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RMP DECISION PAPER

PROGRAM DESCRIPTION

A. Legislative and Program History

An understanding of Regional Medical Programs -- its current status, criticisms voiced about it, the program's principal features and strengths -- must take into account its legislative and programmatic history and evolution.

RMP's immediate genius was the 1964 Report of the President's Commission on Heart Disease, Cancer, and Stroke. It proposed that a major national effort be mounted to reduce morbidity/mortality from those categorical diseases which accounted for 75% of all deaths. Regionalized networks of specialized treatment centers and diagnostic stations, linked to the Nations major medical centers, was the principal means recommended to achieve that end.

The initial authorizing legislation (P.L. 89-239; see Appendix 1), modified significantly the concepts and recommendations encompassed by that Report. That law, enacted in late 1965, in effect emphasized (1) regional "cooperative arrangements" linking the broad gamut of existing health institutions and resources rather than the creation of new facilities; (2) involvement of all providers, especially the practicing profession, rather than ~~relying~~ relying chiefly on the medical schools/centers for "energizing" the program; and (3) and local antonomy by mandating Regional Advisory Groups, broadly representative of all provider groups and interests, as an intregral part of each RMP.

These changes were largely the result of pressures from outside groups, especially the practicing community and organized medicine.

Early implementation of the program, however, did reflect several major areas of congruence between the Commission's Report and P.L. 89-239.

* A strong and rather narrow categorical focus.
* The notion of putting into large-scale practice the "latest advance" in the diagnosis and treatment of these diseases which had resulted from the prior decade's massive biomedical research effort. Thus, technological advances and continuing education were stressed.
* Closer, continuing ties between the medical schools, the centers of excellence, and the community and day-to-day practice.
* The concept of regionalization, however ill-defined.
* Improvement of patient care as the ultimate objective.

The organizational placement of RMP and administrative responsibility for it, in NIH initially, and the first legislative extension in 1968 (P.L. 90-574; see Appendix 2) without any substantive modifications of the program tended to reinforce RMP's early course.

The subsequent two years, the period leading up to the current legislative extension, however, did witness a number of changes, ~~and~~ the emergence of new forces, and posed questions about RMP not previously raised. Among them:

* The creation of HSMHA, with its "services" focus, and the transfer

of RMP to it in June 1968.

* A growing recognition by an increasing number of the RMPs that in order to effectively address categorical disease problems and needs frequently required more comprehensive approaches, that the unavailability and inaccessibility of primary care insofar as many groups and areas were concerned precluded direct categorical services.
* Confirmation as a result a two-year study (6/68 - 11/70) of the program by A.D. Little that some RMPs were beginning to play a significant facilitate role that was resulting in productive dialogue and cooperative action among the disparate health interests and groups at the local level that often went far beyond categorical concerns and seemed to relate to "systems transformation" or "change." That same report found/concluded that RMP was the best available connection mechanism between the Federal government and the private health care sector.
* A plateauing of RMP funds in FY70 and 71 followed by an actual decrease in FY72. (See Appendix 3, "RMP Budget and Grant History.")
* Increasing questions and concerns about the relationship of RMP and CHP, particularly with respect to planning responsibilities and local priority setting.

The Administration's proposed "Health Services Improvement Act of 1970," sought to substantially modify and better relate programs one to another as well as extend a number of legislative authorities, including that of RMP. The extension enacted (P.L. 91-515; see Appendix 3) in

October 1970 was not nearly as far reaching. In the case of RMP, however, a number of changes were made. The (1) improvement of primary care, (2) regionalization, (3) better manpower utilization, and (4) improvement of health services in underserved areas, were emphasized; and (5) CHP review and comment of RMP applications was made a requirement. The net practical effect of these changes was to expand the program's mandate, to encourage and accelerate the more comprehensive approaches already underway; this despite the fact that the categorical focus had been retained, with kidney disease explicitly added.

In the two years since then, further developments have taken place. Most importantly:

* The development of an "RMP Mission Statement" (see Appendix 4) reflecting the order-of-magnitude changes in program scope and focus suggested by the legislative revisions and in effect legitimizing the expanded, more comprehensive program operations already emergent.
* An increasing responsiveness at both the ~~control~~ central, HS/RMPS, and local RMP levels to national priorities such as HMO development and EMS.
* Further decentralization of decision-making authority from the central to local RMP level.

Concurrently there has been a growing concern, indeed dissatisfaction, about RMP's seemingly ill-defined or amorphous role and a corollary searching for more specific missions for RMP that would tie it more closely and consistently to a larger national purpose.

B. Current Program Status and Characteristics

There presently are 56 functioning RMPs, nationwide coverage having been achieved by 1968. All but two, South Dakota and Delaware which reflect recent break-a-ways from larger Regions, are fully operational. Their summary characteristics and features are as follows:

* Thirty-eight (38) encompass one (e.g., Maine) or several whole states (e.g., Washington-Alaska). Of the remainder, 11 are parts of single states with Pennsylvania, New York, and Ohio accounting for nearly all of these; and 7 are parts of two or more states (e.g., Bi-State which encompasses metropolitan St. Louis and Southern Illinois). There are only three areas of significant overlap.
* These Regions range in size from Washington-Alaska (638,000 square miles) to Metropolitan Washington, D.C. (1,500 square miles); and in population from California (over 20 million) to Northern New England (under 500,000).
* Thirty-three (33) of the grantees are universities, of which 26 are public (e.g., University of Missouri) and only 7 are private (e.g., Albany Medical College). New cooperations specifically established to administer an RMP (e.g., Michigan Association for RMP) are grantees in 16 instances; previously existing cooperations or consortia (e.g., WICHE) in 3; and state medical societies in 4. Over the past years there has been a modest but continuing trend towards new corporations.

* Their total staffs exceed 1,400 FTE. These range in size from 10 or so to over 150 in the case of California. The average is slightly over 25.
* About 2,700 practicing physicians, hospital administrators, other health professionals, community leaders, and public representatives presently serve on the 56 Regional Advisory Groups. Practicing physicians constitute the single largest group (28%); public representative has continously increased over the years (21% presently); conversely, medical center officials have steadily decreased (currently 8%).
* Well over 12,000 physicians (50%), nurses and allied health professionals (23%), and others currently serve on other RMP task forces and committees (e.g., health manpower, hypertension) and local and area advisory groups.

The 56 RMPs received $111.4 million in grant funds, or about $104.5 if those awards are annualized, in FY72. Of that amount ($111.4M), $76.5 (or ~~65%~~ 70) was being channelled into just over 1,000 operational projects.

* In dollar terms, 61% of those activities were multi-categorical or comprehensive in nature, whereas only 39% had essentially a single disease focus (e.g., kidney, cancer). That is almost a complete reversal over the previous year, FY71, when the figures were 37% and 63% respectively.
* Viewed another way, in terms of primary purpose, patient care demonstrations, including those where there was some element

of training also, constituted the single largest broad group of RMP-supported activities (41%). Manpower development and utilization was a close second (38%).

* In terms of the latter, manpower development and utilization, some $13.3 million was being spent for training designed to provide existing health personnel, principally nurses, with new skills (e.g., pediatric nurses), and an additional $3.7 million was for training new categories of health personnel (e.g., physician assistant). Only $12 million of the total was for general continuing education activities, some of which, an estimated 25 - 33% was for nurses and other non-physician categories of health personnel.
* Over one-fourth of the projects and 38% of the funds were, in terms of health care delivery methods, aimed at expanding or improving ambulatory care or emergency services. Twenty-eight (28) RMPs received $8.4 million in supplemental funds for EMS activities specifically late in FY72.

Roughly $35 million (Direct Costs) was for so-called program activities, which have always constituted a significant part of the RMPs' overall efforts. These program activities also have been a source of misunderstanding, having frequently been equated with "overhead," the costs of administering the local programs. While they do include the costs of program direction and administration, that accounts for only a fraction of the total as the following breakdown for FY72 clearly shows:

	Est. Amt.	%Total
* Program Direction and Administration:	$ 9.5M	27%
Overall direction and coordination, policy development, financial management, project coordination, communication and information activities, program evaluation.		
* Project Development, Review and Management:	7.7M	22
Assistance to local applicants in project design and conduct, processing of individual operational applications, staff support to project review groups, project monitoring and evaluation.		
* Professional Consultation, Community Relations and Liaison:	9.1M	26
Staff assistance to other health programs, facilitation of cooperative relationships, development of and assistance to sub-RMP groups, etc.		
* Planning Studies and Inventories:	3.7M	11
Staff time and/or sub-contract costs for studies designed to provide guideline in development of program objectives, baseline data, etc.		
* Feasibility Studies:	2.7M	7
Staff time and/or sub-contract expenditures for activities designed to assess the potential of prototype programs or techniques for larger scale application.		
* Central Regional Services:	1.8M	5
Centralized services supported on a continuing basis, such as libraries, data banks, etc.		

