstration of advanced diagnostic and treatment methods relating to heart and pulmonary disease.

D. *Cancer Control Programs*—Section 409—Programs of prevention, diagnosis and treatment of cancer similar to activities supported by Regional Medical Programs in the past.

E. *National Cancer Research and Demonstration Centers*—Section 408—Aimed at clinical research, training, and demonstration of advanced diagnostic and treatment methods relating to cancer.

F. *Kidney Disease Funding under the Social Security Amendments of 1972*—Section 2991 of P.L. 92-603—Provides for coverage under parts A and B of Medicare for workers and dependents under social security disabled with chronic renal disease. Much of the RMP effort in the area of developing national capability for transplantation and dialysis is expected to be integrated into the financing system provided through this additional Medicare coverage.

G. *Emergency Medical Services Systems*—Section 304—Coordinated EMS systems which tie together transportation, communication, and patient care subsystems will be supported under the broad development authority of Section 304.

H. *Project Grants for Health Services Delivery Improvements*—Section 314 (e)—A variety of activities formerly supported by RMP, such as multiphasic screening components of neighborhood health centers, and training of community health aides, can be supported under the 314(e) authority.

II. QUALITY OF CARE ASSESSMENT AND ASSURANCE

PSROs

Much of the RMP effort in the area of quality assessment and assurance will be taken over by the *Professional Standards Review Organizations*, authorized by Section 249F of the Social Security Amendments of 1972. This is particularly so in the area of development of standards of care for certain diseases and for certain patterns of patient care management.

III. MANPOWER TRAINING AND UTILIZATION

A. *Health Manpower Education Initiative Awards*—Section 774—Some RMP-type activities can be funded under this authority, particularly such items as

- Training programs leading to more efficient utilization of health manpower.
- New types of training emphasizing paraprofessionals such as physicians' assistants.
- Projects promoting the team approach to delivery of health services.
- Projects promoting regional arrangements among educational institutions and health care delivery institutions (e.g., Area Health Education Centers).

B. *National Center for Health Services Research and Development*—Section 304—A variety of demonstrations in terms of improved utilization of manpower and new types of manpower can be supported by NCHSR&D. Particular interest has been shown, for example, in studies which evaluate the impact of changes in licensing and regulation of manpower.

C. *National Research and Demonstration Centers for Heart Disease*—Section 415—Some training activities of the type formerly supported by RMP will be done by these centers.

D. *National Cancer Research and Demonstration Centers*—Section 408—Some training activities of the type formerly supported by RMP will be done by these centers.

IV. CONTINUING EDUCATION OF EXISTING HEALTH PROFESSIONALS

AHECs

Health Manpower Education Initiative Awards—Section 774—Projects similar to those supported by RMP promoting regional arrangements which coordinate the activities of health professional schools, hospitals and other health care delivery institutions are being supported under this authority. In some cases, those take the form of Area Health Education Centers, in which continuing education is one of many responsibilities.

V. HEALTH SERVICES RESEARCH AND DEVELOPMENT

NCHSR

National Center for Health Services Research and Development—Section 304—Many of the activities supported by RMP in the area of health services research and development can be funded under the 304 authority.

VI. PROGRAM (CORE) STAFF ACTIVITY

CHP

A. *Comprehensive Health Planning Agencies*—Section 314(a) State CHP; 314(b) Areawide CHP agencies—The Regional Medical Programs have been involved with a variety of joint planning and data system efforts which involve cooperation with other agencies, particularly the Comprehensive Health Planning agencies. It is expected that much of the RMP activity in this area can be picked up by the CHP agencies as they are expanded in both number and size.

RHL

B. *Regional Medical Libraries*—Section 397(a)—Some of the RMP support for central regional services such as communication and information systems can be picked up by the Regional Medical Libraries.

Mr. ROGERS. Also, I would like copies of the telegrams sent to the directors of the regional medical programs advising them of termination. Please supply that for the record. Supply for the record how the decision was made and who, by name, made the decision. I would like copies of the memoranda justifying termination so that, in recasting the legislation, the committee will have the benefit of your review. Also for the record, please submit the review of the regional medical programs and give us what you see taking place in these programs and its funding.

I won't pursue some questions I was going to ask of Dr. Margulies. I think we are clear that you did have the grading and we have the results of that. You will let us have all the criteria.

[Testimony resumes on p. 162.]

[The following information was received for the record:]

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE	SECURITY CLASSIFICATION
DHEW, PHS, HSMHA, Regional Medical Programs Service	ACTION INFO	
ACCOUNTING CLASSIFICATION 3-3971015 7530321 23.6J	DATE PREPARED Feb. 1, 1973	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☒ MULTIPLE ADDRESS
FOR INFORMATION CALL		
NAME Gerald T. Gardell	PHONE NUMBER 31800	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO: TO ALL RMPS COORDINATORS
PER ATTACHED LIST

THE PRESIDENT HAS SUBMITTED HIS BUDGET PROPOSALS TO THE CONGRESS. WHILE THE AMOUNT FOR FISCAL YEAR 1973 FOR RMPS GRANTS AND CONTRACTS IS SHOWN AS $125,100,000, THE ACTUAL AMOUNT AVAILABLE TO THE PROGRAM FOR GRANTS AND CONTRACTS DURING THE PRESENT FISCAL YEAR IS $55,358,000. THE ACTUAL REDUCTION IN THE AMOUNT AVAILABLE IS DETAILED ON PAGE 384 OF THE APPENDIX TO THE OFFICIAL SUBMISSION.

YOU ARE AWARE THAT WE HAVE BEEN OPERATING UNDER A CONTINUING RESOLUTION. EARLY IN THE FISCAL YEAR, 17 RMPs WERE FUNDED FOR ANOTHER YEAR WITH START DATES OF SEPTEMBER 1, 1972. THIS WAS FOLLOWED BY AWARDS AT THE END OF DECEMBER TO 18 RMPs WITH START DATES OF JANUARY 1, 1973. THERE REMAIN 21 RMPs WITH MAY 1, 1973 START DATES.

BY TELEGRAM ON DECEMBER 29, 1972, I ADVISED THE 18 RMPs WITH JANUARY 1 START DATES THAT BECAUSE OF THE LIMITED FUNDS AVAILABLE, THEIR AWARDS WERE AUTHORIZED ONLY THROUGH JUNE 30, 1973, FUNDED AT ONLY HALF THE AMOUNT ESTABLISHED FOR ONE YEAR. SIMILARLY WITH THE LIMITED FUNDS AVAILABLE WE HAVE DETERMINED THAT THE 21 REMAINING AWARDS WITH MAY 1 START DATES CAN BE EXTENDED ONLY THROUGH

SECURITY CLASSIFICATION

PAGE NO	NO OF PGS
1	4

STANDARD FORM 14
REVISED 6-30-57
GSA FPMR 101 CFR 101-33.304

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

TO:

JUNE 30, 1973.

NO GRANT FUNDS ARE INCLUDED IN THE PRESIDENT'S BUDGET REQUEST FOR RMP IN FISCAL YEAR 1974. THEREFORE, WITH NO ADDITIONAL FUNDS PROPOSED TO BE MADE AVAILABLE IN FISCAL YEAR 1974, AND WITH THE LIMITED FUNDS AVAILABLE THIS YEAR, THE ABOVE FUNDING DECISIONS WERE MADE TO AVOID THE POSSIBILITY OF OVEROBLIGATING FISCAL YEAR 1973 FUNDS. FURTHER, IN ORDER TO TREAT ALL 56 RMPs AS EQUITABLY AS POSSIBLE AND ATTEMPT TO PROVIDE FUNDS FOR THE MOST CRITICAL SITUATIONS, ALL OF FISCAL YEAR 1973 GRANT AWARDS WILL TERMINATE ON JUNE 30, 1973. IT FOLLOWS, THEN, THAT THE 17 GRANTS AWARDED AS OF SEPTEMBER 1, 1972, WILL RECEIVE AMENDED AWARDS REDUCING THE BUDGET PERIOD BY TWO MONTHS WITH APPROPRIATE PRORATED FUNDS. AS STATED ABOVE, ALL RMP GRANTS WILL BE TERMINATED ON JUNE 30, 1973.

IT IS OUR INTENTION TO PERMIT GRANT EXTENSIONS BEYOND JUNE 30 BUT TO NO LATER THAN FEBRUARY 15, 1974. ADDITIONAL FUNDS WILL NOT BE AWARDED EXCEPT AS DETERMINED NECESSARY TO ADHERE TO THE PRINCIPLE OF EQUITABLE TREATMENT. THIS WOULD BE TO ACCOMMODATE ONLY THOSE ACTIVITIES AND PROGRAM STAFF IDENTIFIED BY THE RMPS AS REQUIRING SUPPORT BEYOND JUNE 30, 1973 THAT CANNOT BE

SECURITY CLASSIFICATION

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2	4

STANDARD FORM 14
REVISED AUGUST 1967

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE SINGLE BOOK MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED [illegible]

TO:

TERMINATED BY THAT DATE DUE TO NEED TO FINALIZE NECESSARY REPORTS, PUBLISH FINDINGS, ETC. UPON RECEIPT OF YOUR PLANS BY MARCH 15, 1973, FOR TERMINATING GRANT SUPPORT, WE WILL ANNOUNCE IN APRIL 15, DECISIONS REGARDING REDISTRIBUTION OF ANY GRANT FUNDS AVAILABLE THROUGH ADJUSTMENT OF AWARDS WHICH CAN BE USED TO PHASEOUT RMPS SUPPORT. IT MAY WELL BE THAT WE WILL NOT BE ABLE TO SUPPORT MUCH OF WHAT IS CONSIDERED ESSENTIAL BY YOU BECAUSE OF THE LIMITED FUNDS AVAILABLE. YOUR PLAN, THEN, FOR BEGINNING AN IMMEDIATE PHASEOUT OF RMPS SUPPORT TO BE COMPLETED NO LATER THAN FEBRUARY 15, 1974, SHOULD BE DEVELOPED AND SUBMITTED TO US NO LATER THAN MARCH 15, 1973. THE PLAN SHOULD REFLECT THE FOLLOWING REQUIREMENTS:

1. DO NOT ENTER INTO ANY NEW CONTRACTS OR AGREEMENTS FOR ACTIVITIES OR PERSONNEL WHICH COMMIT RMPS FUNDS.
2. REQUEST CONTINUED SUPPORT FOR ONLY THOSE ACTIVITIES REQUIRING RMPS FUNDS THAT WILL PRODUCE A PREDICTABLE RESULT JUSTIFYING THE FEDERAL INVESTMENT, OR
3. REQUEST CONTINUED SUPPORT FOR THOSE ESSENTIAL ACTIVITIES WHERE A MECHANISM HAS BEEN ESTABLISHED TO CONTINUE WITHOUT INTERRUPTION SUPPORT OF THE ACTIVITY FROM OTHER RESOURCES.

SECURITY CLASSIFICATION

PAGE NO. 3 | NO. OF PGS. 4

Standard Form 14
[illegible]

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

IT IS REQUESTED THAT YOUR PLAN BE SUBMITTED IN WRITING, ACCOMPANIED BY PAGES 1, 6, 15 and 16 OF THE APPLICATION FORM 34-1, FOR PHASING OUT ALL RMPS SUPPORT BY JUNE 30, 1973, AND A SEPARATE PLAN AND SET OF FORMS FOR ACTIVITIES PROPOSED FOR CONTINUATION BEYOND JUNE 30, 1973, BUT IN NO EVENT BEYOND FEBRUARY 15, 1974.

MAY I ALSO REMIND YOU THAT YOUR PLAN FOR PHASING OUT OPERATIONS MUST INVOLVE THE GRANTEE OFFICIAL AND THE RAG IN ACCORDANCE WITH THEIR RESPONSIBILITIES DELINEATED IN RMPS-NID DATED AUGUST 30, 1972. STAFF IN THE DIVISION OF OPERATIONS AND DEVELOPMENT ARE AVAILABLE TO CONSULT WITH YOU IN THE PREPARATION OF YOUR PLAN.

IT IS EXPECTED THAT ALL EXPENDITURE REPORTS UNDER THIS PROCEDURE WILL BE RECEIVED IN RMPS BY NO LATER THAN JUNE 15, 1974.

I AM SURE EACH OF YOU RECOGNIZE THAT IN THE LIGHT OF THE PRESIDENT'S RECOMMENDATIONS WE NEED TO PROCEED WITH THE DEVELOPMENT OF PHASEOUT PREPARATIONS IN AN ORDERLY AND PROMPT MANNER.

HAROLD [illegible], M.D.
DIRECTOR
REGIONAL MEDICAL PROGRAMS SERVICE

SECURITY CLASSIFICATION		
PAGE NO	NO. OF PGS	
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STANDARD FORM 14
REVISED AUGUST 1957

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION
ROCKVILLE, MARYLAND 20852

February 22, 1973

REGIONAL MEDICAL PROGRAMS SERVICE

TO ALL RMP COORDINATORS AND GRANTEE OFFICIALS

The purposes of this letter are to refine and clarify points in the telegram sent to you on February 1, and to provide you with as definitive information as is possible at this time about (1) current plans for phasing out both individual Regional Medical Programs and the Regional Medical Programs Service in accordance with the Administration's budgets for FY 73 and FY 74; (2) the process by which phase-out plans will be reviewed and the criteria to be employed in review; (3) what additional items of information must be submitted by each Regional Medical Program at the time it submits its phase-out plan; and (4) appropriate regulations and policies for a number of specific issues which many or all Regional Medical Programs face and about which a number of questions have arisen. These topics are discussed below in order.

1. Because no funds for Regional Medical Programs Service have been requested by the Administration for FY 74, a phase-out plan had to be developed by Regional Medical Programs Service for the Office of the Administrator, HSMHA, and a maximum termination date (February 15, 1974) set for the Regional Medical Programs. Immediately on receiving approval from HSMHA for this plan, a telegram was sent to you on February 1 indicating that each region should submit two written plans, one "for phasing out all Regional Medical Programs Service support by June 30, 1973, and a separate plan and set of forms for activities proposed for continuation beyond June 30, 1973, but in no event beyond February 15, 1974."

Following the telegram our staff has received many questions, some of which lead us to believe that possibly some inappropriate interpretations have been placed upon the February 15 date. This is an important matter which I wish to clarify in in the event that any region is proceeding upon such an interpretation. The February 15 date is merely the last possible termination date for any Regional Medical Program, in that no Regional Medical Programs Service funds can be expended beyond then for any purposes except where funds

previously were obligated under contracts which subsequently are approved during the forthcoming review of phase-out plans, or where otherwise specifically authorized by Regional Medical Programs Service.

Apart from any consideration of how much money may actually become available for possible redistribution among Regional Medical Programs to support extensions of approved activities beyond June 30, let me emphasize three important points. First, approval by Regional Medical Programs Service for the extension of any proposed activity beyond June 30 depends first and foremost upon the ability of the region to demonstrate fully that any activity identified for Regional Medical Programs Service review is meritorious and meets one or the other of the requirements (#2 or #3) stated in the telegram. Approval will not depend upon whether funds might be available within a Regional Medical Program for its support beyond June 30. (Note: To meet requirement #3 the region will have to provide a written guarantee, or equivalent proof, that continued support will be provided from another source by a date consistent with the needs of the project.)

The second point is that support of program staff beyond June 30 can be given only to the extent that the work to be accomplished within the Regional Medical Programs Service-approved phase-out plan for the region including completion of required final reports, clearly justifies the proposed staff level(s). Although every possible consideration will be given to circumstances which may be unique to a given region, the Administration believes that the February 1 notification of phase-out constitutes reasonable notice to all program elements. In a parallel action and consistent with this philosophy, the Department is requiring a sharp reduction in headquarters staff by this June 30 with further reductions scheduled thereafter.

The third point is that no advance assurance can be made that any region will retain at least its own unexpended balance beyond June 30. All funds unexpended as of June 30 will be available to Regional Medical Programs Service for disbursement or redistribution in a manner to best implement the phase-out of the overall program. Some regions may voluntarily terminate their activities as of June 30, others undoubtedly will be required to do so because of an inability

to meet the criteria set forth for requesting extensions of activities. Thus, in view of the uncertainties, it is our judgment that Regional Medical Programs should realistically consider June 30 or soon thereafter as likely termination dates, with perhaps only the Regional Medical Program under exceptional circumstances continuing its activities into FY 74 for a limited time. In no event can grant funds be used for any purpose, including preparation of final reports, beyond February 15, 1974.

In stating these considerations we in no way are attempting to anticipate either what any given Regional Medical Program's phase-out plan will be or the merit thereof; we do wish to inform you for your consideration at this point in time realistically what we see from our position in HSMHA.

2. General Criteria for Review of Phase-out Plans and Procedure to be Employed.

Each region's plans will be reviewed thoroughly by all appropriate senior professional staff, with individual and overall analyses made of key elements both for individual regions and across the entire program relative to such factors as proposed costs, timetables, staffing levels and justifications for those grant and contract activities which are requested for continuation beyond June 30.

The merit of a region's proposed activities will be determined in the light of whatever information can be obtained from records for that region from Review Committee and National Advisory Council deliberations which bear upon the subject, together with an independent staff assessment of how well the phase-out plan meets the conditions cited in the telegram. It is expected that all the information required to arrive at sound decisions may not be available to us from our records or from a thorough study of your plan. Therefore, should further information be needed telephone calls will be placed and, as deemed necessary by the Director, visits to the regions will be arranged. Visits will be made for specific purposes which will be clearly identified and discussed in advance with the region. In the limited time available we will be required to utilize both our staff and our professional discretion to the fullest extent. Major decisions made by Regional Medical Programs Service as the result of reviewing the plans of the Regional Medical Programs certainly will be subject to review by HSMHA and the Department. Such reviews will be conducted as expeditiously as possible so that decisions can be transmitted to you no later than April 15.

To assist you in preparing your phase-out plans and to assist us in reviewing them prior to arriving at final funding decisions, attached are three sets of requirements we would appreciate your incorporating in your phase-out plans.

Sincerely yours,

Harold Margulies

Harold Margulies, M.D.
Director

Enclosures

ATTACHMENT 1

REQUIREMENTS FOR THE JUNE 30, 1973 PLANS TO BE SUBMITTED NO LATER THAN MARCH 15, 1973

Fifteen (15) copies of the following items are to be sent to Regional Medical Programs Service, Room 10-12, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20852:

1) Page 1 of Form RMP 34-1

2) Page 2 of Form RMP 34-1

3) Page 6 of Form RMP 34-1 listing staff on duty and date of departure

4) Page 15 of Form RMP 34-1 for each operational project now funded whether or not support is being requested beyond June 30. Include in left hand "Progress" column, information on status of project as of June 30, i.e., completed, terminated without completion, continuation under other auspices, etc. Also when possible, list accomplishments of project.

