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Regional Medical Programs
Report to Congress -- P.L. 91-515

I. INTRODUCTION AND SUMMARY

The initial concept of Regional Medical Programs was to provide a vehicle by which scientific knowledge could be more readily transferred to the providers of health services and, by so doing, improve the quality of care provided with a strong emphasis on heart disease, cancer, stroke, and related diseases. The mission of Regional Medical Programs as originally conceived was, broadly stated, to assist the health professions and institutions of the Nation in their efforts to improve the quality of care and to organize and develop preventive, diagnostic, and treatment services directed toward the control of heart disease, cancer, stroke, and other related diseases. This original mission strongly reflected the program's origin, namely the President's Commission on Heart Disease, Cancer and Stroke. In its report, that Commission recommended that a major national effort be mounted to reduce the toll from these diseases which account for 75% of all the deaths in America. During the legislative process an awareness of the need to involve all health providers and institutions in an attack upon this problem, and a recognition of the potential which regionalization of service patterns and education would bring, led to the concept of regional "cooperative arrangements" among providers as the principal means (or mechanism) to be employed in the pursuit of that end.

The implementation and experience of RMP over the past six years,

coupled with the broadening of the initial concept especially as reflected in the most recent legislation extension (P.L. 91-515), has clarified the operational premise on which it is based -- namely that the providers of care in the private sector, given the opportunities, have both the innate capacity and the will to provide quality care to all Americans.

The concept and the reality of the Regional Medical Program has evolved and changed considerably since the enactment of the initial authorizing legislation (P.L. 89-239) in October 1965. Its goals have been broadened considerably; and there is every reason to believe that these goals will be expanded and altered in future years as the major health problems and needs of the Nation change.

It is RMP's approach rather than its goals (or mission) which is unique. For RMP, as a mechanism, has and continues to be a functioning and action-oriented consortium of providers responsive to health needs and problems. It is aimed at doing things which must be done to resolve those problems.

RMP is a framework or organization within which all providers can come together to meet health needs that cannot be met by individual practitioners, health professionals, hospitals and other institutions acting alone. It also is a structure deliberately designed to take into account local resources, patterns of practice and referrals, and

needs. As such it is a potentially important force for bringing about and assisting with changes in the provision of personal health services and care.

RMP also is a way or process in which providers work together in a structure which offers them considerable flexibility and autonomy in determining _what_ it is they will do to improve health care for their communities and patients, and _how_ it is to be done. As such, it gives the health providers of this country an opportunity to exert leadership in addressing health problems and needs and provides them with a means for doing so. RMP places a great corollary responsibility upon providers for the health problems and needs which they must help meet are of concern to and affect all the people.

Insofar as _mission_ is concerned, it has become clear that RMP shares with all health groups, institutions, and programs private and public, the broad, overall goals of (1) increasing availability of care, (2) enhancing its quality, and (3) moderating its costs -- making the organization of services and delivery of care more efficient.

Among government programs RMP is unique in certain of its salient characteristics and particular approaches. Specifically that (1) it is primarily linked to and works through providers, especially practicing health professionals, which means the private sector largely; (2) RMP essentially is a voluntary approach drawing heavily upon existing health resources; and (3) though RMP continues to have a categorical emphasis,

to be effective that emphasis frequently must be subsumed within or made subservient to broader and more comprehensive approaches.

RMP's more specific mission and objectives, as outlined and discussed below, are the product of the above broad, shared goals on the one hand and its unique characteristics and approaches on the other.

II. LEGISLATIVE AND ADMINISTRATIVE BACKGROUND

In addition to extending the RMP legislative authority through June 30, 1973, P.L. 91-515 made a number of changes in that authority. Among them:

(1) Explicit contract as well as grant authority was provided.

(2) "Kidney disease" was specifically added as a categorical disease concern of RMP.

(3) The scope of the program in non-categorical terms was considerably broadened. Specifically the attention of RMP was directed to -

(a) "Strengthen and improve primary care and the relationship between specialized and primary care."

(b) "Improve generally the quality and enhance the capacity of health manpower and facilities available to the nation."

(c) "Improve health services for persons residing in areas with limited health services."

(4) Requirements with respect to Regional Advisory Group composition were expanded. Most importantly, RAG membership had to include representatives of "health planning agencies."

(5) Required areawide CHP agency review and comment on RMP applications prior to their final consideration by Regional Advisory Groups (which must approve all RMP operational proposals) and submission to RMPS.

(6) Expanded National Advisory Council on Regional Medical Programs membership to 20, with specific provision made for -

(a) "One person outstanding in the study or health care of persons suffering from kidney disease."

(b) Four public members.

(c) The Chief Medical Director of the Veterans Administration as an ex-officio member.

(7) The so-called Multiprogram Services authority under Section 910 was significantly broadened to allow grants to public or non-profit or private agencies (including but not limited to RMPs) to -

(a) "Assist in meeting the costs of special projects for improving or developing new means for the delivery of health services concerned with the diseases with which this title is concerned."

(b) "Support research studies, investigations, training, and demonstrations designed to maximize the utilization of manpower in the delivery of health services."

The above changes have been or are in the process of being implemented administratively and/or reflected programmatically.

Kidney Disease

Since the categorical scope of RMP was broadened to specifically include kidney disease, a growing number of Regions have submitted pro-

posals in this disease area. Kidney disease treatment capabilities now are being expanded in 20 Regions. The current annual level of RMP grant funding to these RMPs for kidney disease activities is about $2.1 million, which is roughly double the level of funding prior to the enactment of P.L. 91-515, a little over one year ago. New awards made (or pending final action), during that period have equalled $.8 million. (In addition, RMPS is continuing to support by contract home dialysis, transplantation, and other demonstration and training projects relating to kidney disease, at a current annual level of approximately $4 million.)

Recognizing beforehand that requests and approvals very probably would exceed RMPS' ability to fund kidney disease activities, specifically end-stage treatment programs, the National Advisory Council early on adopted a policy according top funding priority to those proposals which in effect build upon and/or link up with existing resources and programs for end-stage treatment of kidney disease. The aim is to expand present capacity and services thus making treatment available to increased numbers of people over larger areas of the country; in short, to maximize the number of additional people served and treated within the limited funds and other resources, such as specialized facilities and trained manpower, presently available.

Thus, proposals funded generally have fallen into one or another of two broad categories. Specifically, (1) those where a modest increment has allowed the expansion in the capacity of existing integrated

dialysis-transplantation programs or (2) those that would help provide the element(s) presently missing but needed (e.g., tissue typing laboratory) in order to put together a comprehensive program for end-stage treatment of high quality. Particular encouragement is being given to programs of an inter-regional character, those serving or linking several (or parts of several) Regions, so that the duplication of expensive facilities and services may be avoided, scarce manpower might be better used, and the patient suffering from renal failure might receive optimal treatment and care.

Scope of Program

The categorical disease emphasis of RMP has in recent years been a major issue; and in the 1970 legislative extension the explicit broadening of the program's scope to include all "other major diseases" was proposed.

Although this expanded language was not retained in the bill finally enacted, P.L. 91-515 did broaden RMP's scope significantly. For as already noted, the amended legislation incorporated specific changes with respect to strengthening primary care, improving services for those presently underserved, developing new means for the delivery of health services, and maximizing the utilization of health manpower as part of RMP's mandate.