	Est. Amt.	% Total
* Other	$ 8M	2

No brief summary description of the RMP structure and activities, however well done, can adequately highlight the programs more fundamental characteristics. An appreciation and awareness of those characteristics, some of which been a hallmark of RMP since the beginning, others which have emerged over time, is necessary. They are:

* RMP is primarily linked to and works through providers, especially practicing health professionals and community health care institutions; this means the private sector largely.
* It essentially is a voluntary approach drawing heavily upon existing resources.
* RMP is action-oriented. Most of its efforts and funds have, over the years, been directed at implementation, getting things done.
* Regionalization has been a constant touchstone.
* The concept of time-limited support has always been central to RMP. Thus, incorporation within the regular health care financing system of RMP-funded projects and activities is an important measure of success (or failure).
* In improving the accessibility and availability of care, and its quality, RMP has concentrated almost exclusively upon resources/services development. It has not been significantly involved with the direct provision of services, or their payment.

* It recently has become a largely decentralized program in the specific sense that decisions with respect to the (1) technical adequacy of proposals and (2) what activities and projects will be supported with the limited funds awarded an RMP, are made by at the local level, by the RMPs and their RAGs. (See Appendix 5, Discretionary Funding and Rebudgeting Authority Statement, for a direct reflection if this.)

C. National Review and Funding Process

Although there has been a significant degree of decentralization to the 56 RMPs as noted above and elsewhere in this paper, decisions as to the level of funds to be received by each within the total amount appropriated/apportioned annually for grants, are made by the Director, RMPS. Made by him after the review of grant requests by the RMP Review Committee and National Advisory Council and their recommendations. Council review of and recommendations on all RMP grant applications is legislatively required.

The process is essentially a competive one; funds are not allocated on a formula or entitlement basis. Moreover this national review now focuses on overall program -- the quality of (1) performance to date, (2) current process and (3) program proposal -- rather than the myriad individual project or activity constituents of each application. (See Appendix 6 for a listing the RMP Review Criteria imployed.) Based upon this program review and the resultant scores, the RMPs are ranked in three broad categories (A,B,C). These qualitative rankings are an important factor in the selective funding policy which has been pursued since FY71. Under that policy, those Regions judged to be more mature and of higher quality (A) receive a disproportionately greater share of any additional funds available. Conversely, no increases or sometimes decreases are applied to the weaker RMPs (C). (See Appendix 7 for the current ranking of RMPs.) The latter, in turn, are singled out to receive special management and technical

consultation and assistance.

The overall RMP review and funding process has a trienniel-anniversary character that is also important. Most RMPs now have been approved for trienniel status. This means that (1) their programs will be subject to full-scale review entailing major site visits and intensive Committee and Council review every third year and (2) they are reasonable assurance of a given annual funding level for three years barring cut-backs in the total grant funds available and/or serious back-sliding on their part. In the intervening two years, between their last and next trienniel applications, their anniversary ones are subject to review by RMPS Staff Anniversary Review Panel (SARP). SARP is composed of RMPS Division and Office Directors and Operations Desk Chiefs. They utilize the same review criteria and their interim rankings and recommendations as to annual funding levels are subject to Committee and Council confirmation.

CRITICISMS OF PROGRAM AND RESPONSES

1. Statement - There has been a lack of any overall program strategy and direction, or specific mission for Regional Medical Programs.

   Response - It is agreed by most concerned that the mandate of Regional Medical Programs as defined by legislation has always been broad. This has been both a source of opportunity for moving into a wide range of activities and remaining flexible, yet also a source of criticism in terms of who was defining what the RMP mission should be at any one particular time.

   In part because of past criticism in this area, a special effort has been made over the past year and a half to define more sharply those areas on which the Regional Medical Programs should concentrate. A Mission Statement was developed specifically for this purpose (See Appendix A). The major point made was that the individual Regional Medical Programs are responsive, provider-oriented local mechanisms which may be used for a range of purposes. Substantive objectives were identified for those RMP's as primary areas of focus. These included:

   - Innovations and improvements in health care delivery systems
   - Manpower development and utilization activities
   - Quality assurance - develop and facilitate the implementation of new and specific mechanisms that provide quality control and improved standards of care.

   Thus the Regional Medical Programs probably have a clearer definition of purpose at this point in time than they have since the program

In addition, specific review criteria have been established in an attempt to rank the RMP's in their efforts to become responsive mechanisms at the local level. (See Appendix B). Although RMPS at the national level will not be telling the local Regional Medical Programs how to do something, it is telling them what areas of national priority are, with the understanding that their future funding depends on their efforts to be responsive to the overall mission being defined at the national level.

Despite this current effort, it is recognized that there are a variety of new developments which will have an effect on the future role of RMP, and that these developments need to be addressed as part of the legislative extension. At least three of these have been under recent discussion: (1) the quality of care issue and what the Federal role should be; (2) manpower development and training programs; and (3) the concept of an implementing agency at the State or local level which would be responsive to CHP definition of plans and priorities.

It is also recognized that there is not complete agreement at the national level (e.g., HEW, HS) as to the future RMP mission. Part of the problem here is that there are some basic policy issues which have not been resolved in terms of the direction HEW wishes to take. Such issues as HEW policy in terms of quality of care and manpower development are among those which need development. Once these directions have been agreed upon at the Department level, it then seems appropriate to determine how the RMP mechanism may best be

2. Statement - Regional Medical Programs have been non-responsive to national priorities

Response - The responsiveness of the Regional Medical Programs to national priorities, both as defined by the Executive Branch and by Congress, has been demonstrated in a number of ways. In FY 1972, for example, the individual Regions responded quickly in the two program areas described below:

* Emergency medical services was highlighted as a national health priority in the President's Health Message in January 1972. By the end of fiscal year 1972, less than six months later, 36 RMPs had responded to the priority with over 50 EMS proposals. As a result, additional funds of $8.4 million were awarded to 28 Regions for new EMS operational projects in fiscal year 1972.

* Congressional interest in kidney disease has been reflected in a variety of statements included in appropriations reports. Between 1971 and 1972, funding for kidney disease rose from $1.5 million to $6.2 million, with 29 RMP's supporting end-stage renal activities. This fourfold increase in the funding of operational projects having to do with kidney disease reflects the response of the RMP's to this Congressional priority on end-stage renal disease programs.

In 1971, the 56 Regional Medical Program Coordinators recognized the necessity of being more responsive to national priorities. They unanimously adopted a Position Paper which described the role the

Regional Medical Programs could and should play in implementing six major areas of health activity emphasized by the President in his Health Message. These included improving the accessibility of health care, demonstration of new techniques for improving the efficiency and effectiveness of health care, meeting the problems in health manpower, and promotion of Health Maintenance Organizations.

In response to the national priority assigned to the HMO effort, for example, the Regional Medical Programs became rapidly involved in development activities across the country. During the first six months of fiscal year 1972, over one-half of the RMP's (29) initiated HMO-related activities without any additional grant inducements. Nine provided some financial assistance in preliminary HMO planning and many more supplied technical assistance and advice. A number of informational and education activities were carried out ranging from the mailing of brochures and convening of meetings to the joint sponsorship of several HEW Regional Conferences on HMO's. Some twelve RMP's designated a staff person as an HMO resource person or focal point.

Because of their linkage to the provider community, the RMP's were able to act as catalytic agents to bring together the various elements of a local community health structure and give staff support and technical assistance as necessary to highlight this national priority.

3. Statement - The major educational and training thrust of Regional Medical Programs is not appropriate. More specifically:

a. RMP support for the subsidization of continuing education for physicians is inappropriate.

Response - The statement that Regional Medical Programs are subsidizing the continuing education of physicians is one of the most heard but least valid statements about the program.

Regional Medical Programs have been involved in continuing education programs, most heavily in the early years of the program. But most of that money has been in the form of seed money for development of continuing education and training programs, not for "subsidies" or stipend support.

RMP funds for operational projects are generally for a three-year period, after which it is expected that costs associated with continuing the project will come from other sources. At this time, for example, the majority of courses for coronary care unit training initially supported by RMP's are now supported by their own communities.

In addition, according to current RMPS policy, stipends are not authorized for training conferences or seminars; for short-term or long-term continuing education activities; or for post-doctoral support. Stipends for training for new types of health personnel is an exception and may be supported with RMP funds. The policy further states that grant funds may be requested and awarded for 50 percent of the total amount budgeted for per diem and travel for the trainees.

The awarded funds may then be paid to the enrolled trainees as considered appropriate by the project personnel, depending on the participants' ability to provide these costs for themselves, and/or the willingness of their employers to provide them.

In terms of the level of funds going into different types of RMP manpower activities, continuing education is receiving an increasingly lower percentage each year. In 1972, such activities made up 16% of all operational project activities (approximately $12 million), in contrast to 21% in 1971. The increasing emphasis of other manpower activities is on the improved utilization and increased productivity of existing health manpower, especially nursing and allied health personnel. These include:

Training in new skills - aimed at enabling the person trained to assume new responsibilities in his already chosen career field. The emphasis is on increasing the productivity of personnel and includes expanding the functions of registered nurses and career mobility for licensed practical nurses.	$13.2 million
Training and development of new categories of personnel - the establishment of training programs for new categories of personnel such as physicians' assistants, nurse practitioners, and community health workers.	$ 3.6 million

For all of the RMP manpower activities, an increasing focus is on developing programs that more closely relate education to the health service delivery needs of an area. Thus even for those continuing education activities which are on-going, an effort is being made to relate them more closely to deficiencies identified as a result of quality of care monitoring.