5) Page 16s of Form RMP 34-1 for:

   a) total budget for your current budget period through June 30, 1973

   b) program staff budget

   c) developmental component, if any

   d) each operational project now funded

6) Concise narrative describing overall phase-out plans including information regarding steps taken to comply with equipment accountability, financial reports, record retention, etc. (See Attachment 3 for details.)

7) Please list feasibility studies, amount of support under current award and status as of June 30, 1973 (i.e., completed, etc.). If possible, we would appreciate a brief description of the studies. In addition, list central resources, amount of support under current awards and proposed disposition of materials after phase-out.

8) Finally, list activities supported under developmental component, dollars invested under current award through June 30, and a brief description.

ATTACHMENT 2

REQUIREMENTS FOR PHASE-OUT PLANS DUE NO LATER THAN MARCH 15, 1973
FOR FUNDS REQUESTED BEYOND JUNE 30

Fifteen (15) copies of the plan are to be sent to Regional Medical Programs Service, Room 10-12, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20852, and should include:

1) Page 1 of Form RMP 34-1

2) Page 2 of Form RMP 34-1

3) Page 6 of Form RMP 34-1 listing names of any staff for which support is requested, description of functions they will perform and termination date of employment (no later than February 15, 1974). If funds are requested to enable staff to be supported from other sources, include signed agreement regarding future support.

4) Page 15 of Form RMP 34-1 for any operational project for which support is requested beyond June 30, state the reason for the request. If it is for requirement #2 outlined in the telegram, state the results predicted, the specific date the project will terminate, and significance of Federal investment (i.e., impact geographically, demographically, and on specific target groups). State when a termination report will be available to Regional Medical Programs Service, and who will develop it. If continuation is requested to enable funding from other sources, indicate source, exact date when other support will commence, and attach necessary documentation that can be verified.

5) Page 16s of Form RMP 34-1 for Program Staff Budget attach narrative justification for each line item requested. The same information is required by line item for each project proposed for support.

6) A listing of activities by priority proposed for funding beyond June 30 would be helpful to Regional Medical Programs Service.

ATTACHMENT 3

GRANTS MANAGEMENT POLICIES FOR REGIONAL MEDICAL PROGRAMS PHASE-OUT ACTIVITIES

Historically, it has been the fundamental requirement of grantees to be responsible and primarily liable for both fiscal and administrative operations involved in the management of a Regional Medical Program (See News Information Data--Vol. 6. No. 15S of August 30, 1972). This means specifically that grantees are held accountable for all Regional Medical Programs Service funds awarded, and the Federal Government will continue to hold the grantee fully accountable and responsible for all Federally supported activities under the grant. Therefore, it is assumed that each Regional Medical Program has made the necessary arrangements to safeguard its interests and also the rights of the affiliates by including appropriate provisions in the contracts and agreements as set forth in the existing policy document, NID, Vol. 4, No. 32S of July 10, 1970.

The following set of policies are considered to be most significant regarding accountability in developing a phase-out plan to protect the grantees' interest and that of the affiliates:

1. Lease Costs for Space, Equipment, etc.

   OMB Circular A-21, Section J.45.e, provides that rental costs under unexpired leases, i.e., leases for space, equipment, and/or maintenance contracts, etc., are generally allowable if (a) the amount of such rental claims does not exceed the reasonable use value of the property leased for the period of the activity, and (b) the grantee and affiliates make all reasonable efforts to terminate, assign, settle or otherwise reduce the cost of such lease.

2. Equipment Accountability

   Grantees are responsible for utilizing equipment purchased with Regional Medical Programs Service funds for continued activities under Title IX of the Public Health Service Act, as amended. The same policy applies to affiliates once title to and accountability for equipment have been transferred to them. Therefore, the following options may be applied and included in the phase-out plans due March 15, 1973. (HEW Grants Administration Manual Chapter 1-410-50A.2.a.).

   A. Transfer title to and accountability for equipment to either another grantee, an affiliated institution or other institution that will provide assurance to the grantee that the equipment will continue to be used for activities within the scope of Title IX of the Public Health Service Act, as amended. To effect such transfer, documentation should be made in accordance with the NID, Volume 6, No. 14S dated August 9, 1972.

B. Present proposal to utilize equipment within the grantee on health-related activities that are within the scope of Title IX of the Public Health Service Act, as amended. Such equipment should be itemized in the phase-out plan.

In the event equipment used in project or program activity is no longer needed for purposes under Title IX by the Regional Medical Program, grantee or affiliate, accountability may be satisfied by either (1) crediting the grant account with an amount equal to the Federal share of the fair market value of the equipment or (2) refunding to the HSMHA proceeds from the sale of the equipment.

Appropriate documentation should be submitted by each Regional Medical Program with the phase-out plan to justify the option selected.

3. Severance Pay

OMB Circular A-21, Section J.36, provides that severance pay is an allowable cost only when it is required by (a) law, (b) employe employee agreement, (c) established policy that constitutes, in effect, an implied agreement on the institution's part, or (d) circumstances of the particular employment. Regional Medical Programs Service will not consider severance pay an allowable cost unless the basis for payment for any of the four options listed above is a formal written policy or agreement of the grante institution, which existed prior to the February 1, 1973, notice of phase-out.

4, Required Financial Reports

In addition to the phase-out plans to be submitted by March 15, 19 the following reports are required to be submitted:

A. Prior to the submission of the final Reports of Expenditure (1) a report listing all non-expendable equipment and personal property on hand and a request for approval from Regional Medical Programs Service of the proposed disposit of said equipment and property, and (2) a list of all ex-pendable equipment and property on hand with a value of at least $50.00 with a request for approval from Regional Medi Programs Service of the proposed disposition of such items.

B. Reports of Expenditure within 120 days after the closing date of the Regional Medical Programs Service grant. (Note: As stated before, grant funds cannot be used for preparation of required financial reports beyond February 1974.)

5. Audio-Visual Policy

Audio-visual materials developed with grant funds may be disposed of as follows: (General Counsel's opinion dated March 15, 1972 and included in General Counsel's Report of March 1972).

(a) They may be sold by the grantee to a distributing organization,
(b) They may be retained by the grantee institution, and distributed as appropriate,
(c) They may be turned over to a Federal distribution center, (i.e., National Audio-visual Center, GSA)

Any royalties or profits realized by grantees on these items must be returned to the Federal Government up to its share of the investment as provided in General Counsel's opinion of March 15, 1972.

6. Records Retention

All records on Regional Medical Program activities must be retained in accordance with existing policy contained in Regional Medical Programs Service Guidelines. Regional Medical Programs should indicate the names and addresses of appropriate personnel to be contacted to determine location of records and to be available should audit questions arise subsequent to (a) termination of Regional Medical Programs Service support, or (b) dissolution of existing organizations funded by Regional Medical Programs Service.

7. Grant-Related Income

All unexpended balances of grant-related income are to be identified as to location and amount and reported as part of the phase-out plans. Plans due March 15, 1973, must contain requests for use of any grant-related income realized or anticipated.

8. Additional Funds Awarded in June 1972 for Specific Projects - (EMS, HSEA, PEDIATRIC PULMONARY)

The provisions of the February 1, 1973 telegram are applicable to all funds awarded the Regional Medical Programs for specific projects under this heading. Therefore, any savings accruing as a result of application of these provisions will either be used to accommodate funding requirements for the programs during phase-out and/or be made available for meeting other needs as determined by Regional Medical Programs Service.

9. Contracts

Although the February 1, 1973, telegram indicates that no new contracts or agreements should be entered into which commit Regional Medical Programs Service funds, this statement has been modified to indicate that contractors may enter into subcontracts during the phase-out period only if (a) the subcontract was part of the

98-872 O - 73 - 11

original contract, which is considered essential during phase-out, but which had not been executed prior to February 1, 1973, and (b) the subcontract increases the rate of phase-out activities without additional costs.

10. Required Audits for Regional Medical Programs

It is the policy of Health, Education, and Welfare that fiscal records be maintained for a period of at least five years (Chapter 1-100-20 of the HEW Grants Administration Manual) subsequent to the termination date of the budget period or longer until audit has been conducted and all findings have been resolved. Since most of the grantees for the Regional Medical Programs are under the cognizance of the HEW Audit Agency, that Agency plans to schedule audits as soon as practicable for those financially dependent, non-profit organizations that have been established solely to receive and administer the Regional Medical Program grant.

Regional Medical Programs may schedule independent audits by certified public accountants prior to the termination of the grant provided it is grantee policy. However, the HEW Audit Agency reserves the right to perform an audit regardless of whether an audit has been performed by a certified public accountant.

The Federal Government maintains the right to recover amounts questioned at final audit whether or not the audit is performed prior to the termination of the Regional Medical Program grant.

Proposed Termination Dates of Regional Medical Programs in Chronological Order

Termination dates for the 56 RMP's are grouped by the following dates, with all RMP's expected to be phased-out by February 14, 1974.

June 30	5	November 30	4
July 31	1	December 31	2
August 31	3	January 31, 1974	4
September 30	4	February 14	27
October 31	6		

June 30, 1973

Delaware
North Dakota
Northeast Ohio
Ohio
Puerto Rico

July 31, 1973

Ohio Valley

August 31, 1973

Greater Delaware Valley
Nassau Suffolk
Susquehanna Valley

September 30, 1973

Connecticut
Northlands
Oklahoma
North Carolina

October 31, 1973

Maryland
Metropolitan Washington, D.C.
Mountain States
New York Metropolitan
Texas
Tri-State

November 30, 1973

Alabama
Florida
Virginia
Western Pennsylvania

December 31, 1973

Northern New England
Wisconsin

January 31, 1974

Albany
Bi-State
Louisiana
South Dakota

February 14, 1974

Arkansas
Arizona
California
Central New York
Colorado/Wyoming
Georgia
Hawaii
Illinois
Indiana
Inter-Mountain
Iowa
Kansas
Lakes Area
Maine
Memphis
Michigan
Missippi
Missouri
Nebraska
New Jersey
New Mexico
Oregon
Rochester
South Carolina
Tennessee Mid Scut
Washington/Alaska
West Virginia

Proposed Termination Dates of Regional Medical Programs

	Region	Proposed Termination Date
1.	Alabama	11/30/73
2.	Albany	1/31/74
3.	Arkansas	2/14/74
4.	Arizona	2/14/74
5.	Bi-State	1/31/74
6.	California	2/14/74
7.	Central N.Y.	2/14/74
8.	Colo./Wyo.	2/14/74
9.	Connecticut	9/30/73
10.	Delaware	6/30/73
11.	Florida	11/31/73
12.	Georgia	2/14/74
13.	Gr. Del. Valley	8/31/73
14.	Hawaii	2/14/74
15.	Illinois	2/14/74
16.	Indiana	2/14/74
17.	Int. Mt.	2/14/74
18.	Iowa	2/14/74
19.	Kansas	2/14/74
20.	Lakes Area	2/14/74
21.	Louisiana	1/31/74
22.	Maine	2/14/74
23.	Maryland	10/31/73
24.	Memphis	2/14/74
25.	Metro. D.C.	10/30/73
26.	Michigan	2/14/74
27.	Mississippi	2/14/74
28.	Missouri	2/14/74
29.	Mt. States	10/31/73
30.	Nassau/Suffolk	8/31/74
31.	Nebraska	2/14/74
32.	New Jersey	2/14/74
33.	New Mexico	2/14/74
34.	N.Y. Metro.	10/31/73
35.	N. Carolina	9/30/73

	Region	Proposed Termination Date
36.	N. Dakota	6/30/73
37.	N.E. Ohio	6/30/73
38.	N. N. England	12/31/73
39.	Northlands	9/30/73
40.	Ohio	6/30/73
41.	Ohio Valley	7/31/73
42.	Oklahoma	9/30/73
43.	Oregon	2/14/74
44.	Puerto Rico	6/30/73
45.	Rochester	2/14/74
46.	South Carolina	2/14/74
47.	S. Dakota	1/31/74
48.	Susq. Valley	8/31/73
49.	Tenn. Mid So.	2/14/74
50.	Texas	10/31/73
51.	Tri-State	10/31/73
52.	Virginia	11/30/73
53.	Washington/Alaska	2/14/74
54.	W. Virginia	2/14/74
55.	W. Penn.	11/30/73
56.	Wisconsin	12/31/73

Mr. ROGERS. Thank you very much.

We now have a distinguished panel of physicians. Dr. Robert Carter, dean of the School of Medicine, University of Minnesota, Duluth, Minn.; Dr. Faxon Payne, chairman of Area Advisory, SW. Kentucky for Tennessee-Midsouth RMP; and Dr. William J. Hagood, Jr., speaker of the House of Delegates of the Medical Society of Virginia.

We are honored to have you gentlemen with us and will be pleased to have you take your place at the table. We are sorry we are running a little late but we are pleased to have you give your statements at this time and then the committee may have a few questions.

STATEMENTS OF A PANEL CONSISTING OF DR. FAXON PAYNE, CHAIRMAN, AREA ADVISORY, SW. KENTUCKY FOR TENNESSEE-MIDSOUTH RMP; DR. WILLIAM J. HAGOOD, JR., SPEAKER, HOUSE OF DELEGATES, THE MEDICAL SOCIETY OF VIRGINIA; AND DR. ROBERT E. CARTER, DEAN OF SCHOOL OF MEDICINE, UNIVERSITY OF MINNESOTA

Dr. PAYNE. If it pleases the committee, I will lead off. I am Faxon Payne.

We thought we might give our statements one after another and then answer any questions.

Mr. Chairman, I feel most humble and most honored in being able to appear before this distinguished committee to briefly state some of my views and experiences in the regional medical program. I am a native of southwestern Kentucky and have been in the practice of medicine in Hopkinsville, Ky., a community of approximately 24,000 since 1953. I am a member of a four-man partnership group which does the radiology for five hospitals, two of which are State institutions.

I have been personally and actively involved in the regional medical program in our area of the country since early 1967, the year that the Tennessee midsouth regional medical program came into existence. Our community lies some 70 miles northwest of Nashville, Tenn., where Vanderbilt University and Meharry Medical College constitute the two largest medical centers of our area and, quite naturally, our program has been integrally associated with these institutions from its inception.

We organized an area advisory group later in that year and were fortunate enough to have a very fine physician retiring from the military service take over as the area coordinator for southwest Kentucky a few months later. I am sure that, like all other nationwide programs of a governmental or nongovernmental nature, there are some regional programs which have never realized their potential or utilized their full capabilities. We do not feel this has been the case in our area for many reasons. From the beginning the physicians and health institutions in our area began to see the advantages inherent in a cooperative relationship that we had never sought nor envisioned in the past.

With the stimulus furnished by RMP the hospitals in our area began a cooperative venture which has continued to the present and will increase in size and scope in the future; involving a cooperative

laundry, linen supply, and supply purchasing department, which now serves eight hospitals in the western Kentucky area, effecting a considerable economy passed on to the patient. This, like many other very worthwhile projects was accomplished with no money from RMP, but was the result of the stimulus and guidance of an excellent staff in the Tennessee Midsouth regional medical program office in Nashville, Tenn.

Seed money has been used through RMP in our area to establish two full scale coronary care units and two holding coronary care units and one school for training cardiac nurse specialists for our southwest Kentucky area. Without RMP this would never have occurred and our death rates from coronary occlusion have decreased significantly since the advent of these units. All of these units are now fully self-supporting and will continue to be so. The seed money got the local hospitals over the hump initially for the expensive equipment involved in establishing these units and these have served us well.

An open toll-free telephone line has been established between three nearby hospitals and the hospitals in which I practice and through our hospital to Vanderbilt University Hospital so that all the practicing physicians in these four areas have rapid and easy access for EKG transmission, telephone consultation, arranging appointments with specialists in the medical center, etc., at their fingertips every day. This was established by RMP money and during the past year was taken over completely by the hospitals involved and is now funded locally without Federal funds. We had hopes of extending this system into even greater sophistication, but this will be impossible if RMP does not continue.

We have seen the rapid development of a continuing educational program for nurses, technologists, nurses aides, surgical technicians, dietitians, and hospital administrators, and trustees, as well as physicians grow rapidly and develop over the past 5 years as a result of the regional medical program. RMP has furnished the seed money for the audiovisual equipment, television tape players, visiting consultants and speakers during these past few years and there is no question in my mind that the standard of medical practice and the practice of allied health personnel have improved markedly as a direct result of this continuing educaitonal program.

I could go on and on relating the success of our stroke projects, patient diabetic education programs, hypertension study projects, cancer registry and even the ultimate formation of a five county medical society to show the fantastic impact that regional medical programs have had in our section of Kentucky, however, time does not permit such a lengthy discussion.

I am sure that the committee has heard examples of the above repeatedly and has heard repeatedly the statements that RMP appears to be an ideal program for involving the private sector in a creative and innovative program of improving health care delivery systems, but I would like to state most positively my strong feeling that the grassroots aspect of RMP is its greatest asset. The entire structure of this system is such that the decisions as to the expenditure of these tax dollars is vested in the local people of the areas and regions involved. I have served on the review and study committees of the Tennessee

Midsouth regional medical program for over 5 years and have seen the strict adherence to the guidelines dictated by Public Law 89-239, and the close watch that these local people have kept on the funds expended in the projects that they have approved. I think I have seen less waste in regional medical program expenditures than in any governmental agency that I know of personally.

Perhaps the grassroots portion of the program is what disturbed the Government, but the ultimate control of appropriations still remains with the Federal Government and is determined by the appropriations of Congress. Believe me, when the small amount that is delegated for a given project in a given small community reaches the bottom it is most carefully expended. The fact that in almost every instance the expenditure has been in the form of seed money which has encouraged the use of other local money and participation by local individuals and institutions indicates to me that the taxpayer has gotten more for his dollar in regional medical programs than he has gotten in any other program around.

Unfortunately, RMP has not put a sign on every project that it has fostered, stimulated, or partially funded and this has apparently been its gravest error. The general public does not realize that many of the health advantages they enjoy in their local small hospitals or, even in their local large hospitals, have been the result of seed money and or stimulus by the regional medical program in many instances.

I understand now from the news and letters I have received from people who work in the program that the idea is to shift the many "worthwhile projects" into other agencies. I feel this is merely a courteous way of writing its epitaph. I, like many others who have been associated with this program as a volunteer, feel almost certain that within the next few years we will see a rebirth of another program to take the place of RMP and, unfortunately, the great expenditure of funds to go over the same ground that RMP has covered for the past 6 years. I do not believe that the thousands of volunteer workers in RMP like myself who have never received a penny for their services to this excellent program will want to go through the groundwork and agony of reorganization again.