Quite apart from these legislative changes, experience in recent years and the directions increasingly pursued by most Regions clearly indicates that the categorical emphasis on heart disease, cancer, stroke, and kidney disease is, operationally at least, viewed as an important

focus rather than a narrow program restraint or limitation. Though the issue perhaps is not entirely a moot one, the following suggests that it largely overlooks what Regions have actually been doing.

* Connecticut's continuing central thrust towards regionalization of services, comprehensively defined, around the community hospitals in that State.
* The early efforts of the California RMP in the Watts-Willowbrook area of Los Angeles and, more recently, their efforts which have been instrumental in leading to OEO funding of community health networks in San Francisco and Los Angeles.
* New Jersey's continuing efforts to help with the health problems of poor urban blacks which have entailed working closely with and supporting Model Cities programs in many cities in that State.
* Georgia's concern with improving and linking emergency care services generally in an eleven-county area in the southeastern part of that State.
* The technical assistance, feasibility studies, and other support provided by the Metro New York, Ohio Valley, and West Virginia RMPs this past year to groups and communities interested in developing HMOs.
* The major contributions made by the Arkansas, Mountain States, and Northern New England RMPs to the development of Experimental Systems proposals funded last year.
* Maine's efforts in promoting and assisting with the development

of a medical school in that State.

* The pilot sickle cell anemia programs funded recently by the Michigan and Western Pennsylvania RMPs.

This reality and the broadened legislative mandate are, it will be seen below, reflected in the "new directions" and priorities of Regional Medical Programs at both the national and regional levels.

Relationships with CHP

The changes made by P.L. 91-515 have served to reinforce the relationships and cooperation between Regional Medical Programs and Comprehensive Health Planning.

The new legislative requirement that RMP Advisory Groups include health planning agency representatives was interpreted to mean representatives of State and areawide CHP agencies specifically and implemented accordingly. While most RAGs previously included CHP representatives, such cross-over representation has increased significantly. There are, based upon the most recent information available, 149 State CHP representatives on RMP Advisory Groups and 124 areawide CHP representatives. In addition, there are over 250 CHP representatives on other RMP working committees and task forces. (Conversely there are 850 RMP representatives serving on the Advisory Councils and other committees of both State and areawide CHP agencies.)

The review and comment requirement was implemented effective May 1, 1971. As of that date all RMP applications submitted had to include the comments of the appropriate areawide CHP agencies. Information available at that time indicated that cooperative review mechanisms had already been

established with 107 funded areawide agencies and with an additional 69 such agencies not yet funded by CHP. Furthermore, 46 RMPs also were providing State CHP agencies with the opportunity to review their proposals.

It is still too early to determine what the effect of this review and comment by CHP agencies will be. It certainly should help over time to insure that activities and efforts proposed by RMPs are consonant with the local needs and problems as perceived by communities and expressed through their CHP areawide planning efforts and priorities.

Decentralization to Regions

One salient characteristic of the RMP mechanism is the large degree of regional (or local) autonomy which Regions have had and exercised. Singular legislative expression of this is that all operational proposals submitted to RMPS for Council review and recommendations must be approved by that Region's Advisory Group.

Another major step in this direction was taken in mid-1971 with the decentralization of project review and funding authority and responsibility to the 56 RMPs. Now Regions are, if their own review processes meet defined minimum standards, given primary responsibility for deciding (1) the technical adequacy of proposed operational projects and (2) which proposed activities are to be funded within the total amount available to them.

Although it is assumed that the review process of all Regions meet the prescribed standards, or can with minimal changes or adaptations, RMPS is verifying this through a series of staff visits and examinations of

their review processes. It is anticipated this verification procedure will have been largely completed by June 30, 1972.

National Review Process and Selective Funding

The Council and national review process now are assessing RMPs largely in terms of their overall program and progress. No longer is the technical adequacy of individual projects or discrete, singular activities the primary focus or concern.

This change from project to program review has led to, and indeed necessitated, the development of program review criteria, aimed at assessing each Region's (1) performance to date, (2) the process and organization that has been established, and (3) its proposal for future activities. These criteria and a corollary scoring system have been used on a trial basis over the past six months, found operationally adequate and workable, and are being incorporated as an integral part of the national review process.

As a result, Regions are now being ranked or 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. This in turn has permitted RMPS to implement a stronger policy of selective funding.

Under this selective funding policy, which was formally initiated this fiscal year, those Regions which have demonstrated outstanding maturity and potential <u>and</u> whose proposals are most nearly congruent with the expanded RMP mission and national priorities, are being awarded proportionately greater increases.

III. PROGRAM DIRECTIONS AND ACCOMPLISHMENTS

The broadened concept of Regional Medical Programs, with its emphasis on improving the availability, efficiency and quality of care, sets the framework within which specific objectives and program priorities are developed. Within this framework, Regional Medical Programs have identified four areas of program concentration, the principal objectives of which are to:

(1) Promote and demonstrate among providers at the local level both new techniques and innovative delivery patterns for improving the accessibility, efficiency, and effectiveness of health care. This might include, for example, encouraging provider acceptance of and extending resources supportive of Health Maintenance Organizations. In relation to new comprehensive health care systems, emphasis will be placed on assistance in developing and implementing mechanisms that provide quality control and improved standards of care, such as performance review mechanisms.

(2) Stimulate and support those activities that will both help existing health manpower to provide more and better care and will result in the more effective utilization of new kinds and combinations of health manpower. Further, to do this in a way that will insure that professional, scientific, and technical activities of all kinds (e.g., informational, training) do indeed lead to professional growth and development and are appropriately placed within the context of

medical practice and the community. At this time emphasis will be on activities which most effectively and immediately lead to provision of care in urban and rural areas presently underserved.

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

(4) Foster close cooperation and coordination with other health programs. Experience to date has shown that the Regional Medical Programs can best help to improve the overall effectiveness of the health care delivery system by working with and contributing to related Federal and other efforts at the State, local and regional levels. Cooperative linkages with the Comprehensive Health Planning agencies and the Experimental Health Services Delivery Systems of NCHSR&D are prime targets to provide effective organizational frameworks for identifying and utilizing community health resources.

During 1970 and 1971 the Regional Medical Programs may be said to have become fully operational in attempting to meet these objectives. Indeed, of the 56 Regional Medical Programs that were established for planning purposes, 55 are now operational, with the 56th region

moving toward operational status. As such, for varying periods of time ranging from over four years to only a few months, these programs are now involved in activities especially designed to meet the health needs of their own Regions.

The approach of these Regions is reflected in certain broad areas of accomplishment which are being realized around the country.

* All operational Regions, the new as well as those which made earlier starts, have developed a base for effective regional planning and decisionmaking through broad representation and participation of health institutions, organizations and individuals on the planning committees, and the Regional Advisory Groups of each Region.

  The Regional Advisory Groups, which serve as the policy-making body of each Region, and are responsible for the selection and content of proposals sent forward for funding, have grown to include 2,700 individuals.