Statement

b. Regional Medical Programs are involved in some of the same activities which BHME is sponsoring.

Response - This statement has some validity, although some of the problems in this area are moving toward resolution. There has not been clear health manpower policy development at the Department level, nor any definitive delineation of who should be doing what in this area. The manpower problem seems to involve at least three elements:

- Absolute shortages of certain kinds of health manpower
- Maldistribution of many kinds of manpower
- Underutilization of physicians and allied health manpower in most medical trade areas.

NIH (BHME) is most heavily involved in manpower productivity. There is not too much being done in terms of maldistribution, although the efforts of the National Health Service Corps might fit in here. Regional Medical Programs and the National Center for Health Services Research and Development in HSMHA are more involved in the problem of underutilization of health personnel and promoting use of the

health delivery team. This is more feasible for groups such as the RMP because of close involvement with the providers at the community level.

The question of who should be involved in the development of Area Health Education Centers led to lengthy discussions last year, in part because all three of these problem elements were involved. The entire health manpower area is one in which there should be a sorting out of functions and areas of responsibility.

4. Statement - There is an inordinate "overhead" cost of supporting the Regional Medical Programs in terms of their program staffs and related activities.

Response - A significant part of the overall RMP effort has always been so-called program activities. In fiscal year 1972 these accounted for approximately $35 million, or roughly one-third of the total amount awarded ($111.4 million) to the 56 RMPs.

Of this $35 million, however, about $18 million or over one-half of the funds for program activities contributes directly to increasing the availability and accessibility of care and enhancing its quality. At least half of the program activity contributes every bit as much to improving care as RMP-supported operational projects and activities.

The program activities perhaps are best defined as those functions central to the operation of an RMP. They include but are not limited to the activities of the program (or core) staffs of the 56 RMPs which now number about 1,400 (FTE). These in turn encompass but are not restricted to program direction and administration. As the following breakdown for fiscal year 1972 indicates, program direction and administration accounts for only a fraction of the total.

	Est. Amt.	% Total
* Program Direction and Administration Overall direction and coordination, policy development, financial management, project coordination, communication and information activities, program evaluation.	$ 9.5 M	27%

	Est. Amt.	% Total
* Project Development, Review and Management Assistance to local applicants in project design and conduct, processing of individual operational applications, staff support to project review groups, project monitoring and evaluation.	$ 7.7 M	22%
* Professional Consultation, Community Relations and Liaison Staff assistance to other health programs, facilitation of cooperative relationships, development of and assistance to sub-RMP groups, etc.	9.1 M	26
* Planning Studies and Inventories Staff time and/or sub-contract costs for studies designed to provide guideline in development of program objectives, baseline data, etc.	3.7 M	11
* Feasibility Studies Staff time and/or sub-contract expenditures for activities designed to assess the potential of prototype programs or techniques for larger scale application.	2.7 M	7
* Central Regional Services Centralized services supported on a continuing basis, such as libraries, data banks, etc.	1.8 M	5
* Other	.7 M	2

Subsumed under some of these categories are examples of the types of activity being carried on:

Professional consultation and technical assistance - The Wayne State component of the Michigan RMP has over the past several years, provided

extensive and continuing technical assistance to the Detroit Model Cities Program in developing comprehensive, prepaid health care for approximately 10,000 inner city residents. Funding for initiation of this program has now been received from HUD and other sources.

Feasibility studies - such studies frequently provide necessary seed money. If the initial results warrant implementation on a larger scale, this can proceed either as an RMP-supported operational project or with funds from other sources. Among examples:

- A pilot-project to screen Pittsburgh students for sickle cell anemia was initiated last year by the Western Pennsylvania RMP. Testing will provide an indication of the problem in school age groups, with the data to be analyzed by the Allegheny County Health Department and the University of Pittsburgh Health Center.
- The American Indian Free Clinic, first facility of its kind in the nation, opened this spring in a remodeled wing of the Grace Baptist Church in Compton, California, which is part of the greater Los Angeles area. With seed money from the California RMP, an OEO grant, and much volunteer help, the clinic handles 35-40 patients every Tuesday and Thursday evening. All equipment for the clinic was donated and almost all the volunteer help are Indians.

In addition, because of their organizational make-up and identification with local resources, RMPs often tend to serve a "medical forum" role for providers, consumers, and others. By design or otherwise, they

also often serve in a sounding board role. Thus, when issues with potentially major impact on the nation's health care system arise, RMPs are often looked to for information, sometimes guidance. Such was the case with the recent Federal initiative to plan, develop, and organize Health Maintenance Organizations, in which a variety of HMO-related activities were undertaken by RMP program staff and/or with funds budgeted for general program activities, as opposed to those earmarked for specific operational projects.

Thus of the total $35 million in 1972 which supported program staffs and program activities, approximately 27% went for program direction and administration, 22% for project development, review and management, and the other 51% went to activities directly involved in improving health care.

5. Statement - Regional Medical Programs is involved in planning, which should be the responsibility of the Comprehensive Health Planning agencies.

Response - A variety of planning and health data activity is carried out by the Regional Medical Programs to help determine specific objectives, needs and priorities within a region. The majority of RMP planning and health data activity centers around particular needs and problems, rather than being on-going, broad-based planning and data systems. Many of the planning and inventory studies are aimed at specific areas and are set up to lead to specific operational proposals which deal with such issues as the manpower and facilities resources in a region, the adequacy of and need for specialized clinical facilities, disease and patient referral patterns, and unmet educational needs.

An example of such a focused planning study is the Physician's Assistant Survey carried out by the Research and Evaluation Unit of the Kansas Regional Medical Program. The study was carried out to determine whether or not Kansas practitioners would use a physician's assistant. Seventy-five percent of the physicians surveyed indicated they would be willing to use such assistants and felt the need for employing them. The results of this survey played a major role in the development of the nurse clinician project which was initiated in July of 1971, the purpose of which is to train nurses to serve as physician's assistants.

In some of the regions, the Regional Medical Program is supporting longer-term data system efforts, aimed at broad functional areas such

as manpower and facilities resources. In Louisiana, for example, the State Department of Health has sponsored a project designed to establish a data base for health planning information which can serve as a clearinghouse service to health planners in the Region. During this year an automated inventory of published health information will be organized into a format for incorporation in the Center's automated inventory file.

The table below shows the types of planning studies and data collection activities carried out during 1970 and 1971, in order to determine the extent of regional problems and the resources available for use in their solutions.

Area of Planning Study or Data Collection	Number of Studies
Manpower distribution and availability	50
Services and facilities	98
Health conditions	95
Categorical diseases	29
Screening	23
Continuing education	42
Data Bank	38
TOTAL	375

In addition, the Regional Medical Programs are involved in a variety of joint planning and data system efforts which involve cooperation with other agencies, particularly the Comprehensive Health Planning agencies. According to a program analysis memorandum completed in

1971 on RMP relationships with CHP agencies, some 45 State CHP agencies cooperated with RMP's on joint surveys, studies, or exchange of services in data collection or analysis. Of the 50 Regional Medical Programs having Federally-funded Areawide CHP agencies in their region, 46 reported having data sharing or other types of joint data activity with at least one Areawide agency in their region.

In Arkansas, for example, Areawide CHP agency staff and committees are utilized to provide subregional data to RMP in the development of subregional plans. The Arkansas RMP and the State CHP agency are also cooperating on the development of a regional hospital plan for health service delivery, and both were closely involved in the planning for the Experimental Health Services Delivery System.

Although the amount of funds being used for planning activities was large in the early years of the program, it has declined rapidly as most of the programs have become operational, and has ranged from approximately $4-5 million in the past two years.

6. Statement - There is a lack of coordination between the planning done by CHP and the operational activities of the Regional Medical Programs.

Response - This is an issue which has arisen in a variety of locations around the country, in relation to both RMP activities and a variety of other HSMHA project activities. It raises in part the entire question of how effective the CHP "review and comment" authority is as currently in effect.

The legislative extension of Regional Medical Programs requires both joint RMP-CHP representation on their respective advisory councils and groups, and provides that the appropriate Areawide CHP agency have an opportunity to consider operational grant proposals before the RMP Regional Advisory Group may recommend approval.

A sample of 64 letters from CHP agencies commenting on RMP applications was reviewed to determine the kinds of comments being made. Some of them commented on overall RMP performance or on the total application package while others commented strictly on individual projects. The results were as follows:

a. Comments on Overall RMP Performance or on Total Application

(1)	Favorable	31
(2)	Unfavorable	0
(3)	No comment	33

b. Comments on Individual RMP Projects

	# Projects
(1) Favorable	
. For general reasons	47
. For technical reasons (e.g., cost, staffing, location)	12
. In accord with general priorities or with CHP Plan priorities	28

	# Projects
(2) Unfavorable	
. For general reasons	13
. For technical reasons	20
. In conflict with general priorities or CHP Plan priorities	4
Total unfavorable	37

From this review of most of the first-year CHP review and comment letters, it is evident that most of the CHP agencies either reacted favorably to the overall RMP application or restricted their comments to specific projects. Of some 124 projects commented on, unfavorable comments were received on 37 or approximately 30%. Of the 37 unfavorable reviews, only 4 or 3% were because the project did not fit in with community or CHP plan priorities. Most of the unfavorable comments were due to technical reasons such as cost and method of operating the project.