I sincerely hope that this committee will see fit to approve the approach of H.R. 5608 as not only reasonable and rational, but also an instrument to save the American taxpayer millions of dollars in future years.

Mr. ROGERS. Thank you very much, Dr. Payne.

Mr. CARTER. Would you yield?

Mr. ROGERS. Yes.

Mr. CARTER. I regret I was not here to introduce Dr. Payne, he is an outstanding radiologist.

I have watched this program and have seen the wonderful effects produced by it. It is one of the outstanding regional medical programs of the United States and I am happy that one physician in Kentucky headed this group and has carried it out to the letter of the law, in my opinion. You have done an excellent job.

Dr. PAYNE. Thank you, Dr. Carter.

Mr. ROGERS. We are delighted to hear this, doctor, and appreciate your giving us the benefit of your experience.

STATEMENT OF DR. WILLIAM J. HAGOOD, JR.

Dr. HAGOOD. I am William J. Hagood, Jr.

Mr. ROGERS. Doctor, I think we should let the committee know some of the background shown on your statement. You are speaker of the House of Delegates, Virginia Medical Society; past president of the Virginia Academy of Family Practice, past speaker of the Congress of Delegates, American Academy of Family Practice; and you have been on the advisory group of the Virginia RMP and a member of Board of Supervisors, Halifax County, Va.

Dr. HAGOOD. Mr. Chairman, I appreciate the honor of being able to present by views on regional medical programs to this distinguished committee. I am a native Virginian, but I was raised in southeastern Kentucky, specifically Harlan County, and am now in the practice of family medicine in Clover, Va., a community of approximately 300 in the piedmont area of Virginia near the North Carolina border. The people served by our small clinic are very similar to those in the area in which I grew up. They are law-abiding, God-fearing, hard-working, independent, salt of the earth folks. Yet, they are in need of good medical care, but unfortunately there are too few doctors and allied health personnel to serve them properly. My days are filled with demanding work, but it is happy work.

I was reluctantly and finally lured into becoming involved in RMP because I became convinced that RMP offered a good deal of hope and promise in assisting doctors such as myself to provide more and better medical care to our patients. This we have tried to do in Virginia, and for the most part, I believe we have been successful. Quality assurance programs are directed into nursing, pharmacy, and dentistry, as well as the medical profession. Private practicing physicians have available systems for self-evaluation to delineate their deficiencies and thereby point out areas in which they can concentrate continuing education. Now you might say that doctors can well afford to pay for their own postgraduate education, and, basically, I agree.

However, RMP in Virginia has the majority of its ongoing studies specifically geared to other less affluent health care providers—for example: clinical nurses, family nurse practitioners, pharmacists in rural areas, technicians in radiology and laboratory disciplines, medical librarians, dental assistants, and other subphysician personnel.

Even for M.D.'s, money may be no objective, but finding a nearby course or facility to educate oneself is difficult. Instead of having to leave one's practice for days, VRMP brings the consultant to the periphery. The patient is served by not having to seek care elsewhere, and by receiving better care from a more up-to-date doctor.

If I may digress, I have two comments I would like to leave with you. These are letters that come from the Waynesboro Hospital and I think these letters speak for themselves.

Mr. ROGERS. They will be helpful and they will be made a part of the record following your statement.

Dr. HAGOOD. I think, when Dr. Roy and Dr. Carter see these, a myriad of memories will come back to them of their medical practice.

There may be other methods of achieving similar results, but until RMP began, everything was helter-skelter with no coordination being

undertaken by anyone. No one had that obligation. In Virginia, we have been able to use Federal tax dollars to fill identified needs not being filled by anyone else. These dollars are not subject to any political machinations. They are allocated on the basis of merit and need by a hardnosed fiscally conservative volunteer regional advisory group. You can take my word that we Virginians have taken our stewardship over the expenditure of these tax dollars most seriously, and try to do the best job we can to see that the money is put to good use. This is true revenue sharing, but without the necessity of going through a governmental structure. This is a key point, and one on which I believe has contributed to whatever success we have been able to accomplish.

Now I don't wish to portray a picture devoid of problems and frustrations. Being involved with RMP has been one of the most frustrating exercises with which I have ever been associated. The reasons for this is the very reason I am before you today. It is, for lack of a better term, the fickleness of the Federal Government itself. We have had our funding levels shifted, funds taken away without notice, promises broken, commitments unmet, told to do one thing one day and another thing another day, and our credibility compromised because of arbitrary and capricious behavior of Federal bureaucrats more interested in form than substance.

The central office of RMP out in the Parklawn Building has been the cause of many of RMP's problems, and this failure of HEW's own administrative arm should not be transferred to the 56 regions themselves, whose paid staff members and cadre of volunteers have literally bled from the difficult task of creating the necessary relationships and involving the necessary people in a program designed to be of benefit to the patient. To cut it off now would be a most serious waste of the taxpayers' dollars. And, I wouldn't be a bit surprised if something else is not promoted in a couple of years to do the same thing RMP is doing now, and it will have to start from scratch—it has taken 4 to 5 years for many in the health field to finally accept and to develop confidence in a federally funded health program. I can assure you, that my future involvement in federally supported programs, and I dare say the involvement of many of my colleagues, will be drawn upon the bitter experience we have gained with RMP.

The approach of H.R. 5608 is reasonable and rational. It still may not be too late to put Humpty-Dumpty together again—if you hurry.

[The letters referred to follow:]

WAYNESBORO COMMUNITY HOSPITAL,
Waynesboro, Va., April 9, 1973.

EUGENE PEREZ, M.D.,
Virginia Regional Medical Program, Inc.,
Richmond, Va.

DEAR GENE: This is to report on the visitation by Dr. Frank McCue to the Waynesboro Community Hospital last week as our "Physician in Residence".

Dr. McCue came over Tuesday afternoon and spent two hours with our nursing staff, including the student nurses of the LPN school, speaking on Rehabilitation in Orthopedic Nursing. His talk was quite well received by the nursing staff. Unfortunately, the group of nurses from Eastern Mennonite College School of Nursing who had been expected to attend were unable to because of unexpected conflicts in scheduling.

Tuesday afternoon from 4:30 until 5:30 Dr. McCue reviewed eight clinical cases of injuries being cared for by the physicians in the Medical Building.

giving excellent pointers in the management of each case. There were four private physicians involved in this conference.

At 5:30 p.m. we had dinner. At 6:15 Dr. McCue presented his talk on "Surgery of Arthritic Joints", followed by an extended period of discussion including the case presentation of a young patient from Woodrow Wilson Rehabilitation Center with the established diagnosis of Still's Disease. There were approximately 35 people including medical staff and nursing staff at this conference. This meeting adjourned at about 8:15 p.m.

Wednesday morning from 9:00 until 12:00, Dr. McCue was in the operating room reviewing certain technical problems in orthopedic surgery with the surgical staff. From 1:00 p.m. until 2:00 p.m. he reviewed x-rays of problem cases of athletic injuries with five physicians. From 2:00 until 3:30 a clinic in management of injuries in the Emergency Room was held, specifically with the use of casting, splinting, taping and physiotherapeutic measures in acute injury. From 3:30 until 4:30 Dr. McCue worked with Dr. H. B. Ryder in the Operating Room demonstrating the repair of acute injury including laceration of a major tendon.

It is my considered conclusion from our experience with Dr. McCue that the "Physician in Residence" program is a most valuable one which should be continued. As in all programs in continuing education on the local level, the same old problem of individual involvement, participation, learning and application of this new learning in daily practice continues to be the major obstacle. Certainly Dr. McCue's contribution to this learning situation was even better than we expected from our previous experiences with him. His range of knowledge and presentation of subject matter cut across all lines of specialty training and his delivery was most effective and his ideas most practical. I would recommend that he return for further teaching.

Just how the involvement and participation of the local physicians can be augmented is difficult for us to evaluate at this time. The Waynesboro Community Hospital plans to have another program of this type in the calendar year 1973. The postgraduate and continuing education committee and the Medical Staff have already voted to dedicate all efforts toward such augmentation of visiting teachers as proposed in the "Physician in Residence" program.

Let me thank you from the bottom of my heart on behalf of the Medical Staff of the Waynesboro Community Hospital for your support in having Dr. McCue come visit us. Again, let me state that this would seem to be a vital addition in the continuing education of the practicing physician to improve his quality of daily care of his patients.

Very sincerely yours,

ROBERT G. BUSBOOM, M.D.,
President Medical Staff.

DEPARTMENT OF ORTHOPEDICS,
UNIVERSITY OF VIRGINIA MEDICAL CENTER,
Charlottesville, Va., April 12, 1973.

Dr. Ed. E. Perry,
Virginia Regional Medical Program,
Richmond, Va.

DEAR DR. PERRY: This is the requested report on my visit as physician in residence at the Waynesboro Community Hospital in Waynesboro, Virginia, on March 27 and 28, 1973.

I certainly feel that programs such as this are valuable in the continuing education of practitioners in any situation. The specific questions that are raised, and the information is passed back and forth will vary from situation to situation depending on the medical community itself, but speaking as far as the orthopedic specialty is concerned, which, as you know, covers a relatively broad area in all ramifications, I believe it to be especially valuable. I certainly hope that the program was of benefit to the members of the Waynesboro Community Hospital, and I certainly feel personally that it was of value, judging from the discussions, and questions which were raised.

I was certainly surprised and pleased at how well Dr. Powell Anderson and the remainder of the staff at the Waynesboro Community Hospital had the program organized, and how fully they participated in the various separate sections. I have been on similar programs previously, but this was as well organized as any that I have ever seen, and covered a great number of fields, and a great number of different groups of individuals very effectively.

Waynesboro in itself is an excellent medical community, with a number of well trained specialists, as well as especially well trained practitioners. I would say in the medical community itself, that one section or another had very few that were in town that did not participate actively as well as attend the program.

There is a rather broad group of specialists in Waynesboro, as I stated before, and in general, most attended. They were general surgeons, chest surgeons, general practioners, internal medicine specialists, radiologists, ob-gyn men, ophthalmologists, otolaryngologists and anesthesiologists. There were also a number of industrial medicine practitioners from the various plants in the area.

They were interested in the discussions and participated in them directly, not only by questions but by their own feelings on the subject, as far as the didactic lectures and talks were concerned. They also directly participated in the clinics which were held in the emergency room, X-ray and the operating room.

In this number of well trained and experienced individuals, there was a great deal of variation in opinion, as in all such broad specialties and discussions, and it was certainly valuable to me to learn of the thoughts, feelings and experience of others.

There was a great number of problem cases presented, both in X-ray, by direct examination and in the operating room. There was a great deal of communication and discourse on the subjects, but, of course, some participating a great deal, some to less degree, and a few not actively participating at all. However, this is usually the situation, particularly when a varied group of specialists and general practitioners are discussing a subject together.

The preparation program of which you have received a copy, I thought was excellent and covering not only medical staff, but the nursing staff and its components as well. There certainly were no major difficulties in any degree which caused some loss of effectiveness of the program.

This period of time, of course, is too short to pass all information or all thoughts on a broad group of subjects such as entailed here. The in depth discussion is certainly not possible in all situations. I certainly think that it is a worthwhile means of continuing education, at least as far as I was concerned. I think especially effective was the combination of didactic and practical material being presented and discussed, which is the case at this time.

I hope that this information will be of some value to you.

If I can be of any further help, or answer any more questions specially, please let me know.

With best wishes and kindest personal regards, I remain

Sincerely yours,

FRANK C. MCCUE, M.D.

Mr. ROGERS. Thank you very much, Dr. Hagood, for your statement, which will be most helpful to the committee.

Dr. Carter.

STATEMENT OF DR. ROBERT E. CARTER

Dr. CARTER. I am Dr. Carter. I am a physician and the dean of the new University of Minnesota Medical School on the Duluth Campus of the University.

I appear as a voluntary witness before this committee to testify in support of a 1-year extension of funding for the regional medical programs.

The United States should and can improve health care in this country, making delivery more efficient and bringing the real benefits to more people. There are still serious gaps in health services for the poor and the isolated; indeed, this is also true for many of our citizens with higher incomes and in urban areas.

The peoples' demand for improved care shows that there are unmet needs. Please make no mistake that these needs are real. Our bad

rank in infant mortality and length of life compared with other advanced countries proves this. These figures are not just statistical oddities, and they won't go away simply by ignoring them. Some blame them on people who won't take care of themselves, or even on the elderly who they feel won't use the health system correctly. I disagree and feel that we must keep trying to do everything we can to improve total health in this country. To me this has been the major part of what the effort of regional medical programs has been all about. Unmet health need is more than infant mortality and the length of life. It is undernourished children, untreated mental disease, chronic illness, and people who can be given hope and rehabilitation. Every doctor and nurse in this country knows what would happen if we opened our hospitals and offices and clinics to bring modern treatment to everyone with real need. We could not possibly keep up with the demand. A visit to any city hospital or country doctor's office will show this more clearly than anything anyone could say.

The way to solve the problem is to give more care, the needed care, at reasonable cost. It can be done with better efficiency and planning in our delivery system, and I think that's what regional medical programs are all about. They were started to improve the delivery of health care with facts and people and ideas for modern treatment. They have done well when you consider the size of the problem they faced from the start. They began while many still said we had no shortage of doctors and while resentment to any Federal role in medicine, even medicare, was near its peak. Actually, they organized and focused our attention on needs and how to really meet them fairly. I don't believe the critics now any more than I did when many criticized the programs to begin with, because my experience has been truly different.

As dean of an established medical school in Mississippi, I worked closely with regional medical programs staff, and saw them improve heart disease and high blood pressure treatment throughout the State. Clinics, new hospital units, and teaching new techniques to help stroke victims worked. Continuing education for doctors and nurses was part of this, and it went on where the need was, in the delta and in the most remote parts of the State.

You have volumes of facts and figures, but let me tell you first hand about a truly outstanding representative program, developed by black and white Mississippians with the help of regional medical programs, State resources and other Federal help. It has put nurse-midwives into delta counties to work with health department staff and community doctors. It has lowered infant mortality at a cost which is as much of a miracle as has been the decrease in infant deaths and the better health for entire families. At this moment, in Holmes, and Sharkey, and Issaquenna Counties, regional medical program sponsored nurses are showing how to extend the doctor's role to bring cancer detection for women, to discover high-risk pregnant women, and to weld the entire health team together. It works. It is done with jeeps and by walking through cotton fields to the shanties to treat the people. It's what regional medical programs is about.

In another State, Minnesota, and involved with a new medical school trying to study and expand family medicine and rural care, I

have seen the same high-quality programs. A mobile health unit is showing an entire county how to bring care to 23 doctorless towns. A clinic in a northern Minnesota town is showing how to run a branch unit on adjacent lands, right where the real need exists.

Once a month, in our area, hospital directors, doctors, nurses, junior college deans, and college university administrators from Minnesota and Wisconsin sit down together to make important plans and to carry them out. They avoid duplication, assign tasks to the unit which can do them best, and they look to see how well things were done afterwards. Regional medical programs started all this. They are the ones who came up with ideas and help make it work for as long as they are needed or for as long as they can.

Why should all this stop so suddenly? Why should other worthy health programs be cut or stopped in a similar fashion? The original idea of regional medical programs was sound. The great majority of the work was carefully planned by professionals, competent providers, and by serious and dedicated consumers. These are the real action programs that can improve the efficiency of our health care delivery in this country. We need this flexibility and the opportunity for creative projects to lead the way throughout our Nation. I feel that the original investment has produced good results in the great majority of areas. It should be given a chance to go on in important work.

Mr. ROGERS. Thank you very much, Dean, for your very helpful statement. I must say, in the rating of the work done by regional medical programs, 13 or 14 were not rated good or excellent. I think that substantiates many of the statements you just have made.

Mr. Nelsen.

Mr. NELSEN. Thank you, Mr. Chairman.

Some of the information that comes to me would indicate that the RMP and the CHP program get into each other's jurisdiction resulting in a duplication of effort. Do you have any comment about that?

Dr. CARTER. Mr. Nelsen, Mr. Chairman, I can only speak from my own experience in two States and I have not seen this to be the case. I have seen them work together and in our regional advisory committee, we have the B agency from our area from Minnesota and from Wisconsin meeting with us.

Mr. NELSEN. We had some visitors and their view was that CHP was doing a better job than RMP. That was the statement of professionals made to me in my office.

I think Mr. Hastings made an important observation a few minutes ago when he said that there are parts of both the RMP and CHP programs which have been doing a good job. Could it be that the two programs would run better as one, and that they should be merged? Do you think this could be done?

Dr. CARTER. I am not an expert in this area. I can only say, where I have seen them working together, one involved in planning and the other in implementation, it seems to be an effective partnership.

Mr. NELSEN. I would like to point out that I was very much disturbed by testimony given at the Minnesotans' breakfast about 2 weeks ago. The university president and three regents were in town and indicated to me that funding for the medical school was not coming through as planned.

I gather some of these proposals coming to us from HEW are motivated by the desire to reduce the total dollars that are being spent while continuing to do a job. I would like to point out though, that it is important that we continue to fund our medical schools properly.

I am not at odds with HEW's search for better ways to spend the dollar. I am sure you are not either, knowing that the Minnesota Medical School is as close to you as to me. I just want to make that observation and thank you, Mr. Chairman, and thank the witnesses for appearing with very fine statements.

Mr. ROGERS. Mr. Preyer.

Mr. PREYER. I want to thank you. It is refreshing to hear this kind of testimony from the grassroots and from the heart.

Mr. ROGERS. Mr. Carter.

Mr. CARTER. Thank you, Mr. Chairman.

I was quite interested in your statement, Dr. Carter. I know you are Dean of the University of Minnesota Medical School at Duluth. Are you in the regional medical program yourself?

Dr. CARTER. No.

Mr. CARTER. Is your school a sponsor of the program itself?

Dr. CARTER. We have one contract with the Minnesota regional medical program.

Mr. CARTER. You provide manpower for that area?

Dr. CARTER. For the RMP operations?

Mr. CARTER. Yes, sir.

Dr. CARTER. Some of our faculty are giving time to this without remuneration at the present time.

Mr. CARTER. Do you get assistance at the university through RMP?

Dr. CARTER. I can only speak to the school on the Duluth campus. We have one contract for $28,000, approximately $28,000 of which over $22,000 is distributed to the other participating institutions, the hospitals, the junior colleges and the other institutions in our area.

Mr. CARTER. Have you developed a good continuing educational program?

Mr. ROGERS. May I *interrupt 1 minute before Members go* to answer the call. We will try to resume at 2 o'clock in this room to hear the rest of the witnesses, and then we will go into executive session.