  In addition, each Region also has a variety of task forces and planning committees designed to ensure broad-based participation. Some 12,000 health professionals and public representatives are on Regional Medical Program planning committees and local action groups. These represent a variety of health and health-related institutions, including all medical schools, every state medical society, health departments, cancer and heart associations, many other voluntary and public agencies, and over 2,100 hospitals. This widespread, voluntary participation in RMP by literally thousands of health professionals and hundreds of health institutions is an important

strength and characteristic of the program.

* The 56 Regions are moving in a variety of ways to achieve their objectives. Perhaps one of the most important roles is played by the professional (or core) staff in each Region. These have developed to include over 1,500 full-time persons.

A primary role of the professional staffs is to serve as a facilitator for cooperative planning and joint programming. Because of its network of relationships, the RMP staff can serve as a convenor of multiple-interest groups to solve local problems.

The staff may encourage health groups to develop joint efforts rather than institute autonomous programs. This involves development of regional linkages which demonstrate methods of institutional planning to avoid duplication of effort, and sharing of resources and facilities to improve efficiency, such as joint employment of certain professionals or common laboratory services.

The professional staff has played another important role in serving as a technical resource and providing consultation services to health organizations such as hospitals, Comprehensive Health Planning agencies, educational institutions, Model Cities, OEO, and others. Professional staff also support many central regional resources, such as data systems, evaluation resources, information networks, and parts of the manpower training system.

* The Regional Medical Programs are working to improve the health care system directly through operational projects as well. The movement toward redirection of grant funds is reflected in the areas of program emphasis of the nearly 600 operational activities. Activities emphasizing organization and delivery of patient services and the training of new types of personnel are increasing, while funds for continuing education and planning are decreasing. Almost one-fifth of RMP operational funds are now in ambulatory care activities such as neighborhood health centers and out-patient departments of hospitals.
* Moreover, these professional staff and operational activities are leading to the creation of important institutional linkages among hospitals, practicing physicians, and medical centers which affect and improve the whole system of delivering medical care.

Within these broad areas of program direction, program accomplishments and problems can be looked at in relation to specific areas of focus.

Innovations and Improvements in Health Care Delivery Systems

New techniques and innovative delivery patterns that lead to improved accessibility, efficiency and effectiveness of health care are being developed and tested under RMP auspices. The need for improvements in health care delivery patterns is evidenced by the poor utilization of physicians and allied health manpower in most medical trade areas; the acute lack of such manpower in rural and ghetto areas; the rising cost of medical care, particularly for hospitalization and related services; the uneven availability and accessibility of health services, again most scarce in rural and ghetto areas; and the development of over-specialization in medicine due, in part, to the rapidity of

medical scientific advances.

Out-Patient Care

In an effort to promote greater out-patient care, for example, five community hospitals in Massachusetts have begun home care programs through the efforts of the Tri-State Regional Medical Program and the Massachusetts Hospital Association. Such programs will provide continuity of care for hospitalized patients after discharge, as well as reduce the length of stay in the hospital. To date, one hospital has achieved a fully coordinated home care program with excellent multi-disciplinary input. Three hospitals are planning to hire full-time nurse coordinators and have opened a much improved information interchange with the local Visiting Nurse Association. One hospital moved the Visiting Nurse Association right into the hospital building and also appointed a full-time qualified nurse as coordinator.

Accessibility in Inner-city Areas

A variety of activities attempt to improve accessibility in inner-city areas where the problems are more concentrated. The New York Metropolitan Regional Medical Program, for example, has undertaken a program, administered by Harlem Hospital, for stroke management of Blacks in the Harlem inner-city area of New York. The activity has three facets: intensive and follow-up care of the stroke victim; screening and surveillance of potential victims; and training of inner city residents as community health aides to assist in follow-up and surveillance activities. In addition, the RMP funds help to support the hospital's hypertension clinic, which reports that all but one of

the patients referred there in the last year have had their ailments brought under control solely through regular out-patient visits. Preliminary mortality statistics reveal that the mortality rate of stroke patients admitted to Harlem Hospital has dropped from 48 to 27.4 percent in the nine months since the project's inception.

Rural Health Delivery Systems

In rural areas and in concert with related Federal, state and local programs, specific efforts are being directed to encourage the providers of health care to make care available and accessible to those areas where there is a distinct scarcity of resources. In the State of Washington, for example, because of a physician manpower shortage, the isolated community of South Bend and surrounding areas were about to lose their hospital until the Washington/Alaska Regional Medical Program stepped in to organize community, State, and Federal interest and resources to save it. Not only are new physicians locating in South Bend but additional services beyond those formerly offered are now available.

Rural health care systems cannot be developed in isolation nor can there be a set pattern for their design. They must be based first on the mix of services available in each area with other services added where the need exists. The emphasis needs to be on bringing the available services together in a systematic approach to meeting health care needs. The Tennessee Mid-South RMP has helped plan for a comprehensive health care program in an isolated community in eastern Tennessee and Kentucky in cooperation with the Ohio Valley RMP and the

Appalachian Regional Commission. Through RMP support it has been possible to link three isolated rural clinics in a mountain valley of eastern Tennessee for the first time by telephone, so that the clinic nurses can communicate with one another and with the physicians on whom they depend for consultation and support.

Emergency Health Care Systems

Another area which will be receiving increasing emphasis by Regional Medical Programs is emergency health care systems. Systems are needed which bring together better transportation services, communication which would tie hospitals, transportation facilities and other emergency organizations into rapid response systems, and emergency medical centers with specially trained physicians and nurses. Once again, care must be taken to assure that such systems are integrated with the total health care delivery system of a community or region.

RMP's and Technological Innovations

Regional Medical Programs are supporting activities which provide opportunities for increasing the rate of implementation of systems innovations, new technologies including automation, and changes in delivery patterns, particularly those developed through the efforts of the National Center for Health Services Research and Development. As Health Maintenance Organizations and Experimental Health Services Delivery Systems reach operating status, RMP's will, where appropriate, link their demonstrations to those ongoing service systems so as to effectively improve the quality of care provided by the latter.

Health Maintenance Organizations

In relation to Health Maintenance Organizations in particular, Regional Medical Programs are becoming involved in developmental activities in a variety of ways. Because of their provider linkages, the RMP's can act as catalytic agents to bring together the various elements of the health care system, provide an environment conducive to planning, and give staff support and technical assistance as necessary. In this way, Regional Medical Programs will support organizations which have the potential for becoming Health Maintenance Organizations. In addition, subsequent to the establishment of HMO's, Regional Medical Programs will be actively engaged in the professional aspects of planning for manpower programs, mechanisms for monitoring the quality of care, ambulatory and emergency medical care services, centralization of laboratory facilities, data systems, etc.

Development activity by the Ohio Valley RMP, for example, includes receipt of a HSMHA planning grant at a level of $51,250 to assist community interests in planning an HMO for the Louisville, Kentucky area. After moving the proposal to the stage of funding, it has turned over major responsibility to the Falls Region Health Council, the Areawide CHP agency for the area. The RMP continues to contribute about 2 man days per week to this Louisville effort.

Quality Standards

As new and more effective comprehensive health systems are developed, such as Health Maintenance Organizations, rural health delivery systems, and emergency health systems, there is a need to ensure that the care

provided meets quality standards. The need for such assurance is particularly pertinent in terms of the new HMO's which are designed to bring together a comprehensive range of medical services in a single organization.