This raises some question about the nature of the on-going CHP review. Considering the extensive technical review which each project undergoes as part of the RMP review process, it seems a duplication of effort to have CHP involved in this type of review. Rather the CHP should be concentrating on the relationship of the project to overall community priorities or relevance to the CHP Plan. It is recognized that these plans are still being developed in a number of areas around the country. Yet this type of review needs to be emphasized as the kind of effort which CHP agencies should be getting involved in. At the same time, it is recognized that as the CHP agencies move forward on developing community plans and priorities, there will need to be a tighter mechanism to make certain the RMP's are making greater

[illegible] plans and application

7. Statement - Regional Medical Programs is dominated by the medical schools and/or providers.

Response - During the initial organizational stages of Regional Medical Programs, the medical schools functioned as one of the significant resources for the RMP's development. Commonly the center of the medical trade areas along whose boundaries the fifty-six regions were formed, the schools provided a natural resource for the establishment of the RMP's and for the conduct of their activities. In addition, many of the medical schools served as the initial grantee for the locally-developing RMP.

As the Regional Advisory Groups began to mature, with their composition of a broad range of provider and public groups, the influence of the medical schools fell more into line with their normal influence in the community health structure.

This shift is reflected in changes in the composition of the Regional Advisory Group, which is responsible for approving applications and setting overall RMP policy. The contrast between 1967 and 1971 of membership on the Regional Advisory Group is shown below:

	1967	1971
Practicing Physicians	23%	28%
Hospital Administrators	12%	13%
Medical Center Officials	16%	8%
Voluntary Agencies	12%	8%
Public Health Officials	7%	5%
Other Health Workers	8%	11%
Members of the Public	15%	21%

As may be noted, medical center officials have decreased from 16% to 8% of the representation, while consumers have increased from 15% to 21%, and practicing physicians from 23% to 28%.

Because of problems in some Regional Medical Programs between the Regional Advisory Group and the actual grantee, which in many cases is a university, RMPS issued a policy statement in May of 1972 entitled "RMPS Policy Concerning Grantee and Regional Advisory Group Responsibilities and Relationships," (See Appendix C). The basic point is that the Regional Advisory Group (RAG) has the responsibility for setting the general direction of the RMP and formulating program policies, objectives and priorities. It has responsibility for:

- Approving overall budget policy and major budget allocations,
- Approving the RMP organizational structure and significant program staff activities,
- Approving any applications submitted to RMPS.

The grantee, on the other hand, shall manage the grant in a manner which will implement the program established by the Regional Advisory Group and in accordance with Federal regulations and policies. This includes:

- Receiving, administering, and accounting for funds on behalf of the Regional Medical Program
- Reviewing operational and other activities proposed for RMP funding with respect to -- their eligibility for and conformance with RMPS and other Federal funding requirements; capabilities of affiliates to manage grant funds properly.

Thus the Regional Advisory Group, as the group representative of a broad range of community health interests, is given the basic responsibility for program policy and priorities.

With regard to the statement that Regional Medical Programs is dominated by providers, this is certainly true and is considered one of the strengths of the program. As is discussed in greater detail under Part 1 of Program Strengths, RMP provides an acceptable mechanism through which providers can work together with considerable flexibility to meet health needs that cannot be met by individual practitioners, health professionals, hospitals and other institutions acting alone. It provides one of the major links between both the Federal government and providers of care, and between consumer-oriented CHP agencies and the major provider groups.

8. Statement - Regional Medical Programs have not decentralized to a great enough extent (the Regional Advisory Groups are window-dressing).

Response - RMPS has made a major effort during the past two years to promote decentralized decisionmaking. A policy statement which makes explicit the general practices developed over the years in terms of RMP grantee and Regional Advisory Group responsibilities and relationships has recently been issued (See Appendix C). This statement, approved by the National Advisory Council, makes it crystal clear that the RAG, which is reflective of the broader spectrum of provider groups, interests, and the larger community, is responsible for determining a Region's program direction, priorities, and scope, rather than the grantee institution (e.g., state medical society, university).

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. (See Appendix D for Review Process Requirements and Standards). It is anticipated this verification procedure will have been largely completed by the end of 1972.

Another important factor to be recognized is that the National Advisory Council and the national review process are now assessing RMP's 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.

Thus RMPS seems to have been moving vigorously to give the Regional Advisory Groups major responsibility for what happens in their particular regions.

9. Statement - There has been inadequate demonstration/documentation of substantive RMP accomplishments.

Response - The problem of how to document the accomplishments of many HEW programs involved in social change and institutional reform is one that needs a great deal more work. The entire HEW effort to develop "output measures" has not been particularly successful for many of the grant programs. The types of activities in which these programs engage is much more difficult to measure than a straight patient services program. It is also difficult to aggregate to the national level what is going on in 56 different regions.

RMPS has made a major effort in the past two years to develop its Management Information System. That system is now capable of presenting descriptive data covering all 1,000 operational components on a national basis. A descriptor summary can present the number of projects and funding level by such categories as:

- Primary activity - e.g., training new categories of personnel, patient care demonstrations, research and development
- Sponsor - e.g., community hospital, medical school, public health agency
- Disease category - e.g., heart disease, cancer, stroke, multi-categorical or comprehensive
- Selected health care delivery methods - e.g., ambulatory care, emergency medical services, home health care.

In addition, work is proceeding on a Management Reporting and Evaluation System, which will eventually link each of the RMP's to

the national Management Information System. This followed-up the FAST Task Force which identified the need for a reporting system over and above the triennial application plan which RMPS was adopting. The development of the two systems should improve both documentation of RMP accomplishments and decisionmaking tied to program planning and evaluation.

10. Statement - Regional Medical Programs emphasize the categorical diseases to too great an extent.

Response - The concept and reality of the Regional Medical Program has evolved and changed considerably since the enactment of the initial authorizing legislation in 1965. The initial concept 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 implementation and experience of RMP over the past eight years, coupled with the broadening of the initial concept especially as reflected in the most recent legislative extension (P.L. 91-515), has made it clear that RMP shares with all health groups, institutions, and programs (private and public) the broad, overall goals of (1) increasing the availability and accessibility of care, (2) enhancing its quality, and (3) moderating its costs -- making the organization of services and delivery of care more efficient. What this has meant in more specific, operational terms is that RMPs increasingly have focused their attention and efforts on helping develop the resources needed if those broad goals are to be achieved and initiating and demonstrating new ways of delivering and organizing health care services. Regional Medical Programs is engaged in resource development and initial implementation; it is principally concerned with providing the necessary foundation for health services rather than being an instrument for the direct provision of services itself.

This expansion in the scope and nature of RMP activities has been a continuing major trend for the past few years. This trend towards the support of multi-categorical and more comprehensive activities was accelerated in fiscal year 1972 because of the significant increase in the availability of grant funds compared to the previous year. In fiscal year 1971, for example, only about one-third of the nearly 600 RMP-supported operational projects were multi-categorical or comprehensive in nature; the bulk, nearly two-thirds, had essentially had a single disease focus (e.g., heart, cancer, stroke). By the end of fiscal year 1972, however, well over one-half of the 1000-odd RMP operational projects were of a multi-categorical or comprehensive nature, as indicated by the summary table below:

	FY71			FY72		
	No.	Amt.	%	No.	Amt.	%
Single, categorical disease focus	373	$28.5M	63	430	$29.6M	39
Multi-categorical or comprehensive	221	16.8M	37	574	26.7M	61

The shift of priorities and areas of emphasis is reflected in the large percentage of funds now being directed toward projects emphasizing primary care. In FY72, this included some $10.7 million for Emergency Medical Services Systems (approximately 14% of operational project funds) and some $18 million for over 200 projects emphasizing ambulatory care (approximately 24% of operational project funds).

Thus, though RMP continues to have a categorical emphasis, the operational experience to date strongly suggests that to be effective, that emphasis more frequently than not must be subsumed within or made subservient to broader and more comprehensive approaches. Moreover, the development or strengthening of grossly inadequate primary care services must often precede categorical efforts, and is receiving increasing attention in terms of RMP grant funds and operational priorities.

11. Statement - Since Regional Medical Programs do not always follow State boundaries, this will cause problems in terms of relating to CHP, etc.

Response - This does not seem to present very much of a problem since most of the RMP's are already closely aligned with State boundaries. Among the major points in favor of and against use of State boundaries are the following:

Points Favoring the Use of State Boundaries

- By precedent, the fact that 34 of the 56 RMP's already make use of State boundaries, and 4 more encompass two or more entire States (serving 11 States), would mean a policy in this direction represented only a moderate change.
- By combining some others, many of the remainder could become State-bounded. This would not involve taking away any territory. (For example, New York has 6 RMP's, Pennsylvania has 3, and Ohio has 3.)
- There would be a greater congruency with State CHP agencies, allowing greater consistency of RMP priorities to community and State established priorities.
- The increasing politicalization of health at the State level would be more consistent with those RMP's that match State boundaries.
- Many emerging and important practical issues are or will be dealt with in a State frame of reference, including production of manpower, licensure, HMO regulation, and other tax-supported activities.