Mr. NELSEN. There is a vote now.

Mr. ROGERS. There is a vote now but the second bells have not rung.

Mr. CARTER. Are you continuing education programs with physicians and nurses?

Dr. CARTER. We are continuing to develop at the school and have not yet come to that point of development. Our first class just enrolled this year.

Mr. ROGERS. Dr. Roy.

Mr. ROY. I want to thank you for your testimony, Dr. Carter. I am aware of the excellent job you have done in training physicians. I could compliment each of you individually but I think the American Academy of Family Physicians has done an outstanding job and your participation therein, I think, is very worthwhile.

What do you have to say about Dr. Margulies telling us RMP's have become a captive of the local provider groups? Is this a legitimate view of the program?

Dr. Hagood. No, I don't feel that way. We in Virginia have had such a time with the shifting emphasis and being told one day to do one thing and another day a different thing. Back in November 1971, we had a site visit. The site visit team was a representative group from across our Nation sent to us from RMP. They went through our whole program. Then, in glowing terms, they told us what a great job we were doing. You could see the A pluses everywhere.

This site visit team's report was submitted to two national review groups. Their response paralleled the site visit team's report. The next thing we had our program chopped off. In December 1971, we went to Dr. Margulies' office who told us to turn this thing around and go in a different direction.

This was after the program was submitted. This has been one of the biggest problems we've had, you didn't know which foot was on the ground or which foot to put down.

They'd give you an explanation of what the guidelines are. They say guidelines are not rules but, like the statement from the general, the general wishes so and so to be done. If you are wise enough, you are not going to pass up the general's wishes. When the guidelines come down, you better hop to or you won't get the dollars.

Mr. Roy. I would say the greatest thing about RMP is its grass roots participation. It is their ability to work together at that level. I spent 2 years on legislation and sat in on many advisory committee meetings and I feel, as I think you said, that we would be hard put to find a better way of destroying physicians and other providers confidence in Federal programs than the present way we are going. Of chopping this off abruptly of not mentioning the people who have worked so hard and given so selflessly without in some way diminishing the excellent accomplishments that have been made.

I thank you very much for coming here. I see you as representatives of the very large number of people of very good faith who worked extremely hard in this program.

Dr. Hagood. This is the second day of a continuing education program I am attending and paying for myself. You said something about a session this afternoon. I wonder if I can be excused to go back to the continuation education I am paying for?

Mr. Rogers. Yes. Thank you for your testimony. We don't always get the same views from the bureaucracy. This is helpful to hear from the people actually involved in providing health care.

Thank you.

We have another distinguished panel and under the circumstances, we will have to recess the committee until 2 o'clock this afternoon.

[Whereupon at 12:50 p.m., the subcommittee recessed, to reconvene at 2 p.m. the same day.]

After Recess

[The subcommittee reconvened at 2 p.m., Hon. Paul G. Rogers, chairman, presiding.]

Mr. Rogers. The subcommittee will come to order. We are continuing our oversight hearings on the regional medical programs.

We are very pleased to welcome to the subcommittee this afternoon, a distinguished panel of regional medical program coordinators, Dr. John R. F. Ingall, executive director of Lakes Area RMP, Buffalo,

N.Y.; Dr. H. Philip Hampton, coordinator of Florida RMP, chairman of AMA Council on Legislation, Tampa, Fla., who I regard as an adviser and friend of mine over these years. I welcome him to the subcommittee.

Paul D. Ward, executive director, California Committee on RMP, Oakland, Calif., who has done a great job with RMP's, and Dr. William H. McBeath, director of Ohio Valley RMP, Lexington, Ky.

We welcome you gentlemen to the subcommittee. If you would like to take a seat at the table, I think it might be helpful to identify yourselves for the reporter if we could and the members will be here shortly.

STATEMENTS OF A PANEL OF REGIONAL MEDICAL PROGRAM COORDINATORS CONSISTING OF DR. R. F. INGALL, EXECUTIVE DIRECTOR, LAKES AREA REGIONAL MEDICAL PROGRAM; DR. H. PHILLIP HAMPTON, CHAIRMAN OF THE BOARD, FLORIDA REGIONAL MEDICAL PROGRAM; DR. WILLIAM H. McBEATH, DIRECTOR, OHIO VALLEY REGIONAL MEDICAL PROGRAM; AND PAUL D. WARD, EXECUTIVE DIRECTOR, CALIFORNIA COMMITTEE ON REGIONAL MEDICAL PROGRAMS

Dr. INGALL. For the purpose of this panel, I am acting as chairman this afternoon.

My name is Dr. Ingall. As you have identified me, I am the executive director of the Lakes Area Regional Medical Program and past chairman of the National Coordinators Group. To my right is Dr. Philip Hampton, who is chairman of the Florida RMP board of directors. To his right, just to right of center, is Bill McBeath, director of Ohio Valley Regional Medical Program, and to his immediate right is Mr. Paul Ward, who is the executive director of the California Committee on Regional Medical Programs.

Mr. ROGERS. We welcome you gentlemen and are very grateful for your being here to give the subcommittee the benefit of your advice and your experience.

Dr. INGALL. Thank you very much.

Mr. Chairman and members of the subcommittee, I value this opportunity to readdress you this afternoon.

You are deluged with data and, I would suggest, by the conflicting interpretations put upon it. Numbers mean something, they are measures of a situation; static indices of a process. It is the process, the way in which it works, which I see the strength of the regional medical program.

Since their inception, the regional medical programs across the country have concentrated on cooperative ventures between the private, voluntary and official agencies. They have been instrumental in catalyzing action in concert by these groups in defining, documenting and resolving problems. There are many outstanding examples of this.

The problems common to all these agencies are the problems of people, of a health market area. The RMP's have become a means whereby institutionalized blinkers have been removed; where groups

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intent in implementing measures to solve their individual problems have been brought to recognize the dimensions of these on a population basis and have been enabled to attack these scientifically, effectively and economically together.

RMP's, Mr. Chairman, have been described as being the most effective and indeed the only national mechanism of putting "together what Federal Government has put asunder." Forgive the liturgical allusion, but I do feel that the RMP process is the first step in the ecumenisism of health and medical services.

RMP's have attracted high quality staff and will continue to do so because the concept is sound and what they're doing makes sense. It has involved those with long experience at the clinical service interface who believe in their colleagues, and their capability to deliver service. They know content as well as process. In my State, testimony to this, has been given by resolutions of support from the State Medical Society, parents of diabetic children, allied health groups, the clergy and many others.

The strength of this body of RMP people with whom I have the utmost pride in associating, is manifest by their retention of effective staff and ability to return to high gear as we recently informed Secretary Edwards.

Development of this capacity, Mr. Chairman, does not occur overnight, as I am sure you will agree. Nor can it be achieved by arrogant FIAT—it comes by learning the concept and experiencing the process. RMP is governed by the people and for the people. It recognizes that the capacity to do so requires a staff ability to alleviate the administrative burden and time commitment that prevents, and indeed deters the involvement in planning of those whose job it is to serve.

I think there were very pertinent observations in this morning's hearing to that effect. It is in this area that we certainly have gained trust.

We have learned, as the previous—Under Secretary for Health acknowledged, that you cannot delegate new authority or ability to an old agency: one that has, by the slow process of community learning come to be seen as a controlling or restricting agency. You cannot expect cooperation with an agency or department which carries with it an already poor track record in the eyes of the constituency it is supposed to serve.

RMP recognized this in the early years. RMP's recognized that authority handed up was much greater than authority handed down. Those of you that are elected, and have to respond to a constituency will recognize this.

For the first time in this country we enjoy acknowledgement by the community—public, private, and consumer, that an enabling agency exists, to help in defining needs and with the capacity to engineer a suitable response.

I suggest Mr. Chairman that RMP's nationally are the only agencies where this trust and capability coincide. This observation by the way, has already been voiced by members of the present administration: a singular example of being deaf to their own observations.

There are great dangers inherent in the dismantling of the RMP process. It cannot be rebuilt any quicker than it has already been built, it will not reattract to any great degree whose with enthuiasm and

dedication: people with seniority and stature from whom it currently profits. It is my conviction that your constituency and ours are identical—you have a concept that in its wisdom Congress put into text, that is undoubtedly effective, that has a responsiveness that mere categorical projects are unable to muster, and that has effective local control and evaluation.

Finally, Mr. Chairman, I would reiterate from my previous testimony that all these pieces of legislation need rewriting to bring them into line with the requirements of 1974—and they will continue to do so—the recognition of this has been voiced repeatedly by the RMP's nationally and we are both able and capable of providing assistance in this effort. We are continually through our evaluation sections, doing this at the grass roots. We would happily give you assistance in government in the revamping of the entire PHS Act.

Mr. ROGERS. Thank you very much, Dr. Ingall. I am sure the subcommittee would welcome any suggestions in the rewriting of these laws. I think it would be very helpful.

Dr. Hampton?

STATEMENT OF DR. H. PHILLIP HAMPTON

Dr. HAMPTON. I am Dr. H. Phillip Hampton of Tampa, a physician in the private practice of medicine and I have served as chairman of the board of the Florida regional medical program since its inception in 1968. I would like to point out, Mr. Chairman, although I am listed on the agenda as coordinator of Florida regional medical program, I am *not* in the sense of the full time active director. That is Dr. Granville Larimore. I am listed as chairman of American Medical Council on Legislation. I am *not* testifying today in that category.

The Florida regional medical program has had a rocky and controversial life and being chairman of the board of directors has been one of my most frustrating experiences.

At times, national direction of regional medical programs seemed uncertain. However, RMP regional organizations gradually became more autonomous and oriented to their particular region's priority health care problems. RMP's performed well in their role of support to health care providers as catalysts for innovation, education and evaluation.

In Florida, early controversy between State medical schools, the physician and hospital providers of health care concerning the structure of the RMP grantee organization delayed for 2 years designation of a nonprofit corporation as the grantee with the board of directors manned by health care providers and educational groups within the State.

The major portion of the funds awarded and the majority of the initial projects approved by the RMP National Advisory Council were campus oriented and hardly apparent to practicing physicians and their patients. As the program matured, many of the projects of the Florida RMP were outstanding successes, such as the statewide development of coronary care units, a kidney transplant program, a statewide emergency medical service program and other current projects described in the appended [see p. 178] supplement to the "Journal of the Florida Medical Association."

In accordance with instructions from RMP's, these programs and projects are being terminated with the total Florida RMP to be completely phased out by November 30, 1973. The need for the development of cooperative arrangements between health care provides and educational institutions is as great as ever. Now that Government is directly financing the cost of health care for 38 percent of the population, the need for liaison between Government and the private medical sector is greater than ever. If the RMP organization is destroyed, what will take its place?

The recently enacted PSRO law giving physicians the initial opportunity to formally assume enormous responsibilities for the monitoring and evaluation of health care delivery requires expertise and technical support, such as RMP's have been providing, to fulfill the expectations of the legislation. RMP's have unique qualifications to assist the medical community in meeting these needs.

The Florida RMP has been involved recently in two projects with the foundation of the Florida Medical Association which, if pursued to their logical conclusions, may provide some direction toward meeting these and other pressing needs and problems in Florida.

One of these projects is concerned with a study of alternative health care financing and delivery systems. In conversations with appropriate departments of the State Department, the Florida RMP and the foundation have been exploring the possibility of the foundation assuring the delivery of adequate health care to medicaid recipients. To this point, the State Department of Health and Rehabilitative Service has expressed a willingness to enter into a contract with the Florida Medical Association, through its foundation, for the conduct of demonstration projects in geographic areas for the delivery of comprehensive health care to all medicaid recipients in that area.

Obviously, to undertake such a program, there must be an operative system and staff for program management, data collection, and processing that would enable efficient processing of claims for payments and provide an adequate regionalized data base for peer evaluations.

The second project with the foundation and its peer review committee concerns development of methodology for evaluation of health care delivery, which must also be dependent on a system of data collection and processing.

If properly designed and implemented the system can provide a common data base for medical program management, peer utilization review, PSRO evaluations, and health care planning. Such systems will facilitate the evolutionary development of alternative health care financing and delivery methods appropriate to the needs of the various regions.

We feel that providing technical and staff support and consultation services to these activities is a proper function of an RMP and would be in accord with governmental roles in health care recently deemed appropriate by Under Secretary Carlucci, in a talk before the American Hospital Association recently. These are: (1) insure adequate health care for the poor and (2) create mechanisms that will permit a private enterprise to regulate itself.

However, lower echelons in DHEW seem determined to prevent State medical associations from playing a part in the development of effective quality assurance mechanisms and apparently do not share the philosophy expressed by Under Secretary Carlucci.

The challenge of this dilemma is how to apply the experience and expertise developed by RMP's to the current pressing problems of health care delivery in order to catalyze innovation, evaluation, and education.

[Testimony resumes on p. 214.]

[The supplement to the Journal of the Florida Medical Association referred to follows:]

Florida Regional Medical Program

Supplement

To the Journal of the Florida Medical Association

Contents

Note: Contents were not photocopied

Mr. ROGERS. Thank you very much, Dr. Hampton for a great statement. Dr. McBeath?

STATEMENT OF DR. WILLIAM H. McBEATH

Dr. MCBEATH. Mr. Chairman and members of the subcommittee, I appreciate the opportunity to appear before this distinguished subcommittee to report on the status of the regional medical program movement, particularly in the Ohio Valley.

I am Dr. William H. McBeath, director of the Ohio Valley Regional Medical Program—OVRMP—which serves an area with over 6 million people in 141 counties of four States. The region boundaries were originally defined to reflect the combined extended service areas surrounding the university medical centers at Cincinnati, Lexington, and Louisville. Most of our region's population and health care resources are about equally divided between Kentucky and southwestern Ohio.

[See regional geography map, p. 216, and selected health resources map, p. 216.]

Dr. MCBEATH. The region's three university medical centers led in the early planning for our program. However, from the first, the direction and policy of our program has been determined by a strong and independent regional advisory council of prominent volunteer members. Our council size is fixed, its members serving staggered 3-year terms, with geographic and interest representations carefully balanced and specified. Twelve of its members are physicians, 12 represent other health interests, and 12 are lay members of the general public. Recently provisions for a few additional members was added.

RMP legislation has always indicated that the mechanism of regional cooperative arrangements was intended to achieve RMP goals. We have tried to emphasize this mechanism, especially regional cooperative arrangements between health professional schools and community hospitals and practitioners. A blending of the education and service environments is a theme which can be seen throughout our efforts.

OVRMP became operational in January 1969, and as of today is scheduled to terminate operations on June 30. In these 4½ years we have funded 29 major operational projects, several with multiple components. Over 50 participating agencies have received funds through OVRMP, including hospitals, health professional schools, health planning groups, neighborhood clinics, health departments, medical societies, and a variety of private voluntary health organizations. I have attached a map which indicate those agencies. [See participating agencies map, p. 217.] Many other groups and individuals have been cooperatively associated with this effort and have derived direct nonmonetary benefit from these operational projects and our program staff activities.

OVRMP support has gone to a variety of program areas. Recently a coordinators' survey of all RMP's showed that in 1972 Ohio Valley allocated a larger than average portion of its resources to improve availability and accessibility of primary and emergency care (47 percent of our direct cost expenditures, as compared to a national average of 27 percent). As a corollary, we allocated relatively less to categorical demonstrations and quality assurance activities, although these still received considerable effort (17 percent). The proportion of

funds we devoted to manpower utilization projects (30 percent) and administrative costs (6.4 percent) were essentially the same as the national average.

Like all other basic characteristics of our program, this operational emphasis was very carefully chosen by our regional advisory council. In early 1969, the great variety of good proposals coming to our council, and the much more limited prospects for Federal funding drove our council to the conclusion that if OVRMP was to achieve regional impact, it should actively focus down on a program priority more narrow than our original operational program.

Accordingly, after reviewing our needs and studying alternatives they selected as our program thrust the development and more effective utilization of health manpower for the delivery of improved ambulatory care. Since that time their funding decisions and our staff effort has given priority to the manpower concerns of ambulatory care.

Presently our program has six target areas within this thrust: In manpower development we are seeking to decentralize the education and training of health personnel through the development of subregional health education networks where university medical centers are cooperating with the health service units and higher education institutions of an area to produce more local educational activity. Our continuing education activities are also increasingly directed toward the provider in his own service setting.

In prevention and followup we are proudest of a large and gratifying demonstration which has brought about the development of nine new multicounty home health agencies, most in the rural areas of our region.

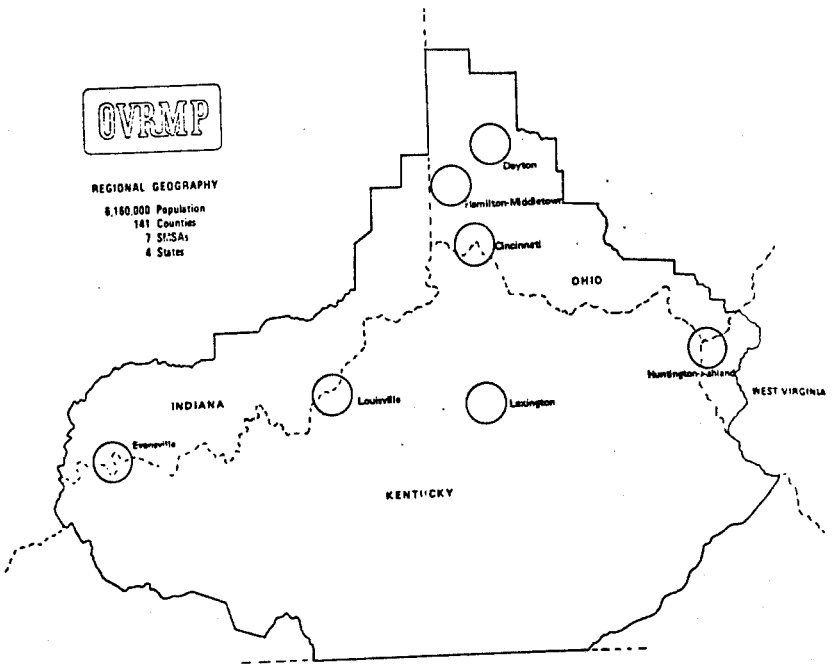
Our effort in organized ambulatory care has focused on startup programs to disadvantaged populations. On the other hand, our emergency services activity has been directed toward the joint development with CHP agencies of metropolitan EMS systems to serve total populations.