To provide guidance in this area, RMPS as the lead agency in HSMHA has taken the responsibility to develop guidelines for review of the quality of medical care delivered by HMO's, and to design procedures and criteria for both internal and external medical audits. RMPS has also developed under contract with the Inter-society Commission for Heart Disease Resources the Heart Guidelines.

As the HMO program and other comprehensive health systems are developed, it is expected that the 56 Regional Medical Programs will be involved in implementing the guidelines and evaluating their impact on the processes of care of individual and institutional providers.

Manpower Development and Utilization

Regional Medical Programs is and will be promoting a broad array of manpower activities, designed around the central concepts of enabling existing health manpower to provide more and better care, and training and more effective utilization of new kinds of health manpower. Among new areas of program priority are Area Health Education Centers.

The basic concept of RMPS efforts in this area will be that better use can be made of existing manpower assets. Within a given situation, this requires an accounting of the types of manpower already there, a task or labor analysis of the kinds of services which each type of manpower

performs, and an effort to determine how the total services rendered can be increased by reorganizing the work structure of this same manpower group. The concept of having the least expensive unit provide as much of a given health service as is consistent with quality care is essential here. If certain medical functions currently being done by professionals are capable of being transferred to a less expensive type of personnel, either existing manpower can be retrained to acquire this skill, or new kinds of health manpower can be developed to take over these functions.

New Categories of Manpower

Many Regional Medical Programs have conducted studies to determine the need for, willingness to accept and feasibility of training categories of manpower to extend the services of physicians. Most of these are related to the physician's assistant concept. Some RMP's are designing such projects and have funded operational activities in this area.

In North Carolina, the Physician's Assistant Program at Duke and Bowman Gray is an effort to provide a well-trained and educated assistant at the intermediate professional level who, by working with the physicians, can complement physician services and thereby reduce the physician manpower shortage. RMP is also cooperating with other HSMHA programs in the preparation of family nurse practitioners who will also augment the services of physicians. The North Carolina RMP, for example, is utilizing its linkages with the Region's practitioners to interpret the program to them and to encourage the identification of nurses for training from the communities where the need exists. To provide a desirable legal structure for the utilization of the professional assistant, in terms of such problems as licensure and malpractice, the Region is supporting work

on the development of model medical manpower legislation.

Improved Utilization of Existing Manpower

Virtually all Regional Medical Programs have projects designed to augment the knowledge and level of performance of health professionals and para-professionals. Many of these projects lead to improvements in the utilization of personnel. Perhaps the greatest RMP thrust in this area is the training of coronary care unit nurses; over 7,000 registered nurses and licensed practical nurses have been trained to date.

The New Jersey RMP, in an effort to improve manpower utilization, is supporting a program to standardize coronary care unit training programs for licensed practical nurses, so that they can function with the same protection and legal sanctions as registered nurses. Given a high turn-over rate among coronary care unit trained registered nurses, their use as supervisors and teachers of licensed practical nurses may represent better utilization of professional nursing personnel.

Other manpower and training activities, although basically designed to provide continuing education for professional and allied health personnel, have important spin-off benefits. A recently completed program to upgrade the quality of continuing education at a community medical center in Columbus, Georgia, for example, has contributed to substantial growth in the city's physician population and the establishment of the medical center as an areawide continuing education resource for smaller neighboring hospitals.

As the basis for the program, the medical center in Columbus established a regular university-affiliated teaching program with the Emory University School of Medicine. Local physicians were sent to the University for a

newly organized clinical training program, and then, on return to the medical center in Columbus, set up similar clinical and didactic training for their associates. As part of its upgrading, the medical center at Columbus was selected by the Georgia RMP as one of five community hospitals across the State which would become areawide continuing education facilities. In addition, approximately 28 new physicians have been attracted to the town during two years of the project, while there had been no increase in the previous eight years.

Area Health Education Centers

As part of this effort to improve manpower utilization and development, Area Health Education Centers will be a major new initiative. Grant funds at a level of approximately $7.5 million will be available in 1972 for initial organizational and development efforts and operational programs aimed at providing the necessary structural linkages among cooperating institutions. These Centers will provide a means to improve the distribution, supply, utilization and efficiency of health manpower in an effort to enhance the delivery of health care in remote or urban areas currently underserved.

Linkages between health service organizations and educational institutions will be established to provide students both academic education and clinical practice appropriate to their discipline. Students will have the opportunity to learn their skills in settings which promote the team concept of comprehensive health service. The network of institutions linked together to carry out the functions of the center will provide means of extending advancements in health to communities. By utilizing existing health care facilities in combination with educational institutions to educate needed health personnel, both the quality and quantity of health

care can be increased in underserved areas.

A current effort in the Watts-Willowbrook project in Los Angeles generally reflects the type of program which could be developed. This is an effort to develop a new academic community which would function within an acute general hospital, the Martin Luther King, Jr. General Hospital, in the deprived central area of Los Angeles County.. The primary aim is to improve the quality and quantity of health care in the community. Training and educational components will revolve around patient services and as a spin-off will provide outpatient and inpatient health services to the area. The program includes undergraduate training and continuing education of community health practitioners. It is anticipated that the project will in the near future include a community mental health center, a school of allied health professions, and a clinical research building with residence for house staff. The project also calls for the provision of technical assistance and resources to other educational and health care institutions in the Watts area for the purpose of developing additional training programs for health care personnel.

Regionalization and Institutional Linkages

Regionalization and new organizational arrangements are major themes of Regional Medical Programs. Working relationships and linkages among community hospitals and between such hospitals and medical centers are among the primary concerns of the program. The linking of less specialized health resources and facilities such as small community hospitals with more specialized ones is an important way of overcoming the maldistribution of certain resources, and thereby increasing their availability and enhancing their accessibility.

The development of regionalized professional and institutional linkages aids in linking patient care with health research and education within an entire region to provide a mutually beneficial interaction. It also helps to emphasize the delivery of primary care at the local or community level, while promoting specialty care as the province of the medical center and larger community hospitals.

In North Carolina, community development of comprehensive stroke programs has been initiated, with a central coordinating unit at the Bowman Gray School of Medicine. A broad range of activities is being undertaken, including publication of guidelines for community stroke programs, educational activities such as training programs for nurses, annual stroke workshops, stroke consultation service for physicians through the cooperation of the neurological staffs of the three medical centers, and a family-patient education unit, designed to help patients and their families learn to cope with the long-term effects of stroke disability.

Working relationships between community hospitals and the medical center or among community hospitals themselves can upgrade local capabilities, thus moving the delivery of semispecialized care closer to the local level. In Oklahoma, for example, continual electronic heart monitoring services comparable to those available in large urban hospitals are being introduced into small community and rural hospitals as a result of a State-wide coronary care program initiated by the Oklahoma RMP. Some 43 monitor-equipped beds for heart attack victims, or attack-threatened patients, in 25 small community hospitals have been linked by special telephone lines to 10 central monitoring hospitals. Specially trained nurses in the

central monitoring unit help monitor remote patients and when an abnormality is detected confer with local staffs by telephone "hot lines."

Kidney disease is one area in which the development of integrated regional systems can prevent the duplication which has characterized certain other specialized resources. It provides the opportunity for a planned and organized model of how such scarce resources can be linked together efficiently.