Points Against the Use of State Boundaries

- In those few cases in which the RMP does not match a State boundary, there is generally strong justification in terms of the natural medical trade area. These include the metropolitan areas of St. Louis (and southern Illinois), Memphis, and Metropolitan Washington, D.C., with others in Ohio Valley (Kentucky plus Cincinatti and other parts of southern Ohio) and Intermountain RMP (Utah, and portions of surrounding States). State boundaries could harm making maximum use of these natural trade patterns.
- Design of a national regional health organization would be inhibited by a priori prescription of 50 or more Regions based on State boundaries.
- Promotion in this direction could result in some destructive infighting. Regionalization patterns which have already been initiated could be damaged. This suggests that movement in this direction should be essentially initiated within or by the Region itself, rather than from outside.
- State boundaries could well lead to creation of unnecessary or redundant specialized services and facilities, such as kidney disease and specialized heart disease resources. There might be less incentive to make optimum use of nearby resources of another State through regional planning and patient referrals.
- Use of a State boundary for an RMP should in no way inhibit it from reaching beyond State boundaries in its activities where the logic of the situation has so dictated. Most regions have followed this logic in developing their programs and activities.

PROGRAM STRENGHTS

1. Regional Medical Programs constitute a functioning and acceptable link between the Federal government and the providers of health care.

The unique characteristic of Regional Medical Programs is that it is primarily linked to and works through providers, especially practicing health professionals. Most of these are in the private sector.

Although the basic HEW orientation is consumer-oriented, it is still necessary to deal with the provider constituency which provides the bulk of medical care. If changes are to be made in the health care system, these providers will need to be involved. They contribute to the decisions of what changes should be made, and are most certainly needed to implement those changes once they have been decided upon. While CHP agencies have been the linkage to the consumer community, the Regional Medical Programs provide the major link to the provider groups.

Dr. Wilson in his memo of August 10, 1972 on "Regional Medical Programs: A Health Care Provider Constituency," makes some good points in this connection:

> "Loss of a direct Departmental role in relation to health care providers, either through abolishing RMP altogether or folding it into special health revenue sharing, would mean loss of contact with the most influential constituency that the Department seeks to change. The primary function which RMP serves, and which only RMP serves at this time, is as provider change agent. It does not function as a source of provider support nor, as some have charged, as a "provider revenue sharing" mechanism. It is provider dominated, purposefully, but not to maintain the provider status quo, as has been suggested. RMP has, in part, a categorical emphasis, but that is because providers are specialized.
>
> To bring about change most readily and efficiently, one applies the lever close to the object to be moved, not at a distance from it. Gaining the confidence and cooperation of providers to change in areas of their interest, permits additional more

positive movement beyond their immediate specialized concerns. And this is accomplished not just because RMP funds provide a stimulus, but because the providers themselves invest in maintenance of improvements and continuing changes."

Dr. Wilson also points out the possibility of increased leadership at the Federal level to assure that all RMP's seek to translate national priorities into local initiatives, as well as the need for improved coordination with CHP priorities. With certain modifications, the RMP can be the mechanism which assures provider participation in the implementing process.

2. Regional Medical Programs provides a forum and a mechanism for productive dialogue and cooperative action between and among formerly disparate health interests and groups at the local level.

The Regional Medical Programs are organized in such a way as to encourage providers to 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.

The Regional Advisory Groups, which set program policies and priorities and approve operational project activities, are made up of some 2,700 practicing physicians, hospital administrators, medical center officials, representatives of voluntary health agencies and CHP agencies, as well members of the public.

Each Region also has a structure of planning, technical review, and evaluation committees, designed to ensure broad-based participation of health institutions and organizations. Some 12,000 health professionals and public representatives are on RMP committees and local action groups. The local action groups serve primarily in a liaison and program development capacity at the community level. Generally, they attempt to foster cooperation among local health organizations and consumer groups, and in many instances provide linkages with CHP areawide groups. Local groups serve as a reactor to community needs and problems and relate these, as well as possible solutions, to decisionmaking bodies at the regional level.

The RMP structure is deliberately designed to take into account local resources, patterns of practice and referrals, and needs. When the

California RMP, for example, nurtured a highly active community action group in the Watts-Willowbrook section of Los Angeles, in an attempt to become more responsive to the needs of the poor and black population in that city, the group decided to become a separate RMP sub-region. The group felt that its needs and resource structure was different enough to warrant a separate sub-regional RMP, and formed itself on such a basis with back-up support provided jointly by UCLA and USC.

The basic focus of the RMP mechanism is thus to provide a framework or organization within which all providers can come together to meet health needs that cannot be met by individual practitioners, health professionals, hospital and other institutions acting alone.

3. The Regional Medical Programs support and strengthen institutional reform in the health arena.

Because of the close RMP linkage with the provider community, and because the RMP's are functioning organizations with staff, committee structures, and operating experience, they lend themselves to serving as a local medical forum and sounding board. Thus they are often looked to for information and guidance in terms of major issues being discussed or new directions being taken which will affect the health care system. In this way they provide one of the better opportunities to promote institutional reform at the regional and community level.

During the recent Federal effort to stimulate interest in HMO development, more than half the RMP's initiated HMO-related activities without any additional grant inducements. This ranged from direct financial assistance to informational and education activities. In addition, with their ties to local communities, the RMP's provided one of the more informed sources as to what was happening in terms of HMO developments around the country.

A major instance of RMP involvement in institutional reform relates to its growing involvement in the quality assurance/control area. In an effort to raise the level of health care provider understanding and experience of the objectives and techniques of quality monitoring, groups such as the Committee on Quality of Care Assessment have been formed, in this case by 14 of the Southeastern RMP's. A major purpose is the constitution of an interregional resource to provide technical assistance and consultation relative to the development

and implementation of mechanisms for quality of care assurance and monitoring to any group or organization (e.g., local medical society, HMO, community hospital) requesting such aid. RMPS plans development of more of such interregional programs this year.

A National Meeting of RMP Coordinators on Quality of Care will be held in January 1973, to develop a common frame of reference and policy for implementing a quality of care program. This will be followed by interregional sectional meetings to apply these policies to their own particular regional problems. It is planned that at least half of the RMPs would gain capability for technical assistance on monitoring the quality of health care by the end of 1973.

4. RMP strengthens local initiative and non-dependency on continued Federal funds.

The concept of time-limited support has always been central to Regional Medical Programs. Furthermore, incorporation within the regular health care financing system of RMP-funded operational projects and activities has been an important measure of their success (or failure). Therefore, one gross measure of RMP's effectiveness is the extent to which in effect, RMP-initiated activities have been able to sell themselves in the medical market-place so to speak, to stand on their own, after several years of support.

This concept of time-limited support initially was given explicit policy expression several years ago. The National Advisory Council in November 1970 considered and approved a policy to the effect that RMP funding of operational projects generally should not be for more than three years. Additional emphasis was given to this policy by the RMP review criteria implemented in June 1971. These formal, specified criteria employed in the national review process to qualitatively assess a Region's overall program and progress, include those of continued support for successful RMP activities from other sources of funding, and evidence of attracting other than RMP funds into the region.

An analysis of termination of RMP support made shortly after Council's initial policy statement in March 1971, indicated that only 40 percent of RMP-initiated operational projects had been terminated within three years or less. It also suggested, however, that most of the activities for which RMP grant support had been phased out

There is every indication that this earlier performance has been improved upon in the last 12-18 months. Based upon data available from recent reports from about one-third of the Regions (19 of the 56), it is estimated that RMP support, in dollar terms, is being phased out within three years in some 75-80 percent of all operational projects.

These same data indicate, again in terms of dollars, that roughly 60 percent of those projects from which RMP grant support is being withdrawn, will be continued from other sources. Sometimes this is at a somewhat reduced level; the average overall is about 80 percent.

A multiplicity of other sources are involved, and these include inkind as well as dollar support, as the examples below show.

- The Progressive Coronary Care Program supported for three years at an annual cost of approximately $100,000 by the Northern New England RMP, is being continued with joint funding from participating hospitals and the Vermont Heart Association.
- A comprehensive Regional Radiation Therapy Program for the St. Louis area, which includes training of radiation therapy technicians, radiation planning and physics services, and multidisciplinary cancer conferences, was initiated several years ago with monies from the Bi-State RMP. It will be continued with support frommultiple sources. These include contributions from each of the nine participating hospitals, tuition fees, and third party payments which will largely offset the continuing consultation and therapy planning costs.

- Costs of operating the chronic pulmonary disease center established at the University of Mississippi Medical Center with RMP grant funds are being assumed completely by the Medical Center.
- The City of St. Louis is continuing the Nurse Demonstration Unit for Intensive Care of Stroke project at the present level of $50-60,000 annually. This project was started with funding from the Bi-State RMP.

The increasing success of RMPs in turning over their grant funds within a reasonably short time, which in turn permits them to reinvest those same funds in new activities, and in attracting continuation support for activities they have helped initiate, is due to a number of factors. The major one seems to be that activities that are problem-oriented tend to elicit community or local support. They are able to attract other sources of funds (or services in-kind) from the very outset. Another reason is that planning for decremental funding is built into many RMP-initiated operational projects.