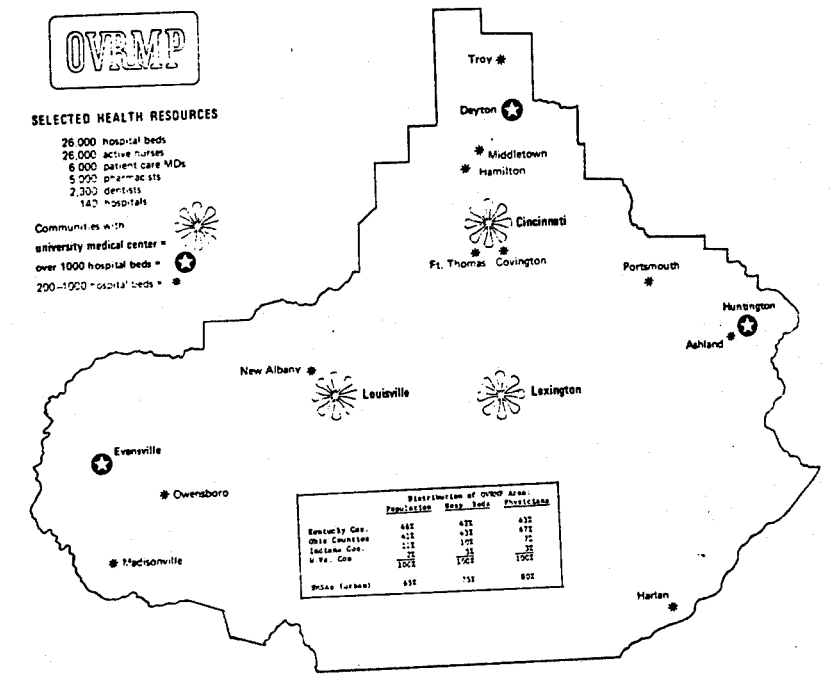
We have continued selected categorical services activities related to heart disease, cancer, and renal disease, and are encouraging use of problem-oriented patient medical records in a variety of ambulatory care settings.

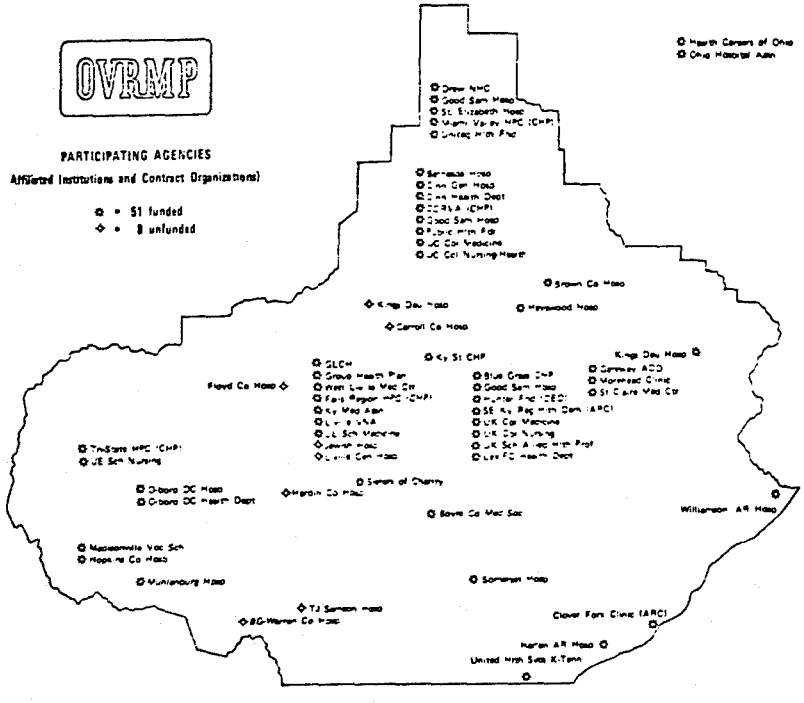
During the past week, some of the implications of a precipitous, premature termination of OVRMP funding have become all too graphic. Most of our active projects have just completed the first of 3 years promised support. Many of these young efforts will have to close down completely. Even those providing essential services will be continued only with serious program compromise, and at considerable cost to worthy competing activities.

To be sure, we can take some comfort in remembering the good already accomplished by many projects. Other tasks may wait suspended for others to resume progress later. On the other hand, a large portion of the time and effort thus far invested in program building will be irretrievably lost if RMP's are permitted to die now. That will represent the proverbial step backward for each two just made forward. In some future day someone will have to regain this lost ground even to restart.

[The charts referred to follow:]


OVRMP
REGIONAL GEOGRAPHY
6,160,000 Population
141 Counties
7 SMSAs
4 States
Dayton
Hamilton-Middletown
Cincinnati
OHIO
Huntington-Ashland
WEST VIRGINIA
INDIANA
Louisville
Lexington
Evansville
KENTUCKY


OVRMP
SELECTED HEALTH RESOURCES
26,000 hospital beds
26,000 active nurses
6,000 patient care MDs
5,000 pharmacists
2,300 dentists
140 hospitals
Communities with
university medical center =
over 1000 hospital beds =
200–1000 hospital beds =
Troy
Dayton
Middletown
Hamilton
Cincinnati
Ft. Thomas
Covington
Portsmouth
Huntington
Ashland
New Albany
Louisville
Lexington
Evansville
Owensboro
Madisonville
Harlan
Distribution of OVRMP Area:
Population
Hosp. Beds
Physicians
Kentucky Cos.
Ohio Counties
Indiana Cos.
W. Va. Cos.
SMSAs (urban)



Mr. ROGERS. Thank you very much. We appreciate your statement. Mr. Ward?

STATEMENT OF PAUL D. WARD

Mr. WARD. Mr. Chairman. I am Paul D. Ward. director of the California program. I was asked to reply to certain points that came up this morning. I would only like to refer to two of them since the list I have is quite long to refer to all of them. The first point refers to defining a clear role for the program. It has been suggested that the regions could not find a real purpose or a set of objectives that they could follow over the past 7 years. Since I served as chairman of the national coordinators during the early period of the program. I was deeply involved in the negotiations around the course that the program would take and I would like to take just a moment of your time to repeat some of that history.

If you will recall when the extension bill 3 years ago was going through the Congress. there was much discussion about whether or not RMP's should retain its categorical image. Many of us argued in favor of retaining the categorical image because we believed that to have a comprehensive program you had to build on the building blocks of the specialties and of the categorical interests to be sure eventually you could broaden the purpose of the program out to include a more comprehensive approach. but essentially you have to approach many of these problems on a categorical basis. This was quite a debate and the administration. if you will recall at that time, was opposed to the categorical approach. The Congress decided to continue the categorical approach. however, and the bill was passed and

signed on that basis. Immediately thereafter there was an indication that funds were going to be withheld from the program. Again, the questions of the categorical nature came up. We had several meetings with the administration about this and we called a meeting of the coordinators as a group and that meeting was held in Atlanta, Ga. We discussed this problem with them and we told the coordinators that we had to meet the national priorities that had been established as a result of the Finch report at that period of time. We thought that we could meet the priorities of engaging in the establishment of those low-income groups which were mentioned in the Finch priorities.

We changed the program at that point from a categorical emphasis, although some of us had been engaged in attempting to improve primary care, to more of a comprehensive emphasis. In doing so we thought we were conforming with the national priorities. It seems strange to us at this point in time then to be so roundly condemned for deserting the original purpose of the bill. But the bill was both amended in Congress and the priorities that had been described as the Finch priorities went in a different direction and we tried to follow that direction.

The second point that I would like to refer to is the 40 percent that has been claimed as going into management or administration of the program. This 40 percent figure was confusing to us in the beginning because we did not know whether they were referring to direct or indirect costs. I think as all of you know, we have nothing to say about the indirect cost rate that is paid to institutions where they participate in a grant award. The so-called lead agency rate applies, whether that is the DOD or the HEW rate, and we simply follow that rate.

Mr. ROGERS. May I interrupt there. What you are saying is that if a grant is given to a university or to an institution, the basic criteria of how the money goes there is set by the Department itself, not by RMP's.

Mr. WARD. Right. It is set in an OMB circular which sets forth the chargeable items that can be inserted as indirect cost. That indirect cost is then negotiated by either an auditor from HEW or an auditor from the Department of Defense. We pay that rate. In fact, we hardly even know the university's rate, because it is in a separate fund set aside in the award itself.

We have suggested perhaps we should not pay the full rate since obviously we do not use all of those things that are listed as a part of the rate. It has been said that it would be confusing if there were more than one rate, and that we should continue to pay the so-called negotiated indirect cost rate. But apparently from this morning's discussion the figure did not refer to that alone because several other items were mentioned.

I would like to refer the subcommittee to the guidelines which indicate how our funds are to be allocated. We have come to call this section the so-called seven steps to medical heaven. It is a kind of in house description that we have of these steps. They are planning steps to regionalization but you are obligated to spend a certain part of your resources for each one of these steps. If you do not then the moment a program auditor comes in and checks the program he raises objections for not having resources in this way.

Mr. ROGERS. So HEW has put out these guidelines for the regional medical program that they have asked for and that you adhere to?

Mr. WARD. Absolutely. Let me briefly go over those steps. The first : "involvement." The guidelines say you must seek the involvement f the medical society, the hospitals, the voluntary associations and ıy people and others including Public Health, planning agencies, 'eterans' Administration, and others in the program. This requires ıat you go out and get these people and bring them into the program. . certain amount of resources have to be allocated for this purpose.

The next is "assessment of need," medical need. Now, we have rgued for a long time that this is the 314B agency's responsibility. ve believe the 314B agency should establish the need of the comunity and we should be implementing the needs to the best of our bility. But nevertheless you are asking when you are audited for your st of medical needs and if you have not spent some resources in rder to obtain these needs, then you have not done your job correctly.

I would hasten to add these are very expensive pieces of data to et. The discharge studies alone where we have over 500 hospitals and equire a great deal of time and effort and money. This tells us where atients come from, what they were diagnosed for, what their treatıent was during hospitalization, what the traveling distance was for ıe patient, and other information. This helps us to locate our needs nd it is worthwhile. But again, this should not be primarily our sponsibility. It should be the responsibility of the 314B agencies. ut they have not had the resources to do this.

Next we are requested to catalog the "resources" of the region for ieeting these needs. Now, it is simple to count the hospitals, the facili.es, the licensed professionals and other providers. But it is not simply) put all of these resources together and make an estimate about your apability of meeting the needs that become known. And this is one f the expensive areas and again one which perhaps should be done y the 314B agency.

The next step is to develop "priorities." Of course, this is done rough the Regional Advisory Committee. The Advisory Committee ets the priorities; you can either set the priorities in a vacuum or you an gain the additional data necessary to set meaningful priorities. To ıe extent that you spend dollars in this area, it takes dollars away rom your so-called operational dollars.

The next step is "development and implementation," operations if ou will.

Again, another story is set forth here. A lot of what we develop in rms of planning is not funded by RMP dollars. We have had many f our programs funded and in fact deliberately designed them to be unded by OEO, by county government, by other sources of funding. et, these dollars that we spent in developing these services that will e funded by other sources are counted as overhead dollars. This makes o sense in anyone's interpretation.

Then we get down to the actual operations. We fund the programs pproved by our regional advisory group.

The next step is "evaluation." Evaluation can be done in a sloppy ay or it can be done on the basis of data. To the degree that you want) do it well and try to provide some meaningful answer, it too costs ıoney. But let me tell you the health field, more than any other field, ieks meaningful data. And you cannot develop honest evaluation in rms of morbidity and mortality without at the same time spending ome dollars to obtain data. You just cannot do it and anyone who

says he can do it is not telling the truth. If you look at the administrative costs in terms of the RMP guidelines, at least a more honest interpretation of them, and administrative costs in the accepted classical definition of administration, it comes much more close to 7 percent than it does to the 40 percent.

Mr. ROGERS. Seven percent?

Mr. WARD. Seven percent and the 7 percent is giving them the benefit of the doubt.

Now we have prepared—which I would be hopeful and pleased if you would make part of the record—we have prepared a breakdown of the program expenditures nationwide, which answers many of the questions raised this morning. When approached about these answers, when asked how do we know that they are accurate, let me tell you this. We had virtually the whole program, once it was about to be phased out, turned inside out to obtain these particular data. We feel they are accurate and no one has challenged them today.

Thank you very much.

Mr. ROGERS. Thank you very much. Without objection that study will be made a part of the record. [See p. 221.]

Are there any highlights that we should direct our attention to?

Mr. WARD. I noticed this morning the question was raised about the actual number of people treated or served by the program. This amazed us, but we can back it up with facts and figures. We created a number of free clinics around the United States, perhaps more in my area than other places. We did not provide the service in those clinics. We did not pay the doctors, but we were able to get volunteer doctors from the medical societies and other areas and also from the National Guard which proved to be a very good source of doctors.

In that area alone nationwide, better than 3 million people received some kind of treatment in the kinds of primary care system that we are creating by this program. Now we are the first to admit we did not pay for the service, but we found a way to pay for the service. A lot of these projects blended into county support or some other kind of support. They would not have been there without our help.

The EMS, I think, speaks for itself, emergency medical service. We not only developed more EMS programs than any other single source in the United States, but most of the $6 million that went for funding the EMS programs from earmarked funds were developed primarily by RMP. We received funds from outside of RMP. When you total the number of people who received some kind of care as a result of RMP efforts in creating primary care, better than 9 million persons in 1972 alone received care. This is not an insignificant figure when you consider that not everybody needs a doctor every year. Only a portion of the public goes to the doctor and this is, I think, a very meaningful figure.

I would point out that we have been asked to participate in hypertension meetings recently. I listened to one program and to the urgency of its continuation. But at the same time I had to remember that almost everyone of those efforts was financed directly or indirectly by RMP and the hypertension effort would virtually drop dead as of February of this year if some quick means is not taken to continue its financing.

[Testimony resumes on p. 233.]

[The report referred to follows:]

SPECIAL PROGRESS REPORT

REGIONAL MEDICAL PROGRAMS

The following summary reports initial findings of a special progress report of the 56 Regional Medical Programs. The progress was analyzed for three program year periods beginning with 1970, including 1972, and projected to the 1973 program year. Many Regions have already initiated those activities included in 1973 projections. Each RMP provided comparable data which serves as the basis for this report.

Measures of progress and assessment of impact is divided into five basic sections:

..... Benefit to Consumers
..... Benefit to Health Provider Community
..... Community Based Activity
..... Resource Allocations
..... Location of Effort

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I. Benefit to Consumers

The RMPs have had a major impact in serving health needs of consumers.

. . . People Directly Served

While RMPs do not ordinarily provide direct health services, there are numerous instances where direct services are provided as part of a demonstration. Examples include: (A) people screened in a multiphasic screening project, (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 supported by an RMP.

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The following table summarizes people directly served in this manner (all tables rounded to nearest thousand).

TABLE I

PEOPLE DIRECTLY SERVED BY RMPs: SUMMARY

	1970	1972	1973
Primary Care	2,622,000	3,054,000	5,749,000
EMS	465,000	2,443,000	4,064,000
All Others	2,716,000	4,143,000	4,085,000
T o t a l s	5,803,000	9,640,000	13,898,000

Table II summarizes in further detail people directly served in the course of RMP activities. Important trends are the increase in people served in primary and emergency care and the decrease of people served in "heart disease," including coronary care. A projected resurgence of effort in hypertension indicates RMPs' flexible posture to respond to opportunities to meet local needs.

TABLE II

PEOPLE DIRECTLY SERVED BY RMPs BY PROGRAM CATEGORY

	1970	1972	1973
Primary Care	2,622,000	3,054,000	5,749,000
Emergency	466,000	2,443,000	4,064,000
Heart Disease	1,126,000	1,086,000	656,000
Cancer	413,000	523,000	595,000
Stroke	140,000	348,000	280,000
Kidney	13,000	33,000	41,000
Hypertension	135,000	84,000	186,000
Pulmonary Disease	300,000	307,000	359,000
Health Services/Educational Activities Consortia & Other Shared Resources	588,000	1,762,000	1,968,000
Total Served	5,803,000	9,640,000	13,898,000

. . . People served by new types of health providers or those who have acquired new skills

The RMPs have made substantial progress toward accomplishment of their early mission of "bringing advances in medical knowledge to the bedside of the patient." For example, many physicians and nurses have developed new skills related to coronary care units; many stroke teams have been developed; large numbers of neighborhood health aides and clinic assistants have been trained, etc. Also, thousands of health professionals have improved or upgraded their skills to reflect new findings and latest advances in patient care procedures. Table III below summarizes services to people during selected one-year periods after health providers developed or improved their skills through RMP activities.

TABLE III

PEOPLE SERVED BY HEALTH PROVIDERS WITH NEW OR IMPROVED SKILLS

	1970	1972	1973
Served by New Types of Health Manpower (e.g., nurse practitioners)	969,000	5,033,000	6,203,000
Served with New Skills developed in existing Health Manpower	19,383,000	25,392,000	32,524,000
Served by Improving Existing Skills of Health Manpower	41,052,000	64,086,000	74,006,000

. . . People served by increased capability of health systems

The RMPs have served consumers by supporting the development of increased capability of the health system in measurable ways. For example, several RMPs supported the development of a transportation and communication network for emergency situations in a defined service area; several RMPs markedly improved the accessibility and availability of primary health care by the development of health centers, clinics, screening programs, and disease control activities. The numbers of persons "at risk" for that specific situation in the service area were thus served by the increased capability.

Another example is the number of heart attack victims in the service area where health system capability was markedly increased through RMP efforts. People actually using the system are counted in Table I; people "at-risk" or potentially served by increased capability of the delivery system are summarized in Table IV.

TABLE IV

POTENTIAL PEOPLE SERVED BY RMP DEVELOPMENT OF INCREASED HEALTH SYSTEM CAPABILITY

	1970	1972	1973
Primary	37,725,000	67,798,000	74,458,000
EMS	24,425,000	71,937,000	75,696,000
Regionalization of Secondary & Tertiary Care	82,583,000	92,476,000	76,770,000

. . . People served by quality assurance programs

The RMPs have increasingly invested resources in fostering the development of systematic programs to improve the quality of health care. The RMP definition of Quality of Care Assurance refers only to systematic efforts of determining deficiencies in individual or collective acts of medical care, developing corrective action, and implementing activities to result in demonstrably improved quality of care.

The RMPs more than doubled their investment in quality assurance programs between 1970 and 1972 ($4.5 million to $9 million, respectively). The projected 1973 expenditure has again almost doubled the 1972 expenditure ($14.6 million). Quality assurance programs have also had the effect of moderating costs to the consumer (e.g., fewer days in the hospital, less "overtreatment").

Table V summarizes the RMPs' accomplishments in this area of patient service by demonstrating the extent of RMP staff involvement and the numbers of health providers trained in medical audit, problem oriented records or PSRO activities. Dramatically increasing numbers of in-patient and out-patient facilities are participating in RMP quality assurance programs.