In Wisconsin, the Regional Medical Program and the Kidney Foundation of Wisconsin are supporting the development of a comprehensive renal disease program. Each year in Wisconsin about 140 persons enter the final stages of renal disease who are judged good candidates for kidney transplants or artificial kidney machine dialysis. Until recently, the latest advances in the care of such patients were high in cost and not uniformly available Statewide. The Wisconsin project is designed to develop a Statewide cooperative kidney transplant program to reduce expensive, long delays in transplantation and to prevent tissue mismatches. This comprehensive effort also includes establishment of a program of dialysis located within patients' homes and in strategic community hospital satellite units. A prevention and early detection program is underway as well, providing local physicians with information and inexpensive testing kits for detecting kidney disease.

Cooperative Relationships with other Health Programs

The passage of P.L. 91-515, the legislative extension of Regional Medical Programs, Comprehensive Health Planning, the National Center for Health

Services Research and Development, and other health components, resulted in an increased emphasis on the need for improved coordination and cooperation with other health programs. Experience to date certainly suggests that the Regional Medical Programs can best help to improve the overall effectiveness of the health care delivery system by working with and contributing to related Federal and other efforts at the local, State and regional levels.

Comprehensive Health Planning

One of the most important of these links is with the Comprehensive Health Planning agencies. Cooperation between Regional Medical Programs and Comprehensive Health Planning agencies in particular is being fostered through emphasis on their complementary roles.

Increasingly, the Regional Medical Programs, with their strong provider links, are being viewed and used as an important technical, professional and data resource by State and Areawide Comprehensive Health Planning agencies in their planning for personal health services. In turn, Regional Medical Programs are looking to Comprehensive Health Planning agencies to express the health needs of the total community from the consumer's point of view and in effect to help set priorities for the Regional Medical Programs efforts.

The legislative extension of both RMP and CHP included changes designed to promote closer coordination between these programs. One change requires that the Regional Advisory Groups which advise the RMP's include representatives from health planning agencies. Similarly, the CHP agencies are required to have representation of Regional Medical Programs on both State

and Areawide Comprehensive Health Planning Advisory Councils. To date, more than 800 individuals have been appointed to fulfill these requirements of cross-representation.

Another legislative change requires that Areawide Comprehensive Health Planning agencies have the opportunity for review and comment of Regional Medical Program applications before they are approved by the Regional Advisory Group. Although this requirement applies only to the Areawide CHP agencies, there has been extensive cooperation in terms of review by the State CHP agencies as well.

Other areas of cooperation include joint data collection, processing or analysis, staff sharing or regular joint meetings, and sharing of equipment and facilities. In Kansas, for example, the RMP and the State CHP agency have jointly funded both a State data bank and a State Health Manpower Information Program. Currently they are also cooperating on the systems design for a Health Information System and on a Consumer Inventory Study in Northwest Kansas. The RMP Core Research and Evaluation staff also provide consultation to CHP.

Experimental Health Services Delivery Systems

Another health program which involves close RMP cooperation is the Experimental Health Services Delivery System effort, funded by HSMHA. The EHSDS program aims to test whether a community management structure can improve the organization of the delivery system, and to determine whether such an approach can achieve greater integration and coordination of Federal funds. Regional Medical Programs are closely involved in these efforts in such places as Arkansas, Boise, Idaho, East Los Angeles, and Vermont.

In Vermont, the Northern New England RMP and the State CHP agency jointly produced the successful application for an Experimental Health Services Delivery System. Funded by the National Center for Health Services Research and Development at a level of $932,000 for a period of two years, the program involves the implementation and evaluation of a series of experimental, regionally integrated community health systems in the geographic area of Vermont, and possibly contiguous areas of New Hampshire and New York states.

A variety of different tasks are being assumed by the agencies involved in Vermont. The State CHP agency, for example, is involved in defining the nature of public accountability in Experimental Systems, and defining the requirements of a regional planning-management system. The Regional Medical Program is determining how various components of the community health system can be integrated into an experimental model. The RMP will also provide a data base and health systems analysis capability. RMP has established a data base which can describe health and health care delivery in terms of demographic and socio-economic characteristics of the communities being served; manpower, facility and dollar resources available; utilization, supply and distribution aspects of the existing health care delivery process; and outcome, as measured by morbidity, mortality and patient satisfaction.

Veterans Administration

Some 83 Veterans Administration hospitals are currently involved in activities with Regional Medical Programs. This includes participation on RMP Regional Advisory Groups as well as operational activities. The

California Medical Television Network operating out of UCLA, for example, is funded in part by the RMP and includes a package of 36 videotape programs distributed annually to 30 participating VA installations in the western United States.

Model Cities

Regional Medical Programs also have working relationships with some of the Model Cities programs, including technical and planning assistance and operational programs. A Model Cities Health and Nutrition Program has been developed by the Alabama RMP to meet the nutritional needs of the chronically ill, dependent pre-school children, and pregnant adolescents in the Tuskegee-Macon County Area. Twenty nutritional assistants, after completing a six months training course at the Tuskegee Institute, will work with the rural poor to implement the program objectives. These individuals will be trained to observe family nutrition practices, instruct and counsel in sound nutrition practices, assist in preparing teaching materials and make follow-up home visits to assist with menu planning, food buying and cooking skills. They will also assist with dietary surveys and work with community groups.

In concert with the broad range of public and private health organizations and institutions, and other Federal, State and local health programs, Regional Medical Programs can work to provide an effective organizational framework for identifying and utilizing community health resources, so that continued innovations in health care planning and delivery systems can be made.

Exhibit I

Budget and Grant History
(Dollars in thousands)

	FY 1966	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971	FY 1972
Authorization	$50,000	$90,000	$200,000	$65,000	$120,000	$125,000	$150,000
Appropriation: grants	24,000	43,000	53,900	56,200	73,500	99,500	90,500
Amount available for obligation*.	24,000	43,934	48,900	72,365	78,500	70,298	135,000
Amount obligated - grants	2,066	27,052	43,635	72,365	78,202	70,298	--
Regions in:							
Planning Status	7	44	41	14	1	1	1
Operational Status.	--	4	13	41	54	55	55
Total RMP's	7	48	54	55	55	56	56

* Includes carryover amounts

LISTING OF REGIONAL MEDICAL PROGRAMS

Exhibit II

REGIONAL)ESIGNATION	ALABAMA	ALBANY	ARIZONA
:OGRAPHICAL)VERAGE	Alabama	Northeastern New York and contiguous portions of Southern Vermont and Western Massachusetts	Arizona
)PULATION ;TIMATE (1971)	3,444,000	1,900,000	1,773,000
:NDS 'AILABLE IN :SCAL YEAR)71 (in 000's)	1,052	1,136	865
:OGRAM)ORDINATORS	S. Richardson Hill, Jr., M.D. Coordinator Alabama Regional Medical Program P.O. Box 3256 1108 South 20th Street Birmingham, Alabama 35205 John M. Packard, M.D. Director Alabama Regional Medical Program P.O. Box 3256 1108 South 20th Street Birmingham, Alabama 35205	Frank M. Woolsey, Jr., M.D. Coordinator Albany Regional Medical Program Albany Medical College of Union University 47 New Scotland Avenue Albany, New York 12208	Dermont W. Melick, M.D. Coordinator Arizona Regional Medical Progr University of Arizona College of Medicine 4402 East Broadway, Suite 606 Tucson, Arizona 85711