While Regional Medical Programs are meeting with growing success in disengaging from activities they have helped initiate and having them supported from other sources, this is an area where even greater progress must be made. For long-term subsidization using RMP funds is self-defeating in at least two ways. In the short-run it means that the only way RMPs will be able to tackle different problems, initiate new activities, on any significant scale will be with ever-increasing funds. That predictably will not happen. In the longer-run new or expanded services and activities must be able to sell

themselves to the providers of care (e.g., physicians, hospitals), the public which stands to benefit from them and which must pay for them, however, indirectly, and their third party carriers.

5. Regional Medical Programs can act to bridge the services-education/ town-gown chasm.

One of the strengths of Regional Medical Programs is the ability to bridge the gap between the research-educational focus of the medical centers and the patient service focus of the community hospitals and practicing physicians. Much of this interrelationship has taken the form of operational project activities which deal with patient care demonstrations involving innovations in health care, and educational efforts aimed at correcting identified areas of deficiency.

But to be really effective in improving such relationships requires that there be more of a two-way flow between the two groups than has usually been the case. Rather than medical center predominance, there needs to be a base of community involvement in addressing health care issues.

This concept has become the focus of RMP activities in a range of areas, including most recently in the health manpower area. The emphasis is on developing programs that more closely relate education to the health service delivery needs of an area. The definition of such health service needs should involve participation of a wide range of health service and educational institutions, such as community colleges, hospitals, health professionals and consumers, as well as the medical centers. A community-based identification of health service needs should logically precede any determination of the numbers and types of health personnel needed and how they should be trained.

It is unfortunate that most data surveys focus on shortages of specific personnel as opposed to gaps in health services which might be filled by existing manpower. It may well be determined that what is needed is not necessarily more manpower but better organization and utilization of manpower resources that are already available. In this connection, educational programs for both traditional and new health occupations need to be designed as more responsive to the skills required by the health delivery team.

This approach to solving health problems through community involvement in the identification of needs and linkage of total health resources in such a way as to ensure a better balance between the resources available and the locally-determined needs for service is an approach which both RMP and CHP can satisfactorily promote.

6. RMP enhances community health planning, both in terms of local capacity and potential pay-off.

As the objectives of both RMP and CHP become more explicitly defined, their respective roles and relationships to each other also take on greater specificity. While CHP is essentially a community-based planning program, RMP is basically a provider-oriented resource development program.

It is becoming clear that the Regional Medical Programs must look to CHPs for increasingly specific health priorities and plans if their funding decisions, which have been largely decentralized, are to have legitimacy within the community. No group representative of the broad spectrum of health providers, the overwhelming majority of whom are in the private (as opposed to public) sector, can hope to abrogate this unto itself.

CHPs in turn need RMPs to assist them in devising workable alternatives and plans that address priority needs and as an instrumentality for helping to implement decisions made by the broader community which require modifications that in large measure will be required of providers and the private sector.

Because of its strong provider links, the RMP cannot only act as a forum for institutional reform among those providers (e.g., individual practitioners, hospitals, and medical centers), but it can provide professional and technical competencies, expertise, and skills to CHP and other health agencies and groups.

There has been extensive RMP-CHP cooperation around the country in terms of such activities as joint data collection and analysis, staff sharing or regular joint meetings, and sharing of equipment and facilities. Regional Medical Programs have reported joint activities in the area of data collection and analysis with 45 of the State CHP agencies. Of some 50 RMP's having recognized Areawide CHP agencies within their region, 46 reported data sharing or other joint data activity with at least one Areawide agency in their region.

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 and Information System and on a Consumer Inventory Study in Northwest Kansas.

The Rochester RMP and the Genesee Region Health Planning Council co-authored a regional data book as well as a joint study of emergency departments of city hospitals.

Coordinated activity and technical assistance between RMP and CHP takes a variety of other forms. The Arkansas RMP currently involves CHP personnel in the development of projects affecting their area since they are used as the subregional advisory committee. In addition, the RMP and CHP worked closely together to develop the successful Experimental Health Services Delivery System application, and both are continuing to contribute to that effort. The Washington/ Alaska RMP, as well as others, have collaborated with State CHP agency

staff on the development of Areawide agencies involving the use of RMP funds for development.

And in the first effort of its kind, a joint award providing support for RMP and CHP activities has been made to the Nassau-Suffolk RMP, Inc. and Nassau-Suffolk CHP, Inc. Both are separately incorporated organizations and were joint applicants for a grant award. With funds coming from RMPS and CHP funds allocated to Region II, it was determined that the two would be more effectively managed by issuance of one jointly-funded award to the Agency.

Thus increasingly around the country, the RMP, with its linkage to the provider community, is becoming an important technical, professional and data resource for the State and Areawide planning agencies. The regions, in turn, look to the planning agencies for expression of broad-based community health needs and priorities.

7. The Regional Medical Programs are becoming increasingly problem-oriented, addressing those issues such as Emergency Medical Systems and quality assurance which have gained national attention.

Regional Medical Programs are supporting a wide variety of activities aimed at increasing the availability and accessibility of health care. Special efforts to improve accessibility are being made in terms of minority and inner-city populations and in rural areas. In fiscal year 1972 activities directed at special target populations such as Blacks, Spanish-Americans, and Indians more than doubled, from 46 projects and $5.4 million to 147 projects with $17 million in RMP funding.

This included activities that ranged from a demonstration testing program for sickle cell anemia for children in Grand Rapids, Michigan, to initiation of a hospital-based family health care service in New Brunswick, New Jersey, which is providing health care to 4,000 of the city's poor.

The problems of developing rural health delivery systems in another area in which Regional Medical Programs involvement in growing. This is reflected in the change in resources directed to this area; the number of RMP funded projects rose from 57 and $3.1 million in fiscal year 1971 to 171 projects and $10.9 million by the end of fiscal year 1972. In terms of total RMP operational funds, this represents a doubling of effort, from 7 to 14 percent of total project activity designed to improve health care in rural areas.

In addition to a variety of patient demonstration activities which link remote areas with larger community hospitals, many Regions

have assisted rural communities in which no physician is present to substitute other types of health care service. An empty doctor's clinic in Rochell, Georgia, for example, has been staffed by nurses with the help of the Georgia RMP in an experiment to provide health care. The clinic is being developed into a new Health Access Station. In Darrington, Washington two registered nurses will staff a long-empty clinic, built to attract a doctor. When no doctor was found, the citizens appealed to the Washington/Alaska RMP, which has now helped finance and staff the facility to provide emergency care, health screening and counseling.

Efforts to improve the quality of health services delivered have centered on patient care demonstrations involving new techniques and innovations in health care patterns, education efforts aimed at correcting identified areas of deficiency, and a variety of systems changes which can improve resources allocation. Between fiscal years 1971 and 1972, patient care demonstration projects rose from 150 and $15.4 million to 250 and $31.4 million, an increase of over 100 percent.

Similarly, the emphasis on developing emergency medical services systems was expanded greatly during FY72 from a level of less than $2 million to approximately $10.6 million.

During 1972, there has been an increasing emphasis on developing practicable methods for assessing the quality of medical care in various types of delivery systems. Three particular areas of effort are: (1) the development of standards and guidelines for high quality

care in particular disease areas; (2) contracts with major medical societies to identify criteria for good medical practice; and (3) surveys to identify hospitals which make available the most advanced techniques for treating heart disease, cancer, stroke and kidney disease.

In an effort to develop methods of monitoring the quality of care of individual health delivery systems, one effort to be undertaken in FY73 is aimed at developing parameters of quality assessment in the three most common forms of ambulatory care delivery systems, namely individual private practice, hospital outpatient clinics, and pre-paid group health practice. This is particularly needed as ambulatory care is the type of medical care received by 96 percent of the patient population today.

RMPS is also promoting the development of interregional resource groups to provide technical assistance and consultation in developing and implementing mechanisms for quality of care assurance. This effort is more fully described in #3 above on institutional reform.

8. RMP provides a good fulcrum for increasing the leverage of limited Federal health dollars.

With a small initial input of program staff time or operational project funds, the RMP's have often been able to generate health care activities on a larger scale which brought in funds from a multiplicity of sources. Among some examples of this:

. New Jersey RMP's four-year old Urban Health Component, funded at $160,000, provides health planners to that state's eight Federally-designated Model Cities Programs. Begun in 1968 when urban health coordinators were assigned to New Jersey's first three Model Cities, it proved so successful that in April 1970 this project was expanded to include the other Model Cities in the state. To date, the staff has secured more than $8.4 million from sources other than RMP to fund health programs in these cities. (This Urban Health Component was expanded again in 1971 when the New Jersey RMP signed a contract with the New Jersey Department of Community Affairs to provide health planning assistance to the 16 cities in the state's ten Community Development Programs.)

. Maine's Regional Medical Program has been primarily responsible for $400,000 of additional financial support from other agencies and organizations during this past year. This includes:

* $75,000 from the Maine State Legislature and $40,000 from the New England Regional Commission working toward development of a College of Physicians
* $29,000 from various voluntary health agencies for public education in health

* $4,300 from a variety of drug corporations for a coronary care project
* $40,000 from the Veterans Administration for Area Health Education Planning
* $9,500 from the Commonwealth Fund for evaluation of the Interactive Television Project
* $43,000 from OEO - New England Regional Commission for a healthmobile project.