People "directly" benefited are those patients visiting in-patient facilities or admitted to out-patient facilities during the time remaining in the year shown after the quality assurance program was developed. "Indirect" patients benefited are the people served by the institutions or offices where quality assurance programs have been fostered by RMP efforts.

TABLE V

PEOPLE SERVED BY RMP DEVELOPMENT OF INCREASED QUALITY OF CARE ASSURANCE

	1970	1972	1973
Professional staff involved in planning, development & instruction	1,208	2,438	2,975
Providers trained	6,872	32,854	58,574
Number of facilities participating in Quality Assurance Programs	1,165	3,312	8,269
People directly served by Quality Assurance Facilities	4,572,000	7,449,000	10,585,000
People indirectly served by Quality Assurance Facilities	37,911,000	65,152,000	87,505,000

II. Benefit to the Health Provider Community

RMPs' efforts have resulted in a substantial number of innovative, new types of health personnel to provide needed service to American citizens. For example, RMPs have supported training and placement of nurse practitioners and physician assistants to extend the services of the family doctor in underserved rural and urban areas of the nation. RMP efforts alone in 1970 resulted in the addition of some 7,500 persons of this and other types of critically needed new health manpower. By 1972, almost 14,000 people had been trained through RMP efforts. Projections for 1973, based on the RMPs' program requests to RMPS, indicate plans to train almost 38,000 new Allied Health Professionals to serve in essentially new roles to fill gaps in service.

The RMPs have provided opportunities for a wide array of health providers to develop new skills or improve existing skills in order to provide improved service to citizens. Table VI summarizes the numbers of health providers who have developed skills in RMP-supported activities.

TABLE VI

NUMBER OF PROVIDERS TRAINED

	1970	1972	1973
MD, DDS, DO			
New Skills - Existing Personnel	13,561	16,164	9,567
Improved Skills - Existing Personnel	62,323	62,153	65,924
RN, LVN			
New Skills - Existing Personnel	38,159	42,812	28,845
Improved Skills - Existing Personnel	79,030	95,480	106,557
ALLIED HEALTH			
New Types of Allied Health Professionals	7,526	13,825	37,926
New Skills - Existing Personnel	34,641	48,663	48,158
Improved Skills - Existing Personnel	41,006	104,144	120,662

III. A Community Based Activity

The RMPs are a decentralized national program working with local health provider systems with decisions made by a broad-based local citizen and professional advisory group. The RMPs have involved large numbers of volunteer citizens concerned about health problems of the nation. Almost 19,000 regular volunteers serve long hours, often at considerable personal financial sacrifice, to study and act upon health problems in a way that is

best suited to local situations. RMPs' regular voluntary advisory structure includes:

	Number	%
Members of the Public	4,505	23.7
Doctors (MD, DO, DDS)	6,920	36.5
Nurses and Allied Health	4,090	21.5
Health Administrators	3,469	18.3
TOTAL	18,984	100.0%

Of this number, over 2,600 advisors are from minority population groups--a significant proportion compared to national averages.

RMP staffs are a unique and effective blend of the wide range of skills, training and experience necessary to move effectively toward solution of today's complex health problems. In 1972, composition of full and part-time staff of the 56 RMPs was as follows:

	Number	%
Doctors (MD, DO, DDS)	1,691	18.8
Nurses and Allied Health	2,294	25.5
Social and Behavioral Sciences	2,434	27.1
Supporting Staff	2,569	28.6
TOTAL	8,988	100.0%

Of this highly qualified and experienced staff, 1,617 persons were from minority population groups. Few other federal programs can make such claims.

IV. Resource Allocations

The RMPs have allocated their program funds in four basic programmatic thrusts:

. . . More effective use of manpower including new skill development, improved skills, sharing training resources with underserved areas, and coordination and improved utilization of health manpower training.

. . . Improved accessibility and availability of primary medical care including new or improved services such as family health centers, free clinics, hospital-based ambulatory care centers.

In response to a recognition of severe access problems to primary care in underserved areas, RMPs have projected more than twice their resources to primary care programs (including EMS) in 1973 than in 1970 (approximately $37 million projected in 1973, $24 million in 1972, and $12 million in 1970).

. . . Regionalization of secondary and tertiary (specialized) care including general institutional sharing of scarce resources such as radiation facilities, joint purchasing and direct categorical disease services in heart disease, cancer, stroke and others.

While percent of total dollars devoted to efforts of regionalization of secondary and tertiary care has diminished slightly, RMPs have actually increased the number of dollars invested in developing shared resources and regionalization of care in cancer, heart disease, and other categorical programs.

. . . Quality of Care Assurance including RMPs' work with hospitals, out-patient departments, and physicians in private practice to stimulate medical audit and improved medical records as a method of assuring high standards of medical care.

Table VII summarizes distribution of RMPs' resources.

TABLE VII

DISTRIBUTION OF RMPs' RESOURCES

Function	1970 $	1970 %	1972 $	1972 %	1973 $	1973 %
More Effective Use of Manpower	24,163,000	32	24,790,000	29	30,930,000	27
Improve Accessibility & Availability of Primary Medical Care						
A. Primary	11,413,000	15	18,205,000	21	28,427,000	24
B. EMS	832,000	1	5,695,000	6	8,637,000	7
Regionalization of Secondary and Tertiary Care	24,039,000	32	23,257,000	27	26,675,000	23
Quality of Care Assurance	4,506,000	6	8,916,000	10	14,622,000	13
Administrative Costs	10,662,000	14	6,186,000	7	7,543,000	6
T O T A L	75,575,000	100	87,049,000	100	116,834,000	100

. . . Administrative Costs including relating the program to the grantee institutions. They show a substantial (50%) decrease from 1970 to 1973. This trend reflects the fact that as RMPs continue to become more efficient organizations, more program staff time goes directly to service programs. Conclusion is that RMPs are well honed, efficient organizations, and have become increasingly so over the five-year period studied.

V. Location of Effort

A previous study of nine Regions from which data were readily available provides an indication of RMPs' resource allocation by location of effort. RMPs have succeeded in implementing a greatly increased number of programs and projects located in community organizations and community hospitals while retaining their efforts located in medical schools, medical school affiliated hospitals, professional organizations, and voluntary societies. Similar data are not yet available for other Regions. Table VIII summarizes the location of effort of the selected Regions.

TABLE VIII

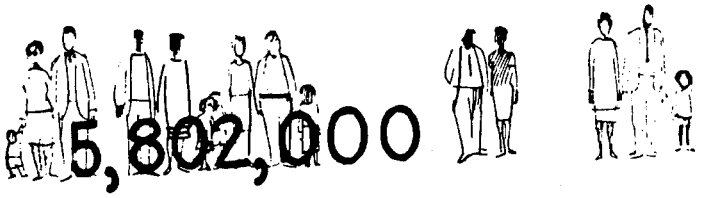
LOCATION OF EFFORT IN SELECTED REGIONS

	1970		1972		1973	
	$	%	$	%	$	%
Medical School	2,943,000	20	2,439,000	16	2,234,000	11
Medical School Affiliated Hospital	2,406,000	16	1,747,000	11	2,214,000	11
Community Hospital	4,218,000	29	4,012,000	26	4,574,000	22
Professional Organization/Voluntary Society	2,260,000	16	2,211,000	14	2,281,000	14
Community Organizations	2,763,000	19	5,172,000	33	8,825,000	42
Totals	14,590,000	100	15,581,000	100	20,128,000	100

February 8, 1973

PEOPLE SERVED

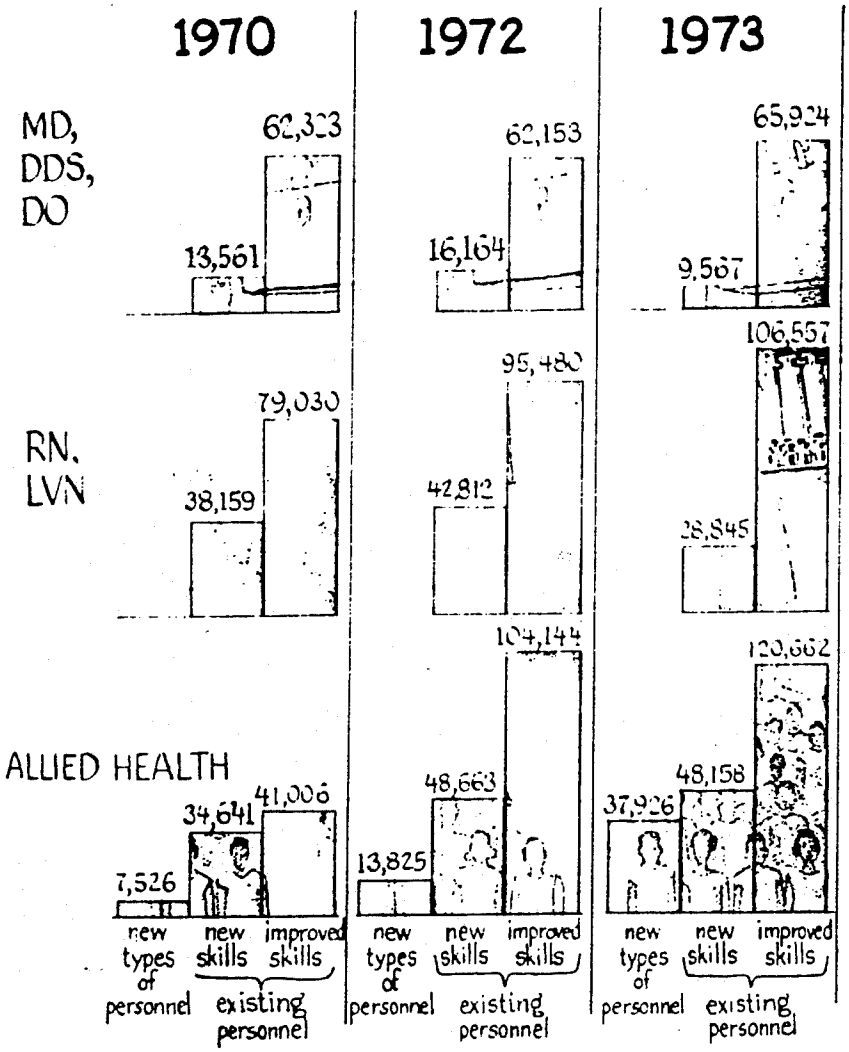
1970 5,802,000

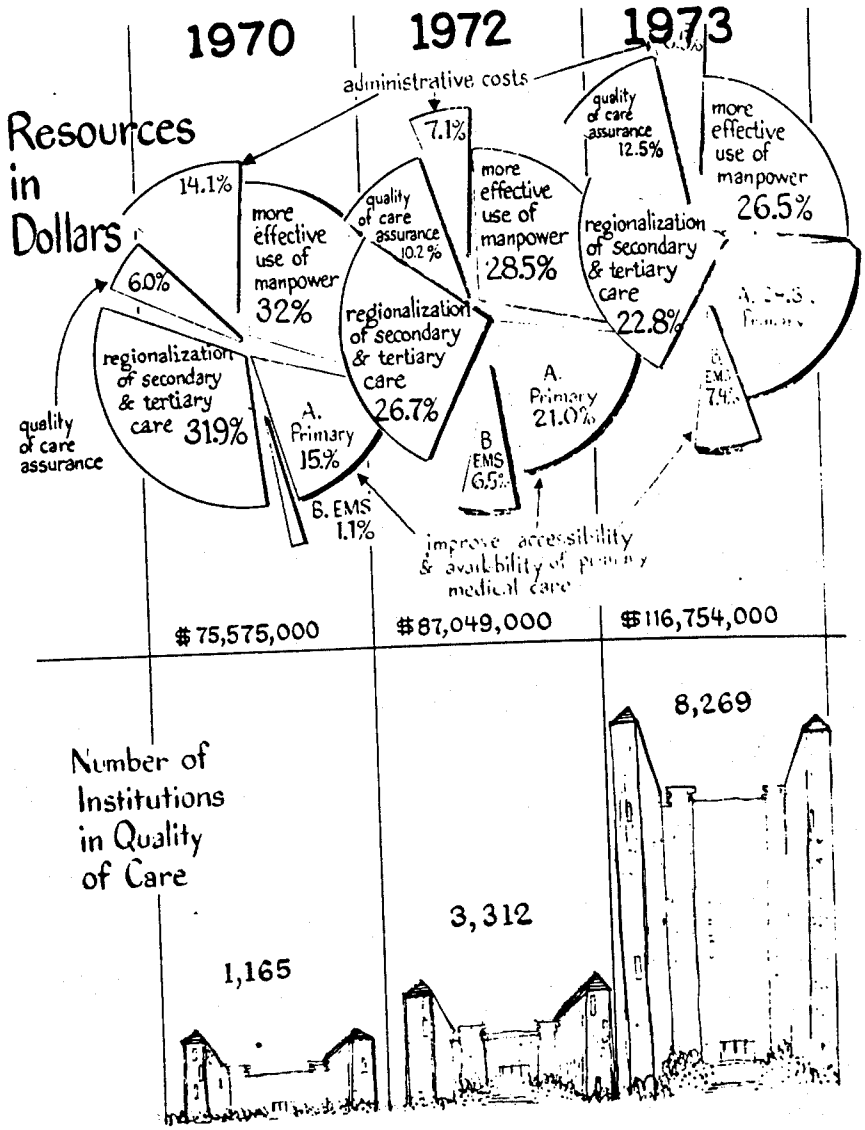


1972 9,940,000

1973 13,898,000

Providers Trained




1970
1972
1973
Resources in Dollars
administrative costs
14.1%
7.1%
6.0%
more effective use of manpower 32%
quality of care assurance 10.2%
more effective use of manpower 28.5%
quality of care assurance 12.5%
more effective use of manpower 26.5%
regionalization of secondary & tertiary care 31.9%
regionalization of secondary & tertiary care 26.7%
regionalization of secondary & tertiary care 22.8%
quality of care assurance
A. Primary 15%
B. EMS 1.1%
A. Primary 21.0%
B EMS 6.5%
B EMS 7.4%
improve accessibility & availability of primary medical care
$75,575,000
$87,049,000
$116,754,000
Number of Institutions in Quality of Care
1,165
3,312
8,269

Mr. ROGERS. Thank you very much, Mr. Ward.

Mr. Nelsen?

Mr. NELSEN. I don't know that I have any specific questions, only to comment again that we in the Congress are sometimes inclined to pass program after program—putting one on the top of the other. Pretty soon they pile up and the dollar figure gets out of hand. We end up spending more on administration than on the real delivery system. I wonder if CHP and RMP can be put together in one program in the hopes of doing a better job of administration. It might also make our dollars go a little farther. It is tragic that we do not have enough money to fund all of the good health programs. We are searching diligently for better ways to finance these services at lesser costs. I think we all would certainly endorse that effort. I just wondered if you have any notions of what we could do.

Now, I do find criticism among professionals who say that the comprehensive health program is doing a better job than RMP in some areas and vice versa. There is also comment that they are stepping on one another's toes and competing with one another.

Some RMP's are starting HMO's which may be getting a little beyond where we wanted them to go. I wonder if you have any suggestions. We need help here.

Mr. WARD. First let me say that I think that CHP—which brings back old memories because I testified before this committee for CHP before it was enacted—has a very very definite role that is so different from RMP that I believe that if the two programs were completely understood the question would resolve itself. What is desperately needed at the community level is a quantitative plan that outlines the health care services that are needed. More and more as we get into this planning procedure, we are going to see facilities and other providers demanding an understandable plan, especially as the certificate of need requirements become more legally binding. The facilities today don't know what they can do because they have no concrete plan to relate to, and the facilities do not want to go out and spend anywhere from $5,000 to $50,000—and especially under today's reimbursement pattern they cannot spend that kind of money any more—to develop a plan for expansion of beds and service, and then just summarily have it turned down by the planning agency. They have to have a plan that they can relate to and then indicate what part of the plan they can fulfill. Only then can they begin to spend money on it.

Now, RMP should be in the position not to determine need, not to determine resources or anything else, but should relate to that plan and help develop the services that are needed.

These are entirely two different functions. I have not seen a 314B agency—and I have served on an agency for many years and am in favor of them—I have not seen an agency with a technical capability to implement plans in the way that RMP has that technical ability, because RMP is composed of specialists. It is composed of people who have unusual technical ability. CHP is a generalist program. It is a planning program. The two should be very closely related. There is no question an RMP should not be charged with creation of the plan. But the plan should be there, and it is not in most cases.

Mr. NELSEN. You are depending on Federal dollars, aren't you? I mean, without that support you would not be able to carry on the program. Is that so?

Mr. WARD. Most regions could not carry on the program. I suppose 90 percent could not. There are some regions that have other sources of income and there are some regions that have been doing things separate from RMP dollars, but that is way in the minority and the vast part of the program would be crippled if the RMP dollars were not there.

Mr. NELSEN. We are running out of dollars here too. That is one of our problems.

Mr. ROGERS. Thank you. Mr. Preyer?

Mr. PREYER. Thank you. I think this testimony has been very helpful. I have one question. Dr. Ingall and others have spoken of their pride in their associates and pride in their ability to retain staff in this program. I wonder what is happening under the present circumstances. Say, within a month from now that Congress extends this program for a year? Will you be able to retain your present staff? What is happening in that area right now as a result of the present circumstances?

Dr. INGALL. I would like to speak for my program and in the information we have already provided to Secretary Edwards we have answered these questions. Currently I have lost no staff and no staff are intending to leave between now and September 30 of this year. That gives you a very strong parish reply. The composite reply from the communities is very encouraging. There is one exception that feels they could not really get going again, but out of 56 programs that is a pretty good reply.

Mr. ROGERS. Dr. Hampton?

Dr. HAMPTON. In Florida regional medical programs our core staff intends to be present as long as it is hoped they will have functions to perform. We have lost some clerical staff, but none of the essential core staff.

May I speak to this matter of the 40 percent overhead costs which is confusing to me. Florida regional medical program administrative overhead, by Federal definition, is less than 5 percent. If you take the entire core staff, all the expenses of the core staff which is far beyond administrative in their activities, it is only 14 percent. So I do not understand this 40 percent administrative overhead. Now, I share Dr. Carter's concern about some of these projects, and have from the beginning, and the institutions such as medical schools that have their automatic override or administrative expenses. As Mr. Ward says, we are hardly aware of that, but if the University of Florida for instance gets a project from regional medical program, that is $100,000, this is not including equipment, that would be for the operation of the project—then there is an automatic, about 55 percent—actually they get $55,000 extra for running the university. That includes the president's salary and the janitors.

Mr. ROGERS. But that comes from HEW and the Office of Management and Budget.