REGIONAL DESIGNATION	ARKANSAS	BI-STATE	CALIFORNIA
EOGRAPHICAL OVERAGE	Arkansas	Southern Illinois and Eastern Missouri	California plus Reno-Sparks and Clark County (Las Vegas), Nevada
OPULATION STIMATE (1971)	1,923,000	4,700,000	19,953,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	1,363	1,147	8,357
ROGRAM OORDINATORS	Charles W. Silverblatt, M.D. Coordinator Arkansas Regional Medical Program 500 University Tower Building 12th at University Little Rock, Arkansas 72204	William Stoneman III, M.D. Coordinator Bi-State Regional Medical Program 607 North Grand Boulevard St. Louis, Missouri 63103	Paul D. Ward Executive Director California Committee on Regional Medical Programs 7700 Edgewater Drive Oakland, California 94621

REGIONAL DESIGNATION	CENTRAL NEW YORK	COLORADO-WYOMING	CONNECTICUT
EOGRAPHICAL OVERAGE	Syracuse, New York and 15 surrounding counties and Bradford and Susquehanna counties in Pennsylvania	Colorado and Wyoming	Connecticut
OPULATION STIMATE (1971)	1,700,000	2,150,000	3,032,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	896	1,123	1,514
ROGRAM OORDINATORS	John J. Murray Acting Coordinator, Central New York Regional Medical Program Upstate Medical Center State University of New York 750 East Adams Street Syracuse, New York 13210	Howard W. Doan, M.D. Director, Colorado-Wyoming Regional Medical Program 410 Franklin Medical Building 2045 Franklin Street Denver, Colorado 80205	Henry T. Clark, Jr., M.D. Coordinator Connecticut Regional Medical Program 272 George Street New Haven, Connecticut 06510

REGIONAL DESIGNATION	FLORIDA	GEORGIA	GREATER DELAWARE VALLEY
EOGRAPHICAL OVERAGE	Florida	Georgia	Eastern Pennsylvania, the southern part of New Jersey an the entire State of Delaware
OPULATION STIMATE (1971)	6,789,000	4,590,000	6,200,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	1,448	1,983	2,433
ROGRAM OORDINATORS	Granville W. Larimore, M.D. State Director Florida Regional Medical Program 1 Davis Boulevard, Suite 309 Tampa, Florida 33606	M. Charles Adair, M.D. Coordinator Georgia Regional Medical Program Medical Association of Georgia 938 Peachtree Street, N.E. Atlanta, Georgia 30309 J. Gordon Barrow, M.D. Director Georgia Regional Medical Program Medical Association of Georgia 938 Peachtree Street, N.E. Atlanta, Georgia 30309	Martin Wollmann, M.D. Executive Director Greater Delaware Valley Regional Medical Program 551 West Lancaster Avenue Haverford, Pennsylvania 19041

REGIONAL DESIGNATION	HAWAII	ILLINOIS	INDIANA
EOGRAPHICAL OVERAGE	Entire State of Hawaii, plus American Samoa, Guam, and the Trust Territory of the Pacific Islands (Micronesia)	Illinois	Indiana
OPULATION STIMATE (1971)	970,000	9,100,000	4,200,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	938	1,794	1,275
ROGRAM CORDINATORS	Masato M. Hasegawa, M.D. Director Regional Medical Program of Hawaii 1301 Punchbowl Street Harkness Pavilion Honolulu, Hawaii 96813	Morton C. Creditor, M.D. Coordinator Illinois Regional Medical Program 122 South Michigan Avenue Suite 939 Chicago, Illinois 60603	Robert B. Stonehill, M.D. Coordinator Indiana Regional Medical Progı Indiana University School of Medicine 1300 West Michigan Street Indianapolis, Indiana 46202

REGIONAL DESIGNATION	INTERMOUNTAIN	IOWA	KANSAS
EOGRAPHICAL OVERAGE	Entire State of Utah, and portions of Wyoming, Montana, Idaho, Colorado and Nevada	Iowa	Kansas
OPULATION STIMATE (1971)	2,073,000	2,825,000	2,249,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	3,383	754	1,869
ROGRAM OORDINATORS	Robert M. Satovick, M.D. Coordinator Intermountain Regional Medical Program 50 North Medical Drive Salt Lake City, Utah 84112	Harry B. Weinberg, M.D. Coordinator Iowa Regional Medical Program 308 Melrose Avenue Iowa City, Iowa 52240	Robert W. Brown, M.D. Coordinator Kansas Regional Medical Progra 3909 Eaton Street Kansas City, Kansas 66103

REGIONAL ESIGNATION	LOUISIANA	MAINE	MARYLAND
OGRAPHICAL VERAGE	Louisiana	Maine	Entire State of Maryland and York County in Pennsylvania, less environs of Washington, D. and Montgomery County, Marylanc
PULATION TIMATE (1971)	3,643,000	994,000	3,222
NDS AILABLE IN SCAL YEAR 71 (in 000's)	776	871	1,998
OGRAM ORDINATORS	Joseph A. Sabatier, Jr., M.D. Director Louisiana Regional Medical Program 2714 Canal Street, Suite 401 New Orleans, Louisiana 70119	Manu Chatterjee, M.D. Coordinator Maine's Regional Medical Program 295 Water Street Augusta, Maine 04330	Edward Davens, M.D. Coordinator Maryland Regional Medical Progr 550 North Broadway Baltimore, Maryland 21205

REGIONAL DESIGNATION	MEMPHIS	METROPOLITAN WASHINGTON, D.C.	MICHIGAN
EOGRAPHICAL OVERAGE	Western Tennessee, Northern Mississippi, Eastern Arkansas and portions of Kentucky and Missouri	District of Columbia and contiguous Counties in Maryland (2) and Virginia (2)	Michigan
OPULATION STIMATE (1971)	2,399,000	1,800,000	8,875,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	1,907	1,217	2,292
ROGRAM OORDINATORS	James W. Culbertson, M.D. Coordinator Memphis Regional Medical Program 1300 Medical Center Towers 969 Madison Avenue Memphis, Tennessee 38104	Arthur E. Wentz, M.D. Coordinator Metropolitan Washington, D.C. Regional Medical Program 2007 Eye Street, N.W. Washington, D.C. 20006	Gaetane M. Larocque, Ph.D. Acting Coordinator Michigan Association for Regional Medical Programs 1111 Michigan Avenue, Suite 2C East Lansing, Michigan 48823

REGIONAL DESIGNATION	MISSISSIPPI	MISSOURI	MOUNTAIN STATES
GEOGRAPHICAL COVERAGE	Mississippi	Missouri, exclusive of most of Metropolitan St. Louis	States of Idaho, Montana, Nevada and Wyoming
POPULATION ESTIMATE (1971)	2,217,000	3,200,000	2,228,000
FUNDS AVAILABLE IN FISCAL YEAR 1971 (in 000's)	1,168	2,282	1,764
PROGRAM COORDINATORS	Theodore D. Lampton, M.D. Coordinator Mississippi Regional Medical Program University of Mississippi Medical Center 2500 North State Street Jackson, Mississippi 39216	Arthur E. Rikli, M.D. Coordinator Missouri Regional Medical Program 406 Turner Avenue - Lewis Hall Columbia, Missouri 65201	Alfred M. Popma, M.D. Coordinator and Regional Dire Mountain States Regional Medical Program 305 Federal Way - P.O. Box 57 Boise, Idaho 83705