. The Nassau-Suffolk RMP and other Long Island health groups recently were granted funds by the National Heart and Lung Institute to set up a clinical and educational program designed to make the public aware of sickle cell anemia and the need for counseling and treatment for those who carry this disease or are afflicted by it.

. The West Virginia RMP spearheaded a successful bid for Appalachian Regional Commission funds needed for a medical care program which will provide a physician and pharmacist for Clay County. The project, approved by the Governor, stipulates that whenever the services reach a self-sustaining point, they may be converted to privately-owned and operated facilities.

9. RMP provides one of the most flexible mechanisms for initiating health policy and program changes.

For a variety of reasons, including its organizational structure, the increasing decentralization of authority, and the growing responsiveness of regions to national priorities due to the selective funding policy, RMP is one of the most flexible mechanisms available in terms of responding to shifts in national policy. This flexibility and ability to respond to new directions quickly is reflected in two recent items:

- Within six months after the President had highlighted emergency medical services as a national health priority in the President's Health Message of January 1972, some 36 RMP's had responded to the priority with over 50 EMS proposals. As a result, additional funds of $8.4 million were awarded to 28 Regions for new EMS operational projects in fiscal year 1972.
- During the first six months of fiscal year 1972, following the recent Federal initiative to promote HMO development, over one-half of the RMP's initiated HMO-related activities without any additional grant inducements. In those regions in which RMP's had HMO development as an objective, there was a higher average number of HMO grants awarded. These HMO-related activities were undertaken by RMP program staff and/or with funds budgeted for general program activities (as opposed to those earmarked for specific operational projects). It illustrates both the flexibility in RMP operations that such funds allow and the relative immediacy in response they permit.

10. RMPS is developing a greater ability to turn the individual Regional Medical Programs around to direct their attention to national priorities.

In addition to defining a more specific mission for the program, RMPS has initiated a selective funding policy. This is designed to promote greater attention to national priorities in that it provides proportionately greater fund increases to those RMP's which have demonstrated outstanding maturity and whose proposals are most nearly congruent with the expanded RMP mission and national priorities.

It is based on a ranking of the RMP's, after National Advisory Council assessment of their overall program and progress. No longer is the technical adequacy of individual projects or discrete, singular activities the primary focus or concern of the review process.

This change from project to program review, in addition to a need to substantiate quality judgments, 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. (See Appendix B -- RMP Review Criteria). These criteria and a corollary scoring system have been used on a trial basis over the past year, 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 has been the basis of the selective funding policy which RMPS has implemented.

Those regions not making adequate progress are given intensive management and technical assistance aimed at improving their decision-making and implementing capabilities as well as the cohesiveness and pertinence of their activities. Those demonstrating maturity and making a strong effort to meet national priorities receive greater fund increases. Thus the selective funding policy has greater improved the RMPS capability to direct regional attention to matters of national concern or priority.

REGIONAL MEDICAL PROGRAMS

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 implementation and experience of RMP over the past five years, coupled with the broadening of the initial concept especially as reflected in the most recent legislation extension, 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.

Given this premise, the purpose of this statement is to specify (1) what Regional Medical Programs are, (2) what their evolving mission has become, and (3) the basis on which they will be judged.

RMP -- The Mechanism

RMP is 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 individ-

ual 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.

RMP -- The Mission

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:

(1) RMP is primarily linked to and works through providers, especially practicing health professionals; this means the private sector largely.

(2) RMP essentially is a voluntary approach drawing heavily upon existing health resources.

(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.

It is these broad, shared goals on the one hand and the characteristics and approaches unique to RMP on the other, that shape its more specific mission and objectives. The principal of these 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. At this time the latter would include, for example, encouraging provider acceptance of and extending resources supportive of Health Maintenance Organizations.

(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 (or 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) Identify or assist to develop and facilitate the implementation of new and specific mechanisms that provide quality control and improved standards of care. Such quality guidelines and performance review mechanisms will be required especially in relation to new and more effective comprehensive systems of health services.

Even in its more specific mission and objectives, RMP cannot function in isolation, but only by working with and contributing to related Federal and other efforts at the local, state, and regional levels, particularly state and areawide Comprehensive Health Planning activities.

Moreover, to be maximally effective requires that most RMP-supported endeavors make adequate provision for continuation support once initial

Regional Medical Program grant support is terminated; that is, there generally must be assurance that future operating costs can be absorbed within the regular health care financing system within a reasonable and agreed upon period. Only in this way can RMP funds be regularly re-invested.

RMP -- The Measure

It follows that the measure of a Regional Medical Program, reflecting as it does both mission and mechanism, must take into account a variety of factors and utilize a number of criteria. The criteria by which RMP's will be assessed relate to (1) intended results of its program, (2) past accomplishments and performance, and (3) the structure and process developed by the RMP to date.

A. Criteria relating to a Regional Medical Program's proposed program, and the intended or anticipated results of its future activities, will include:

(1) The extent to which they reflect a provider action-plan of high priority needs and are congruent with the overall mission and objectives of RMP.

(2) The degree to which new or improved techniques and knowledge are to be more broadly dispersed so that larger numbers of people will receive better care.

(3) The extent to which the activities will lead to increased utilization and effectiveness of community health facilities and manpower, especially new or existing kinds of allied health

personnel, in ways that will alleviate the present maldistribution of health services.

(4) Whether health maintenance, disease prevention, and early detection activities are integral components of the action-plan.

(5) The degree to which expanded ambulatory care and out-patient diagnosis and treatment can be expected to result.

(6) Whether they will strengthen and improve the relationship between primary and secondary care, thus resulting in greater continuity and accessibility of care.

There are, moreover, other program criteria of a more general character that also will be used. Specifically:

(7) The extent to which more immediate pay-off in terms of accessibility, quality, and cost moderation, will be achieved by the activities proposed.

(8) The degree to which they link and strengthen the ability of multiple health institutions and/or professions (as opposed to single institutions or groups) to provide care.

(9) The extent to which they will tap local, state and other funds or, conversely, are designed to be supportive of other Federal efforts.

B. Performance criteria will include:

(1) Whether a region has succeeded in establishing its own goals, objectives, and priorities.

(2) The extent to which activities previously undertaken have been productive in terms of the specific ends sought.

(3) Whether and the degree to which activities stimulated and initially supported by RMP have been absorbed within the regular health care financing system.

C. Process criteria will include:

(1) The viability and effectiveness of an RMP as a functioning organization, staff, and advisory structure.

(2) The extent to which all the health related interests, institutions and professions of a region are committed to and actively participating in the program.

(3) The degree to which an adequate functioning planning organization and endeavor has been developed in conjunction with CHP, at the local (or subregional) level.

(4) The degree to which there is a systematic and ongoing identification and assessment of needs, problems, and resources; and how these are being translated into the region's continuously evolving plans and priorities.

(5) The adequacy of the region's own management and evaluation processes and efforts to date in terms of feedback designed to validate, modify, or eliminate activities.

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 in-patient, out-patient, extended care, and home health services?
   d. Have any RMP-supported activities resulted in attracting 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 possess adequate administrative and management capability?

2. CORE STAFF (3) (continued)

   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 committtee 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?

2. DISSEMINATION OF KNOWLEDGE (2) (continued)

   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?

5. SHORT-TERM PAYOFF (3) (continued)

   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?

APPENDIX C

RMPS POLICY CONCERNING GRANTEE AND REGIONAL ADVISORY GROUP RESPONSIBILITIES AND RELATIONSHIP

May 26, 1972

A. Introduction

There are three major components of the Regional Medical Program at the regional level: the grantee organization; the Regional Advisory Group; and the Chief Executive Officer (often referred to as the RMP Coordinator) with his (or her) program staff. The responsibilities that each has and how they relate and interact with one another are important factors in a successful Regional Medical Program. The following outline sets forth a framework for these responsibilities and relationships.

B. Grantee

The grantee organization shall manage the grant of the Regional Medical Program in a manner which will implement the program established by the Regional Advisory Group and in accordance with Federal regulations and policies. This shall include:

1. Initially designating a Regional Advisory Group in accordance and conformance with Section 903(b) (4) of the Act. Such designation includes selection of the Chairman until such time as the bylaws of the RAG have been approved by RMPS. (This is a responsibility of the applicant organization which requests planning support for the establishment of an RMP).

2. Confirming subsequent selection of RAG Chairmen.

3. Selecting the Chief Executive Officer on the basis of Regional Advisory Group nomination.

4. Receiving, administering, and accounting for funds on behalf of the Regional Medical Program.

5. Reviewing operational and other activities proposed for RMP funding with respect to:

   a. their eligibility for and conformance with RMPS and other Federal funding requirements,

b. capabilities of affiliates to manage grant funds properly.

6. Prescribing fiscal and administrative procedures designed to insure compliance with all Federal requirements and to safeguard the grantee against audit liabilities.

7. Negotiating provisional and/or final indirect cost rates for affiliates.

8. Providing to the RMP all those administrative and supportive services that are included in the grantee's indirect cost rate.