Dr. HAMPTON. Right, that is automatic and then they assign that to us as being overhead. But we never heard of it.

Mr. ROGERS. That is what I thought the Department was doing from some of the figures I had seen.

Dr. HAMPTON. I questioned the advisability, as Mr. Ward says he has.

Mr. ROGERS. He said his was 7 percent at a maximum, and yours was 5.

Dr. HAMPTON. Five percent maximum. This led to many very traumatic controversies of which I still bear scars because the medical schools were really dependent upon NIH grants to fund themselves. That is the only way they kept alive, which is a very expensive way to run a medical school. And they looked upon the RMP funds as the same sort of funds they would have to run the medical schools if they had full control of the funds. As soon as we let those initial grants, at the beginning, we would inquire about the expenditure of funds and we were told that was none of your business. That is our money now and we will do with it as we see fit. Finally, I had to employ Peet Marwick and Mitchell to make an audit of every project we had in order to find out what was doing and we found things that needed definite attention. But this is a problem in regional medical programs, in the funding and expense, and the question is whether this should continue and be part of regional medical program funding activity.

Mr. NELSEN. You say that you made some examination and you straightened it out. You had the authority to do this, didn't you, to straighten some things out that needed it?

Dr. HAMPTON. Yes; we did.

Mr. NELSEN. I wonder how this ties in with the testimony we heard this morning. There seemed to be criticism of HEW: that they did not direct the program properly. And yet it now appears that you have this authority. Isn't it possible that some have not done what you have done. They have not stepped in to straighten things out.

Dr. HAMPTON. I don't know how many programs have employed outside accounting firms to make an audit.

Mr. ROGERS. I think the point we are trying to make is that those that had not straightened themselves out should have been dealt with by HEW. HEW had the authority to do so and, obviously, they have not done it. Earlier today the director of the program himself said there were bad programs, and he had the authority to straighten them out. That is what concerned me.

Mr. Carter?

Mr. CARTER. Thank you very much.

Dr. McBeath, what do you consider your mandate under regional medical programs for your actions in Kentucky? What do you think you are supposed to do according to the law?

Dr. MCBEATH. The Regional Medical Program Act as it exists now is rather broad, but it clearly indicates that we should work—in my opinion of the interpretation of it—with our Council to determine what the needs of our area are and how they can best be addressed by the cooperative efforts of the providers of our area to meet the

health needs that particularly can be addressed through regional cooperative arrangements.

Mr. CARTER. Mr. Chairman, I would like to ask a couple of questions. Does that meet with your concept of the Regional Medical Programs Act?

Mr. ROGERS. I think we fashioned the act to be more categorical.

Mr. CARTER. What was it for?

Mr. ROGERS. For cancer and stroke.

Mr. CARTER. And kidney.

Mr. ROGERS. And kidney and related diseases. I think the administration of the act has brought that into less categorical——

Mr. CARTER. Never once did Dr. McBeath mention one of the purposes for which this act was written. Not once. Am I correct?

Mr. ROGERS. Yes.

Mr. CARTER. Doctor, I hope you are doing good work down there. But it seems that you have forgotten the goals, what is written in the law, and it has been interpreted incorrectly. I regret this. This was and is heart, cancer, stroke, and kidney act. How much money did you spend last year in Kentucky in your valley region?

Dr. MCBEATH. Well, I believe Congressman Carter—let me look here a second—our last fiscal period was not a 12-month year but I have the region's expenditure figures here for the last 18 months. Is that satisfactory? This is our fiscal 1972 period.

Mr. CARTER. We can take two-thirds of that and arrive at a correct figure.

Dr. MCBEATH. That was about $2 million in direct costs.

Mr. CARTER. I believe the computer printout here that I have, November 20, 1972. I suppose, gives $5 million in one case and in another case $5,072,000 which would be a little bit more. In another case $3,020,000. And have you really reached down into these communities, into the counties to educate the physicians to try to give them an opportunity for continuing education?

Dr. MCBEATH. Yes; we feel our continuing education activities have been particularly decentralized, particularly in the orbit around the University of Kentucky.

Mr. CARTER. Decentralized. Centralization can cover a multitude of sins. Are you actually educating those doctors down there at the county level?

Dr. MCBEATH. We believe we are.

Mr. CARTER. Have you ever been in some of these counties? Isn't it true that you have never been in some of them?

Dr. MCBEATH. Kentucky has 120 counties and there may be some of them I have not been in, but I would say I have been in most.

Mr. CARTER. I am going to tell you there are some counties you have not been in and no one in your group has been insofar as I can tell. And I regret this. I think in some areas you have probably done good work. I hope that you have. But you have a different concept entirely from that for which the bill was intended. I don't know. I hope that you have handled your finances well. I have not seen much evidence of misuse of funds. But your program does not have much of a profile at

all. And I helped write the bill. It has been rather disappointing that I have not been able to see in my own area why the results, beneficial results of what has been done. And this has caused great alarm. When you appear before my committee and you give the concept of this legislation, which has been called over the years heart, cancer, stroke and kidney, and you do not even mention one of those goals for which this bill is written. I think it is amazing. I have talked with some of the physicians in your area. You have contacts with some of them I found out. I don't know how good. But some seem to like it. Others say they have not received much assistance. I contacted them by phone and I have talked with them personally.

Do you use the local physicians in your health delivery system?

What you have actually gone into is service really.

Dr. McBeath. There have been some of our projects that provide service. There are many that do not.

Mr. Carter. I cannot find fault with that if you are actually getting service to the people but I still say that you are differing from the intent of the legislation, in that it should be focused on heart and cancer, stroke, and kidney.

Tell us some of the things that you are really doing down there. I want to see some of these accomplishments when I go to Kentucky again. I just got back yesterday. I am going back tonight.

Dr. McBeath. I am sorry you are not convinced we had done good things in your district. I thought we supplied you information about how some of the physicians in your area have been reached and how the people have been served.

Mr. Carter. You have not done that. I may have gotten a catalog or something from you, but no information that is meaningful. If you want to get information to your representative, write on one or two sheets of paper and no more because he has no time for catalogs. Each agency of the Government, when it writes a report, sends in a catalog. And it just is absolutely impossible for any Congressman or any group of Congressmen to read one-tenth of what comes across his desk. Actually in the past 8 years I have seen you approximately twice, is that correct? Once or twice?

Dr. McBeath. Twice here in Washington, yes.

Mr. Carter. And in Kentucky?

Dr. McBeath. I have seen you more there.

Mr. Carter. I don't know. I am in hopes that you are doing good work and I supported this bill and I would like for you to remember the intent of it. The purpose behind it. Thank you very much.

[The following information was received for the record:]

98-872 O - 73 - 16

Ohio Valley Regional Medical Program
SERVICE ACTIVITIES
Fifth Congressional District of Kentucky

Home Care Programs

One of OVRMP's most successful patient care demonstration projects--the Somerset Home Care Program--is in this district. It is the oldest and largest of nine multi-county home care programs now operational which were begun with OVRMP seed money and developed with the technical assistance and professional consultation of our OVRMP core staff. We have focused particularly on rural areas with these home care projects and their progress has been gratifying indeed. This initial program (based at Somerset City Hospital) started with three counties in 1970, expecting to eventually serve five counties through the development of satellite service units. It is now already serving eight counties (Adair, Casey, Clinton, Cumberland, McCreary, Pulaski, Russell, and Wayne) and two more currently are being phased in. (Five other 5th District counties are in the present or projected service area of other OVRMP-supported home care programs.) During 1972, over 700 5th District residents were provided home health services through the base and satellite units of the Somerset program alone. Home care is rated a priority need by the CHP agency in this area, now being met by this effort. Financial stability of these programs has been better than expected, permitting OVRMP to support expansion, extension, and replication of this activity on an accelerated basis. This success reflects the enthusiastic support and cooperation of area physicians. Total OVRMP support to this project, phased over three years, amounts to approximately $225,000. (It is interesting to note that while this type program is not usually counted as "categorical", most of the people it directly serves are patients with chronic degenerative disease such as heart disease, cancer, and stroke.)

Rural Clinic Development

Another patient care demonstration in this district supported by OVRMP is the rural clinic program of United Health Services of Kentucky-Tennessee, which serves an isolated 4,500 population in Bell, Whitley, and two adjoining Tennessee counties. This is a joint venture of two RMPs and the Appalachian Regional Commission, with strong community support and involvement. Three struggling mission/settlement clinics have coordinated and expanded their service program, integrated their administrative operations, adopted a consolidated problem-oriented medical record system, incorporated the use of upgraded nurse practitioners and community health extension workers, and secured the local services of a full-time primary care physician. OVRMP has invested over $100,000 in this program, which will be severely compromised now by the involuntary termination of RMP support at the mid-point of an intended three year project. The project has now served about half of the 1,000 families in the area.

Pediatric Heart Clinics

OVRMP support to a Regional Pediatric Heart Clinics project is an effort to coordinate and stabilize a multi-agency program of special field clinics for ambulatory pediatric heart disease patients, and to expand the scope of clinic services while extending sessions to new patient groups. Since our participation began in 1972, the itinerant cardiologists and supporting staff have had 439 patient visits at the Beattyville, Campbellsville, Harlan, Hyden, Irvine, London, Manchester, Monticello, and Richmond sites. All patients are referred and followed by their local family physicians.

Computerized Radiotherapy Dosimetry

About 90 cancer patients from the 5th District have benefitted from better dosimetry planning for external beam supervoltage radiotherapy at the University of Kentucky since OVRMP began support of this project in 1972. The first phase linked the three university medical centers of our region to a joint computerized linear programming capability which quickly gave radiotherapists a highly optimized treatment plan for each patient. A second phase (now threatened by loss of funds) would have provided telemetry links to this system for all cobalt units in the region.

Emergency Medical Services

OVRMP recently signed a contract with the Kentucky State CHP agency to provide for Emergency Medical Services development personnel in those rural areas of Kentucky which do not have local CHP agency staffs. This will apply to a large part of the 5th District. This effort is being closely coordinated with the emergency services actions of the state's new Certificate of Need Board.

April, 1973

Ohio Valley Regional Medical Program
EDUCATION ACTIVITIES
Fifth Congressional District of Kentucky

Any contact w medical libraries?

Area Health Education Networks

Concern for long-range sub-regional health manpower development is a continuing major theme of OVRMP operations, with current emphasis on the development of Sub-regional Organizations for Health Education and Training (SOHMET) in selected pilot areas over the region. The present effort is funded by OVRMP but is being implemented in concert with Kentucky's Comprehensive Health Planning agency and both university medical centers. Eleven counties in the 5th District (Bell, Clay, Harlan, Jackson, Knox, Laurel, Lee, Leslie, Owsley, Rockcastle, Whitley) are included in the service area of a new Appalachian SOHMET, only the second developed under OVRMP auspices. Twelve hospitals and other health service organizations, and twelve higher education institutions (all within the area) have joined the University of Kentucky Medical Center in promoting this new area health education network. These SOHMETs offer considerable potential for improvement of our health manpower problems, by increasing training program capacity (aiding supply) and by using geographically dispersed locations for on-site education (aiding distribution). The increased involvement of private patients and practitioners in student learning situations will have a positive effect on both professional education and medical care.

Mini-Residency

Eleven 5th District physicians (from Columbia, Hyden, Lynch, Manchester, Middlesboro, Oneida, Russell Springs, and Somerset) have taken an OVRMP-sponsored "mini-residency" in a clinical area of their choice. In each case, the doctor returned to the university medical center for one, two, or more weeks carefully planned, well structured individual learning experience especially designed to enhance his knowledge and skill, and has then returned to the community better equipped for his practice.

Medical Center Courses

156 physicians (and 129 other health professionals) from the 5th District have participated in shorter courses and rounds at one or more of the three medical schools receiving OVRMP funds for basic operating costs of their continuing education programs. This comprises 60% of the active patient care physicians of the district.

Local Opportunities

Nor are all these CE opportunities confined to the medical centers. OVRMP supports the University of Kentucky medical CE extension program, which has held 27 courses and 14 radio-TV conferences during the last 3 years within the 5th District (at Buckhorn, Columbia, Corbin, Harlan, Hyden, Middlesboro, Pikeville, Richmond, Russell Springs, and Somerset). These sessions permit small groups of physicians (ten is the average attendance) to share in a special educational exercise without leaving their local area.

Library Extension Service

OVRMP also began a very popular WATS line telephone reference service as part of our Library Extension project. During a twenty months period, 241 persons from the 5th District (including 108 physicians) used this WATS reference service to request bibliographic search and reprint services. When it looked like the service might have to be terminated because of cessation of OVRMP support, several of its constituents wrote letters to let us know it was a valuable service they wanted to see continued.

Weed!

POMR

The problem-oriented medical record represents one significant instrument for restructuring patient records, health education, and medical care. It focuses on ambulatory care, emphasizes comprehensive service, encourages prevention, facilitates continuity of care, enhances care for the chronically ill, supports health professional education, accepts multi-discipline inputs of team care, adapts readily to automation, and aids peer review. OVRMP has awarded eleven contracts in an effort to implement, demonstrate, and evaluate POMR in various ambulatory care settings within the region. One of these contracts is with a family practitioner in Columbia, Kentucky.

April, 1973

Mr. ROGERS. Thank you.

Mr. Hastings?

Mr. HASTINGS. Thank you very much.

Gentlemen, I am delighted to see we have Dr. Ingall here who has maintained very close association with me and provided me with probably more information than I have been able to assimilate.

Doctor, have you talked with Dr. Edwards recently?

Dr. INGALL. No, we have in fact an invitation to meet with him next in about 10 days time. I gather he is out of the country at the moment.

Mr. HASTINGS. I have some reason to believe Dr. Edwards may be a little closer to feeling that RMP's should be in fact kept in operation for a while until we can take a closer look and I hope the results of your meeting with him will bear that out.

Dr. INGALL. I think with respect to everything that has gone before this is the only logical or sensible thing to do. I hate to sort of burrow in the absence of people that are not present to defend themselves but I was extraordinarily worried this morning for example that the administration told us that $500 million had been spent. That is certainly a long way from the truth: $500 mililon was appropriated but the actual amount spent was in the $350 or $400 million mark.

Mr. ROGERS. That is an interesting point. How much did you say has been spent?

Dr. INGALL. Certainly less than the amount appropriated.

Mr. ROGERS. We had appropriated $500 million but you have not had all of that to spend. About $350 million?

Dr. INGALL. $350 or $400 million. That is a figure I would like to confirm.

Mr. ROGERS. It would be helpful if we could have that figure for the record.

[The following information was received for the record.]

DATA ON RMP APPROPRIATIONS AND RMP SPENDING

[In millions of dollars]

Fiscal year	Authority	Budget request	Appropriation	Obligation	Outlay
Planning years:					
1969	65	62.9	56.2	72.4	42.0
1970	120	73.5	73.5	78.2	74.2
Operational years:					
1971	125	79.5	99.5	70.3	84.3
1972	150	40.0	90.5	135.0	88.0
1973	250	125.1	159.0	55.4	134.6
Revised		(55.4)			
Total	710	381.0	478.7	411.2	423.2
Revised		(311.3)			

The Administration's testimony that RMP has spent $500 million appears to be overstated by $76.8 million.

The Administration has used "authorization" figures repeatedly to give a "budget ceiling buster" coloration to H.R. 5608. It has been rumored that your subcommittee will mark up the bill to make the extension authorizations identical to recent fiscal '74 Presidential budget requests. The exception, of course, would be to use FY 1973 appropriations where the President indicated he would terminate programs.

If this is only a rumor, I would strongly suggest it be made a fact. It would help in the case of a veto.

To prevent the bill, in fact, from becoming a budget buster the money for terminated programs can be taken from the Community Mental Health Center FY 1974 Presidential budget which includes several hundred million for phasing-out the program. M.H. Center leaders agree on this.

Curiously, OMB put money enough in the FY '74 budget to phase out Community Mental Health Centers through FY '78. While the basic law requires H.E.W. to fulfill all M.H. Center grant obligations once those obligations are made, it is odd, if not unique, that the President put money needed through FY '78 into the FY '74 budget. But it's there and, under an extension, won't be needed in FY '74.

LAKES AREA REGIONAL MEDICAL PROGRAM, INC.,
Buffalo, N.Y., May 22, 1972.

Hon. PAUL G. ROGERS,
Rayburn Building,
Washington, D.C.

DEAR MR. ROGERS: During the Oversight Hearings on Regional Medical Programs, I took great exception to the Administration witnesses portraying the recommended appropriation on Regional Medical Programs as an actual expenditure. This letter is supplemental testimony for the record as required by you.

I wish to go on record as objecting to the technique whereby authorization and appropriation is presented as a statement of money spent.

This is untrue.

The implication that appropriated funds have been continually expended since 1966 to improve the health care delivery system augments the inaccuracy of the Administration's testimony. The facts are:

1. That from 1966 through to 1968 most of the funds distributed were for planning and structuring Regional Medical Programs into existence.

2. From 1969 the funds were made available for operational projects under the original *fully categorical* terms of the law.

3. The fiscal year 1972 budget released in January 1971 was the first statement of new policy for Regional Medical Programs "a shift in emphasis . . . directed towards improved and expanded service by existing physicians, etc."

4. The budget narrative for 1974 says "despite federal expenditures in excess of $500 million for *these activities* there is little evidence that on a nation-wide basis the RMP's have materially effected the health care delivery system". *These activities* refer to the improvement of access and strengthening of the health care delivery system alluded to in the preceding sentence of the budget statement. I have reviewed the sequence of events with consummated care. Since the new policy was stated (as recorded in 3 above) our expenditure has been fractionally under $200 million. To lead your committee to conclude that $500 million had been spent for this purpose is, therefore, even more misleading than would appear on first examination.

My facts come from the budget narrative for Regional Medical Programs over the years stated and from the RMPS Fact Book, both of which are produced by the Administration.

Yours sincerely,

JOHN R. F. INGALL, M.D.,
Executive Director.

Mr. HASTINGS. I am interested—and if you will agree to answer—in a statement made previously by Dr. Margulies about the National Advisory Board and how they maintain some oversight or control over the various 56 programs. Have they in fact maintained that type of oversight. They talk about arranging them and saying "if you are not doing the type of job that the legislation has intended you to do, or the administration has intended you to do," that they pull off the funding and go into a 6-month funding period to straighten out. Has that in fact happened throughout the RMP's in this country?

Mr. WARD. The threat has been posed to at least two regions that I can think of. I believe that one was actually put on probation.

Mr. HASTINGS. You say one was put on probation?

Mr. WARD. As I recall.

Mr. HASTINGS. Yet this statement indicates they "put lagging programs," plural, on probation where they have not lived up to their obligation.