REGIONAL)ESIGNATION	NASSAU-SUFFOLK	NEBRASKA	NEW JERSEY
:OGRAPHICAL)VERAGE	Counties of Nassau and Suffolk (Long Island) of the State of New York	Nebraska	New Jersey
)PULATION STIMATE (1971)	2,540,000	1,484,000	7,168,000
JNDS /AILABLE IN :SCAL YEAR)71 (in 000's)	794	626	1,351
:OGRAM)ORDINATORS	Glen E. Hastings, M.D. Coordinator Nassau-Suffolk Regional Medical Program, Inc. 1919 Middle Country Road Centereach, New York 11720	Deane S. Marcy, M.D. Coordinator Nebraska Regional Medical Program 700 CTU Building 1221 N Street Lincoln, Nebraska 68508	Alvin A. Florin, M.D. Coordinator New Jersey Regional Medical Pr 7 Glenwood Avenue East Orange, New Jersey 07017

REGIONAL DESIGNATION	NEW MEXICO	NEW YORK METROPOLITAN	NORTH CAROLINA
EOGRAPHICAL OVERAGE	New Mexico	New York City and Westchester, Rockland, Orange, and Putnam Counties, New York	North Carolina
OPULATION STIMATE (1971)	1,016,000	9,266,000	5,082,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	1,337	2,706	2,337
ROGRAM COORDINATORS	James R. Gay , M.D. Coordinator New Mexico Regional Medical Program University of New Mexico Medical School 920 Stanford Drive, N.E. Building 3-A Albuquerque, New Mexico 87106	I. Jay Brightman, M.D. Director New York Metropolitan Regional Medical Program The Associated Medical Schools of Greater New York 2 East 103rd Street New York, New York 10029	F. M. Simmons Patterson, M.D. Executive Director Association for the North Car Regional Medical Program 4019 North Roxboro Road Durham, North Carolina 27704

REGIONAL DESIGNATION	NORTH DAKOTA	NORTHEAST OHIO	NORTHERN NEW ENGLAND
GEOGRAPHICAL COVERAGE	North Dakota	12 counties in Northeast Ohio	Entire State of Vermont and three contiguous counties in Northeastern New York
POPULATION ESTIMATE (1971)	618,000	4,115,000	445,000
FUNDS AVAILABLE IN FISCAL YEAR 1971 (in 000's)	309	368	800
PROGRAM COORDINATORS	Theodore H. Harwood, M.D. Coordinator North Dakota Regional Medical Program 1512 Continental Drive Grand Forks, North Dakota 58201 Willard A. Wright, M.D. Director North Dakota Regional Medical Program 1512 Continental Drive Grand Forks, North Dakota 58201	David Fishman, M.D. Acting Coordinator Northeast Ohio Regional Medical Program 10525 Carnegie Avenue Cleveland, Ohio 44106	John E. Wennberg, M.D. Coordinator Northern New England Regional Medical Program University of Vermont College of Medicine 25 Colchester Avenue Burlington, Vermont 05401

REGIONAL DESIGNATION	NORTHLANDS	NORTHWESTERN OHIO	OHIO STATE
EOGRAPHICAL OVERAGE	Minnesota	20 counties in Northwestern Ohio	Central and southern two-thirc of the State of Ohio (61 count excluding Metropolitan Cincinnati area)
OPULATION STIMATE (1971)	3,805,000	1,381,000	4,660,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	1,251	431	360
ROGRAM OORDINATORS	Winston R. Miller, M.D. Program Director Northlands Regional Medical Program, Inc. 375 Jackson Street St. Paul, Minnesota 55101	C. Robert Tittle, Jr., M.D. Coordinator Northwestern Ohio Regional Medical Program 1600 Madison Avenue Toledo, Ohio 43624	William G. Pace III, M.D. Coordinator Ohio State Regional Medical Program 1480 West Lane Avenue Columbus, Ohio 43221

REGIONAL DESIGNATION	OHIO VALLEY	OKLAHOMA	OREGON
EOGRAPHICAL OVERAGE	Greater part of Kentucky, South-west Ohio, and contiguous parts of Indiana and West Virginia	Oklahoma	Oregon
OPULATION STIMATE (1971)	5,300,000	2,559,000	2,019,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	1,172	963	930
ROGRAM OORDINATORS	William H. McBeath, M.D. Director Ohio Valley Regional Medical Program P.O. Box 4025 Lexington, Kentucky 40504	Dale Groom, M.D. Director Oklahoma Regional Medical Program University of Oklahoma Medical Center 800 N.E. 15th Street Oklahoma City, Oklahoma 73104	J. S. Reinschmidt, M.D. Coordinator Oregon Regional Medical Progra University of Oregon Medical School 3181 S.W. Sam Jackson Park Roa Portland, Oregon 97201

REGIONAL ESIGNATION	PUERTO RICO	ROCHESTER	SOUTH CAROLINA
OGRAPHICAL VERAGE	Puerto Rico	Rochester, New York and 10 surrounding counties	South Carolina
PULATION TIMATE (1971)	2,690,000	1,234,000	2,591,000
NDS AILABLE IN SCAL YEAR 71 (in 000's)	938	611	1,478
OGRAM ORDINATORS	Cristino R. Colon, M.D. Coordinator Puerto Rico Regional Medical Program P.O. Box M.R. Caparra Heights Station San Juan, Puerto Rico 00922	Ralph C. Parker, Jr., M.D. Coordinator Rochester Regional Medical Program University of Rochester Medical Center 260 Crittenden Boulevard Rochester, New York 14620	Vince Moseley, M.D. Coordinator South Carolina Regional Medical Program Medical University of South Carolina 80 Barre Street Charleston, South Carolina 294(

REGIONAL DESIGNATION	SOUTH DAKOTA	SUSQUEHANNA VALLEY	TENNESSEE MID-SOUTH
EOGRAPHICAL OVERAGE	South Dakota	27 counties in Central Pennsylvania	Tennessee and Southwestern Kentucky
OPULATION STIMATE (1971)	666,000	2,140,000	2,816,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	472	626	2,130
ROGRAM COORDINATORS	John A. Lowe, M.D. Coordinator South Dakota Regional Medical Program University of South Dakota Medical School 216 East Clark Street Vermillion, South Dakota 57069	David H. Small, Acting Coordinator Susquehanna Valley Regional Medical Program 1104 Fernwood Avenue, Box 541 Camp Hill, Pennsylvania 17011	Paul E. Teschan, M.D. Director Tennessee Mid-South Regional Medical Program 1110 Baker Building 110 21st Avenue, South Nashville, Tennessee 37203