Mr. WARD. I am speaking from memory now. I have not had a chance to look that up. The National Advisory Council does review all of the funding of a region and then approves it for a 1-year period, a 2-year period, or a 3-year period. Regions that are considered to be operating or functioning well usually get what is called a triennial review. In other words, they go the full 3 years without reviewing them.

Regions that are going exceptionally well—and this is a part of the funds they call administrative costs—get what is called a developmental component. Now this developmental component can be awarded for purposes that are not specifically stated in your original grant application. But if you are funded for 3 years, you must state specifically what kind of things you are going to do during those particular 3 years and if you deviate too much from that, then you must seek another approval for that deviation. The only thing that you have a great deal of freedom with, or relative freedom, is the developmental component. You can make small awards for a 1-year period without having specific approval in your triennial review.

Mr. HASTINGS. I would also like to have answers to some charges by the administration where RMP's have not been successful and I will quote from Dr. Zapp's testimony this morning. "RMP's have been unsuccessful in reconciling the conflicting emphasis between categorical disease activities and comprehensive health care problems."

Dr. INGALL. Mr. Hastings, I think one would be tempted to really run away with this as a dog worrying a bone. I think the question of categorical and comprehensive medical raises the question that I related last time when Mr. Kyros was chairing this committee. You know, if you are looking at comprehensiveness you have to take for example, the emergency medical service as we discussed it. Coronary heart disease is an emergency. People die in the first 2 hours. It did not seem economically reasonable not to consider that a cancer patient could have a sudden hemorrhage, an obstruction, a thoracic collapse, and would not need the same treatment. It did not seem unreasonable to say a person with stroke, that had a hemorrhagic stroke that could be syphoned off so he could get back into the community as a productive individual, should not fall into this comprehensive attitude to heart, cancer, stroke; the same applies to kidney disease, the same applies to trauma and the same applies to poisoning. It was this comprehensiveness of thought that has been a problem when people have said, "Don't the regional medical program adhere to the categories." By George, it adheres to the categories, but it adheres to them economically. In other words what is good for one category is equally good for the other and one must look to the fundamental shortcomings in all the categories if they are going to serve the community at large.

Mr. HASTINGS. Do I interpret that to mean that you do not agree with the interpretation outlined by Dr. Zapp, that you do not agree?

Dr. INGALL. Yes.

Mr. HASTINGS. Next he said, "There is no significant evidence that RMP's have achieved their goal of getting research advances in regular large-scale practice. The training programs undertaken are typically of limited scope and duration and there is no substantiating evidence that these have had a significant impact on actual medical practice or in demonstrating improved quality care." Would you care to comment on that, one or all of you?

Dr. INGALL. From the professional point of view, I would take direct issue on that. In telling a physician or somebody else what is available to him at the research level which is medically and clinically applicable, getting that message across is the marketing businesses that RMP has been in. It is not just teaching people. It is getting the information across. They are intelligent enough to use it. They just want to know it is there. This information transfer has been crucially successful in our area. It helps the physicians to realize that in fact the commitment, for example, to a coronary care unit is more than they can assume. This has prevented a great deal of expenditure in every single little hospital developing an enormous coronary care unit, because they know—they have learned with this information transfer, this marketing of what are the standards in the accepted institutions—they have come to realize where they can meet those standards and to what extent they can do it. That has really made a difference to the practitioners in our area. It has also made singular difference—and I have to go across the State line for example, to Pennsylvania here—physicians have said, "We have learned one other thing. The referred patient with loyalty to our old institution we had been sending patients 400 miles for help whereas we should not adhere to that referral pattern. There is equally good treatment 200 miles away." That is good sense. That is saving patients travel, overnight stay. It is saving patients discomfort and it is saving money.

These are terribly important things to grasp. Now how successful has this information transfer in the regional medical program been? In our own area, Mr. Congressman, as you know, people are being taught really what they require and we are finding people, just by educating them to their needs, we are finding people needing care and they are getting care. We are keeping them out of hospitals. These are all very important factors to consider.

Dr. HAMPTON. I note the comment that physicians are well able to pay for their own education, which I agree. I received a letter from a respected physician in Florida not long ago saying "Why should regional medical programs involved in the health education in programs for physicians." He says there are plenty of these programs. Every day I get in the mail announcement of a tour to Greece for medical education or the Mediterranean or Caribbean or something going on in London. And it is true physicians can go to these places and get these dynamic lectures, even in their local medical schools, but what regional medical programs have been addressing themselves to as far as continuing education of physicians is to try to make it available to them within their practice, through consultation services that are available by telephone, or other means of providing them with consultation, while they are faced across the bed or across the table from the problem, right there.

That is the best time to gain education, when you have the problem before you. When I go to didactic lectures in about 15 minutes I often find myself asleep and I think this is not a very good way for continuing education, or to go off to Greece or the Mediterranian or Caribbean.

Mr. HASTINGS. If you were a Member of Congress taking those trips to far off places you would be going on a junket, not continuing education, I am afraid.

I do very much appreciate the testimony of all four of you gentlemen. I hope we have the opportunity after we have extended this program for the year hopefully, to get together again to try to develop continuing programs, encompassing the best parts of RMP's.

Thank you again.

Mr. ROGERS. Mr. Roy?

Mr. ROY. Thank you very much.

Isn't it essentially correct that RMP did start out to provide to the local practitioner, the knowledge that we have gained about cancer and heart, stroke and so forth.

Dr. INGALL. Yes, sir.

Mr. ROY. This was the thrust of the program during the first few years?

Dr. INGALL. Yes, sir.

Mr. ROY. Isn't it also true there was a white paper by HEW under this present administration.

Mr. WARD. The Finch paper.

Mr. ROY. What did that Finch white paper recommend?

Mr. WARD. The Finch paper set forth the priorities in the health field insofar as the administration was concerned. One of those major premises so far as we were concerned was the delivery of health care to those who did not have it and it named five categories of citizens: mothers with children under five, Indians, migrant workers et cetera. It was pointed out that RMP was a categorical approach and the continuing education program and therefore did not fit in with these priorities and if funds were going to be released for the program it had to find a way of fitting into these particular priorities.

A long meeting was held with the Secretary. We negotiated these points. We came to a general agreement on how the program should proceed along the Finch priorities.

Mr. ROY. So the decategorization came about as a result of the thrust of the Finch white paper, isn't that correct?

Mr. WARD. Right. It changed the emphasis in our program, not necessarily the entire approach, but certainly the emphasis.

Mr. ROY. As I hear it the administration says "We are going to criticize you because you are not doing those things which the program originally said you were going to do", but now you are doing many, many things.

Is it correct to say you are doing many, many things because HEW under the Nixon administration requested that you do many, many things.

Mr. WARD. We have felt that was true and we felt somewhat hurt by the fact that those negotiations were not remembered.

Mr. Roy. Isn't it also correct that the RMP's which were to get the greater share of the money were indeed those RMP's that implemented the variety of service programs outlined by the Finch white paper?

Mr. Ward. Right, and as coordinator we were obligated to go back and sell our advisory committees on the feasibility and the advisability of going along this particular line, and we did.

Mr. Roy. That was the only thing I wanted to make clear.

Mr. Rogers. I think it is well for the committee to understand this.

Dr. Hampton. Along the same line.

One of the criticisms of the RMP's has been that it has not achieved the regionalization of health care delivery envisioned by the RMP program.

This is not in the law. That was in the original DeBakey Commission recommendation but Congress rejected that concept. We are in fact prohibited to tamper with the health care delivery system to that extent.

Mr. Roy. Let me ask for the record, the Finch white paper 3 years ago requested you not to go forward in categories, heart stroke, cancer, and lung disease, to the degree you had formerly but you do a number of other things.

What were those other things?

Mr. Ward. It did not say that. It just did not list what we were doing with any degree of priority and therefore there was a reluctance to release the appropriated funds for the program.

This issue was raised by the inability to get funds released for the program. The priorities that could apply to us were priorities that dealt primarily with the creation of primary care for those people who did not have it.

I am not sure I can recall all of the categories but they were, as I remember, mothers with children under 5, Indians, migrant workers—somebody help me with the other two—intercities, but the report that was dated February 1970, set forth these priorities then a group of coordinators tried to comply with them.

Mr. Roy. That is the point I wanted to make. Your mission was changed substantially 3 years and 3 months ago at the request of HEW rather than as a result of your own initiative.

Mr. Rogers. This is what concerns the committee. We write the law and then HEW, in this instance through Secretary Finch's white paper, tries to change the thrust of what we write.

Mr. Heinz?

Mr. Heinz. Thank you, Mr. Chairman.

I want to commend the coordinators for having brought to the committee this very helpful testimony. I would appreciate comments on how from the standpoint of men in the field, HEW might have brought about the following situation.

I have here the budgets of two different RMP's, both rated quite satisfactorily by HEW. One of these is the Minnesota RMP where the program staff components is about $859,000 of a budgeted total direct costs of $2,699,000 for the 0–3 program year.

In this case, program staff account for a little less than one-third of total cost. In the western Pennsylvania RMP, also getting high

marks from HEW. the core cost component was $899,000 out of a total direct involvement of $1,375,000 or nearly two-thirds administrative cost. if I can tell the core component, administrative costs

Would anybody care to make the leap and comment on how there could be such wide discrepancy from your own experience with the evaluations performed by HEW which I am sure you all have familiarity with.

Mr. WARD. I think I can answer that.

First this program has undergone an unusual amount of cuts.

In other words. we get an appropriation. We expect to be funded at a certain level. We do our planning to reach this particular level, and understand you just cannot do this planning overnight.

It takes months to put all this together. Then you go through the review cycle which is approval by the National Advisory Council. You get your projects approved and you tool up your core staff which are people that you have to have on full time, or whatever you contracted for.

You tool up to meet this level. Then the program gets cut and the cut in many cases has come just before the new projects were to be funded.

Western Pennsylvania if I recall—and again this is from memory—had literally hundreds of thousands of dollars in unfunded projects and these are projects that the planning had been done on. The expectations were they would be funded but just before their funding period came funds were withheld.

I was fortunate in California in that my funding cycle came at such a time that I got in before the cuts came although we suffered a very serious cut on occasion and it throws your staff—what you are trying to do in the five to seven steps that I have outlined—it throws you out of synchronization with your operational side to have these cuts come because you almost always have to take the cut out of the unfunded projects.

I am pretty certain that is what happened in the case of Pennsylvania.

Mr. HEINZ. Even though these numbers I just quoted were from their 4th year of operation. for 1 year. this could still happen.

Mr. WARD. Right.

Mr. HEINZ. Thank you very much.

Mr. Chairman. I have no further questions.

Mr. ROGERS. Any other questions?

Dr. Carter?

Mr. CARTER. In the field of drugs you have gone into that somewhat I take it. is that correct? Drug education.

Dr. MCBEATH. I am not sure we have. Dr. Carter. if you are speaking to me.

Mr. CARTER. It is on this list here.

Dr. MCBEATH. You are speaking about a project in area of drug information. We had a project of drug information earlier.

Mr. CARTER. What was your authorization for that?

Dr. MCBEATH. I do not recall the amount.

Mr. CARTER. I think much of this probably has been good. You say the white paper may have been responsible for part of it.

Dr. McBeath. May I respond on the drug information project.

The drug information project was directed toward providing ractitioners in the field, physicians, with instant telephone communiations with a drug information system to provide them with informaion about drugs that would be used therapeutically in their practices nd it was used that way until we had to cut our program and our ouncil itself placed a lower priority on that project and terminated it.

Mr. Carter. Was that ever a part of your program at all, drugs or nything to do with drugs. We usually take care of that under——

Dr. McBeath. We felt drug information very much a part of the xpertise that had been developed in the medical centers in the area f heart, cancer, and stroke, having to do with pharmaceutical therpy; and to get that disseminated throughout our region was a good ipport of the categorical emphasis of the law.

Mr. Carter. Since we have mental health centers which have with iem arrangements and beds and specialists for treating this, don't ou think that is another layer on the cake, that you're spreading into n area you should not. This is not your field at all.

Dr. McBeath. To provide information about clinical pharmaology?

Mr. Carter. Concerning drugs. That really is not specified in this rintout.

Dr. McBeath. This project had nothing to do with drug addiction r the illicit abuse of drugs.

Mr. Carter. This just says drug information and really, the bill oes not mention drugs as related to anything except heart, cancer, nd stroke.

Dr. McBeath. I think this is directly in that channel. It is talking bout the latest findings with respect to clinical pharmacology in conection with heart, cancer, and stroke.

Mr. Carter. You have four purposes. I think you probably develped some good. I hope some good home-care facilities in this area. I oticed you spent quite a bit of money on this in that area.

Would you describe what you have done in the field of home care?

Dr. McBeath. The program is supported with seed funds to start p—and with considerable technical assistance and consultation from ur core staff—the formation of multicounty home health agencies, ost of them in rural areas.

There are nine of them now. These programs are aided in starting p in areas where it appears that there is good receptivity to them on ie part of local physicians. They provide services—about 60 percent f the services, as I recall, go to medicare and medicaid patients. The ther 40 percent are to patients paid from other auspices.

Mr. Carter. What part do you play in that?

Dr. McBeath. Of underwriting the deficits of these programs durig their early inception until they are self-supporting, and of proiding technical assistance and organizational skills that are required o put them together.

Mr. Carter. Where do you provide kidney dialysis?

Dr. McBeath. We do not provide kidney dialysis per se. We train nal dialysis technologists and we have provided considerable staff

support to the Ohio Coordinating Committee on Renal Disease and the Kentucky Kidney Institute.

Mr. CARTER. Do you provide funds for training people in this area?

Dr. MCBEATH. In the renal dialysis area; right.

Mr. CARTER. Where do you do that?

Dr. MCBEATH. University of Kentucky.

Mr. CARTER. University of Cincinnati?

Dr. MCBEATH. No: just University of Kentucky, that project.

Mr. CARTER. What is the approximate cost of that per year?

Dr. MCBEATH. I have to refer to my notes.

About $50,000 per year is budgeted for that project. We had another kidney project that was turned down.

Mr. CARTER. I think it should have been more rather than less.

Mr. ROGERS. Thank you.

If there are no other questions the committee is grateful for your presence here today and your testimony has been most helpful.

Mr. ROGERS. Thank you. The committee is adjourned.

[The following letters were received for the record:]

AMERICAN NURSES' ASSOCIATION, INC.,
Kansas City, Mo., May 4, 1973.

HON. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, Rayburn Building, Washington, D.C.

DEAR MR. ROGERS: The abrupt termination of Regional Medical Programs even before its legal authorization expires is most disheartening to those concerned with improving the health care of the American people. This country's leadership in the field of health research has long been a source of national pride.

Health research, if it is to result in better health care, must be rapidly fed into the health care delivery system. The Regional Medical Programs have made it possible for thousands of health personnel to be brought up-to-date on changes in care, thus making possible better services to the ill.

Many RMP groups have been innovative in developing programs of continuing education that meet the specific needs of their communities. For example, T. V. communications for an area where travel is difficult, development of teaching materials to be used when convenient by busy, overworked health professionals, and educational meetings arranged at locations that do not usually have access to continuing education offerings.

It is now being said by DHEW spokesmen that RMP's provide continuing education to those that can well afford to pay for it. The reality is that it costs, on the average, three times tuition charges for most higher education programs. Health professional education costs are considerably more. Support of staff while courses are being planned and developed is also costly. Speaking for nursing, there are staff nurses in rural and other areas of this country, many of them with families to support, earning $7–$8,000 a year! How realistic is it to expect them to pay $300–$400 for a workshop (if full costs were to be charged)?

Right here in the District of Columbia RN's start at $8,500 a year and you are well aware of the high cost of living in this area.

In addition to the educational programs supported by RMP's, the demonstrations of services-to-people portion of the program should not be underestimated. The catastrophic nature of the diseases focused on in this legislation and the large number of Americans disabled by them indicates that there continues to be a need for improvement in prevention measures and care for people with those diseases.

When specific legislation is introduced to revise or extend these RMP programs, we will address ourselves to the specifics but at this time we want to indicate our support for many of the RMP's throughout the country. This does not mean that we support long-term renewal without changes in the law, but precipitous close-out of programs without plans for the future seems most wasteful of resources it took years to develop.

I ask that this statement appear in the record of the oversight hearings on Regional Medical Programs.

Sincerely,

EILEEN M. JACOBI, Ed. D., R.N.,
Executive Director.

AMERICAN OSTEOPATHIC ASSOCIATION,
Arlington, Va., May 4, 1973.

Hon. PAUL G. ROGERS,
Chairman, Subcommittee on Public Health and Environment, Committee on Interstate and Foreign Commerce, Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: On behalf of the American Osteopathic Association, the American Osteopathic Hospital Association, and the American Association of Colleges of Osteopathic Medicine, we wish to state for the record our views on Regional Medical Programs (RMP), which have been earmarked for eradication June 30, 1973.

Approximately 75 percent of the osteopathic profession is engaged in the delivery of primary health care needs, and many of these doctors practice in rural areas. In these areas, RMP's have served a vital function.

When Regional Medical Programs were established during the Johnson administration, they were charged with the relaying of new medical advances from the laboratory to the practicing physician. We feel that this goal has been attained with a reasonable amount of success. Through these projects many physicians, both M.D.'s and D.O.'s, have derived further knowledge of medical advances and techniques which otherwise might have been nearly impossible to acquire. Tremendous strides have been made in the fields of heart disease, cancer, stroke, kidney and other related diseases through RMP research activities. In addition, numerous patients have been served, new health manpower has been trained and deployed, the quality of care has been improved and new health care services have been made available. These are generalized accomplishments of this program, accomplishments which we submit State and local governments could not have attained alone. The abrupt phase-out of RMP projects will impede the development of high calibre health service, at what we, as primary physicians, feel is the core area that needs to be upgraded.

In our opinion, many of the 56 RMP's in existence have proven their effectiveness. Although there are a few which have apparent weaknesses, we believe that RMP's have made a solid contribution to correcting the maldistribution of proper health care in this country. It will be the poor, the elderly, and the residents of rural areas who will suffer the most with the demise of this program.

We strongly urge the Congress to once again concern itself with the real issue at hand and re-examine our nation's values and priorities as it did in establishing this program almost a decade ago.

With respectful regard.

ROY J. HARVEY, D.O.,
Director, AOA Washington Office.
ROBERT W. OLIVER, PH. D.,
Executive Secretary, American Association of Colleges of Osteopathic Medicine.
JOHN A. ROWLAND,
Chairman, Legislative Committee, American Osteopathic Hospital Association.

[Whereupon, at 3:40 p.m. the committee was adjourned.]

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