REGIONAL DESIGNATION	TEXAS	TRI-STATE	VIRGINIA
EOGRAPHICAL OVERAGE	Texas	Massachusetts, New Hampshire and Rhode Island	Virginia (less parts of Metropolitan Washington, D.C.)
OPULATION STIMATE (1971)	11,197,000	7,377,000	4,300,000
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	2,094	2,022	737
ROGRAM OORDINATORS	Charles B. McCall, M.D. Coordinator Regional Medical Program of Texas 4200 Lamar Boulevard, North Suite 200 Austin, Texas 78756	Leona Baumgartner, M.D. Coordinator Tri-State Regional Medical Program Medical Care and Education Foundation, Inc. 1 Boston Place, Suite 2248 Boston, Massachusetts 02108	Eugene R. Perez, M.D. Coordinator Virginia Regional Medical Prog 700 East Main Street, Suite 10 Richmond, Virginia 23219

REGIONAL ESIGNATION	WASHINGTON/ALASKA	WEST VIRGINIA	WESTERN NEW YORK
OGRAPHICAL VERAGE	Washington and Alaska	West Virginia	8 Western New York counties and Erie County in Pennsylvania
PULATION TIMATE (1971)	3,711,000	1,744,000	1,985,000
NDS AILABLE IN SCAL YEAR 71 (in 000's)	1,644	721	1,363
OGRAM ORDINATORS	Donal R. Sparkman, M.D. Director Washington/Alaska Regional Medical Program 500 "U" District Building 1107 N.E. 45th Street Seattle, Washington 98105	Charles D. Holland Coordinator West Virginia Regional Medical Program West Virginia University Medical Center Room 2237, University Hospital Morgantown, West Virginia 26506	John R. F. Ingall, M.D. Program Director Regional Medical Program for Western New York State University of New York at Buffalo 2929 Main Street Buffalo, New York 14214

REGIONAL DESIGNATION	WESTERN PENNSYLVANIA	WISCONSIN	
EOGRAPHICAL OVERAGE	Pittsburgh and 28 surrounding counties in Pennsylvania	Wisconsin	
OPULATION STIMATE (1971)	4,284,000	4,418,000	
UNDS VAILABLE IN ISCAL YEAR 971 (in 000's)	1,312	1,855	
ROGRAM OORDINATORS	Francis S. Cheever, M.D. Coordinator Western Pennsylvania Regional Medical Program University of Pittsburgh 1217 Scaife Hall Pittsburgh, Pennsylvania 15213 Robert R. Carpenter, M.D. Director Western Pennsylvania Regional Medical Program 3530 Forbes Avenue 501 Flannery Building Pittsburgh, Pennsylvania 15213	John S. Hirschboeck, M.D. Coordinator Wisconsin Regional Medical Program 110 East Wisconsin Avenue Milwaukee, Wisconsin 53202	

CHARACTERISTICS OF REGIONAL MEDICAL PROGRAMS

DEMOGRAPHIC FACTS

There are 56 RMPs which cover the entire United States and its trust territories. The Programs include the entire population of the United States (204 million) and vary considerably in their size and characteristics.

* LARGEST REGION

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

* SMALLEST REGION

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

* SOME REGIONS ARE MAINLY URBAN (NEW YORK METROPOLITAN), SOME RURAL (ARKANSAS)

* GEOGRAPHIC BOUNDARIES: Number of Regions which

. Encompass single states 33
. Encompass two or more states 4
. Are parts of single states 11
. Are parts of two or more states 8

* POPULATION: Number of Regions which have

. Less than 1 million persons 5
. 1 million to 2 million. 11
. 2 million to 3 million. 14
. 3 million to 4 million. 8
. 4 million to 5 million. 7
. Over 5 million. 11

REGIONAL ADVISORY GROUPS

SIZE:

- 1967 — 1849 Persons (Total); 38 (Average Group)
- 1969 — 2324 Persons (Total); 42 (Average Group)
- 1970 — 2481 Persons (Total); 45 (Average Group)
- 1971 — 2696 Persons (Total); 48 (Average Group)

COMPOSITION OF REGIONAL ADVISORY GROUPS

	FY '71 (10/71)		FY '70 (4/70)	
	Number	Percent	Number	Percent
Total	2696	100	2481	100
Practicing Physicians	726	27	656	26
Hospital Administrators	376	14	327	13
Medical Center Officials	217	8	259	10
Voluntary Agencies	200	7	212	9
Public Health Officials	150	6	134	6
Other Health Workers	298	11	216	9
Members of Public	556	21	468	19
Other	173	6	209	8

TASK FORCES AND COMMITTEES

NUMBER AND SIZE:

- 1969: 492 Committees in 54 Regions: 5,320 Total membership
- 1971: 410 Committees in 55 Regions: 6,379 Total membership

COMPOSITION:

By Profession	Number		Percent	
	(1969)	(1971)	(1969)	(1971)
Physicians	3273	3523	61	55
Nurses	486	580	9	9
Allied Health	672	802	13	13
Other*	889	1456	17	23
Total	5320	6379	100	100

(* Includes members of the public, hospital administrators, and others)

TYPE OF TASK FORCE/COMMITTEE:

Category	No. of Committees		Percent	
	(1969)	(1971)	(1969)	(1971)
Heart	65	41	13	11
Cancer	60	42	12	10
Stroke	54	36	11	9
Other Disease (including Kidney)	39	30	8	7
Planning & Evaluation	30	27	6	8
Continuing Education & Training	45	47	9	12
Health Manpower	11	27	2	4
Other	188	160	39	39
Total	492	410	100	100

REGIONAL HEADQUARTERS

	Coordinating Headquarters	Grantees
Universities	31	34
Public	(25)	(27)
Private	(6)	(7)
Other	25	22
Medical Societies	(4)	(4)
Newly Organized Agencies/ Corporations	(18)	(15)
Existing Corporations	(3)	(3)

REGIONAL MEDICAL PROGRAMS CORE STAFF

Core staff in the 56 Regional Medical Programs are involved in project development, review and management, professional consultation and community liaison; program direction and administration; planning studies and inventories; feasibility studies; and central regional services.

* DISTRIBUTION OF CORE STAFF EFFORT BY FUNCTION

- Project Development 20%
- Professional Consultation 29%
- Program Direction 22%
- Planning Studies 14%
- Feasibility Studies 7%
- Central Regional Services 6%
- Other 2%

* COMPOSITION

	Core FTE
TOTAL	1,584
Physicians	184
Registered Nurses	63
Allied Health	37
Other Professional/Technical	677
Secretaries	623

OPERATIONAL PROGRAMS

The LEVEL OF FUNDING as of 12-31-71 reflects the following program emphases:

Operational Activity Emphasis

Activity	Percent
Organization and Delivery for Patient Services	37%
Training Existing Health Personnel in New Skills	31%
Training New Health Personnel	3%
General Continuing Education	20%
Other activities, such as communications networks, improved patient record systems, and coordination of services	9%

Categorical Emphasis

An analysis of all the operational grants awarded to date along categorical lines indicates the following breakdown:

- Single Disease
  - Heart 22%
  - Cancer 12%
  - Stroke 11%
  - Kidney 5%
  - Related Diseases 7%
- Multicategorical 43%

HOSPITAL PARTICIPATION IN REGIONAL MEDICAL PROGRAMS

	Total # of short-term non-Federal hospitals	Number participating in planning and operational activities	Number participating in operational activities only
FY 1968	5,850	851	301
FY 1969	5,820	1,638	1,246
FY 1970	5,853	2,084	1,471
FY 1971 (est.)	5,880	2,693	2,079