Chief Executive Officer

As an employee of the grantee, the Chief Executive Officer -- the full-time person with day-to-day responsibility for the management of the RMP -- is responsible to it; he is also responsible to the Regional Advisory Group which establishes program policy. His responsibilities include:

1. Providing day-to-day administrative direction for the program in accordance with the procedures established by the grantee and the program policies established by the Regional Advisory Group.

2. Providing adequate staff and other support to the Regional Advisory Group and its committees for effective functioning.

3. Developing the RMP staff organization, selecting program staff, and supervising their activities.

4. Insuring both the effectiveness of operational activities and integration of all operational and staff activities into a total program.

5. Monitoring grant-supported activities to insure that all Federal requirements are being complied with.

6. Establishing and maintaining an effective review process in accordance with RMPS requirements.

7. Maintaining appropriate relationships and liaison with RMPS, including Regional Office staff. This shall include the dissemination of Federal program policies and requirements to staff, Regional Advisory Group, and regional provider groups and institutions; site visit preparations; and communication of important developments within the Region and program to RMPS.

C. Regional Advisory Group

The Regional Advisory Group (or RAG) has the responsibility for setting the general direction of the RMP and formulating program policies, objectives, and priorities. More specifically, RAG responsibilities shall include:

1. Establishing goals and objectives for the Region's total program; setting priorities for both operational and staff activities; and evaluating overall program progress and accomplishments.

2. Approving any applications submitted to RMPS.

3. Approving the RMP organizational structure and significant program staff activities.

4. Approving overall budget policy and major budget allocations.

5. Nominating the Chief Executive Officer for selection by the grantee (see B.3 above).

6. Selecting the Chairman for confirmation by the grantee.

7. Subsequent to its establishment (see B.1 above), procedures for selecting its own members; insuring appropriate representation on the Regional Advisory Group in accordance with the Act, RMPS regulations, and guidelines; insuring its continuity; other than the Chairman, selecting its own officers; and establishing an executive committee from its own membership to act on its behalf between RAG meetings.

8. Developing, formally adopting, and periodically updating RAG bylaws which set forth duties, authorities, operating procedures, terms of office, categories of representation, method of selection, and frequency of meetings for the RAG and its committees.

9. Approving any delegations of authority, including those relative to specific budget allocations, to the Chief Executive Officer, its executive committee, and others.

APPROVED: National Advisory Council on Regional Medical Programs
June 5, 1972

APPENDIX 3

APPENDIX D

RMP REVIEW PROCESS REQUIREMENTS AND STANDARDS

This document sets forth the requirements governing the decentralization of project review and funding authority to Regional Medical Programs. That is, it defines those minimum standards which must be met by a Region for it 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 it. The document also outlines the general manner and schedule for implementation to be followed.

A. Requirements

The minimum requirements or standards that a Region's review process must meet if project review and funding authority is to be decentralized to it are grouped as follows:

- Review Criteria and Program Priorities
- Application
- Staff Assistance, Review, and Surveillance
- CHP Review and Comment
- Technical Review
- Project Ranking and Funding Determinations
- Feedback
- Appeal Procedures

1. Review Criteria and Program Priorities: There must be explicit (1) technical review criteria and (2) program priorities which are applied to all operational proposals. These criteria and program priorities must be made available to all prospective applicants and appropriate areawide CHP agencies within the Region as well as RMPS.

The review criteria must as a minimum reflect those factors considered in assessing the technical and intrinsic adequacy of operational proposals (e.g., the feasibility of the project, quality of the personnel and facilities, resources to be involved, and adequacy of the proposed evaluation). These criteria must in fact be used in the technical review process -- for example, those committees and other groups with substantive responsibilities for reviewing and making recommendations to the Regional Advisory Group as to the technical adequacy of operational proposals.

Program priorities should reflect regional needs and problems and appropriately complement RMPS and other national priorities. Put another way, those things which the Regional Medical Program and its

Regional Advisory Group have identified, and perhaps are actively promoting, that warrant particular and more immediate attention and thus have a special claim on their limited dollar and other resources. As such, the program priorities constitute a major factor taken into account in determining which regionally approved proposals (i.e., technically adequate) are to be funded. The final responsibility for funding determinations, and thus the application of these program priorities, must reside with the Regional Advisory Group.

2. Application: The Region must have a standardized application form or format (e.g., instructions and outline to be followed) that is employed by community hospitals, local medical societies, medical centers, and other applicants in requesting grant funds of it. It would be desirable if the review criteria and program priorities of the Region were an integral part of the application package sent to all prospective applicants.

3. Staff Assistance, Review and Surveillance: Core staffs must respond to preliminary applications and stand prepared to advise and assist all prospective applicants in a similar or equitable fashion.

It is suggested that core staffs prepare summaries of proposed projects for the technical review committees and Regional Advisory Group. Furthermore, where proposals have been substantively reviewed by core staff, these critiques should be provided to the technical review committees. Similarly, any suggested substantive changes in the proposal should be transmitted to applicants.

Periodic surveillance or monitoring of funded operational projects by core staff is required so as to insure that the original intent and purpose of such projects are being fulfilled and progress is satisfactory. One way in which this requirement might be satisfied would be to assign a core staff member this responsibility at the outset of a project and have him follow that project through to its completion. It also would be desirable if periodic progress reports on projects were made to the Regional Adviosry Group.

4. CHP Review and Comment: P.L. 91-515 provides that an RMP application may be approved at the Federal level only if recommended

by the Regional Advisory Group and only "if opportunity has been provided, prior to such recommendation, for consideration of the application by each public or nonprofit private agency or organization which has developed a comprehensive regional, metropolitan area or other local area plan referred to in Section 314(b) covering any area in which the regional medical program for which the application is made will be located."

As noted in the advice letter from the Director of RMPS to all coordinators, dated January 18, 1971, the agencies from which comments must be solicited include:

(1) Areawide Comprehensive Health Planning agencies receiving Federal assistance under Section 314(b) of the Public Health Service Act as amended ("B" agencies).

(2) Other organizations meeting the requirements of Section 314(b) and designated as areawide comprehensive health planning agencies by the appropriate State Comprehensive Health Planning Agency ("A" agency).

Furthermore each application to RMPS requesting grant Federal support must be accompanied by copies of any "B" agency comments received by the Region or in lieu of such comments, by a letter signed by the Chairman of the Regional Advisory Group certifying that the application or materials adequately describing the activities proposed in the application have been furnished to the appropriate "B" agency or agencies and that, after a period of thirty (30) days, no comments have been received. While the signature of the Chairman of the Regional Advisory Group on the application, among other things signifies that any comments received have been taken into consideration by that Group, it would be highly desirable if the application submitted to RMPS explicitly took cognizance of and spoke to any especially critical and/or negative "B" agency comments.

Material sent to "B" agencies for comment should describe RMP activities in sufficient detail to enable the "B" agency to make appropriate comments. It is suggested that such material,

(1) List or call attention to all health care facilities or institutions involved in the RMP activities described in the application.

(2) Indicate the amount of RMPS funds to be requested for each.

(3) Summarize any proposed steps to strengthen primary care through cooperative arrangements and regional linkages among health care institutions and providers.

(4) Identify any major therapeutic equipment to be acquired or constructed or major alteration or renovation of health care facilities to be undertaken in connection with proposed RMP activities.

Materials sent to "B" agencies for review and comment should encompass and include proposed core and developmental component activities as well as operational proposals. Information relating to core activities or a developmental component must be sent for comment to all "B" agencies serving the Region, in whole or in part. Information relating to projects whose impact is confined to a specific area within the region, need to be sent for comment only to those "B" agencies directly concerned.

5. Technical Review: Each Region must have, in addition to the legislatively required Regional Advisory Group, technical review committees or groups. These may be either standing committees or ad hoc groups; they may be subcommittees of the Regional Advisory Group itself, linked to it, or quite separate from it; and they may be single or multi-purpose groups (e.g., ad hoc review group, categorical planning and review committee). In short, Regions have considerable latitude as to how their technical review is structured.

The composition of these technical review committees, individually and collectively, must be such that the technical, scientific, and professional expertise represented adequately embraces the scope of its review function (e.g., cancer, manpower, research and evaluation). This may necessitate bringing in additional expertise, possibly from outside the Region, to provide adequate technical review of specific proposals from time to time.

It would be desirable if the selection process for technical review committees include nominations or suggestions from a variety of sources, including the Regional Advisory Group. It also is desirable that the composition of these committees reflect a broad spectrum of health interests and institutions, including private practitioners, community hospitals, and allied health personnel.

The manner in which members are chosen or appointed, procedures or practices governing the frequency and conduct of meetings, and the like must be in writing and have the concurrence of the Regional

Advisory Group. In addition to employing explicit review criteria, these committees should always have available to them and be guided by an RMPS requirements currently applicable.

Summaries of technical review committee findings and recommendations must be available to the Regional Advisory Group prior to their meeting at which the projects in question will be considered.

With respect to technical review committees, the Regional Advisory Group and any other groups taking actions on applications, situations involving a potential conflict of interest must be avoided in the regional review process as well as in the Federal review system. Thus, it is required that persons affiliated with an institution or project being considered, not be a part of the review process considering that application.

6. Project Ranking and Funding Determinations: Inherent in Anniversary Review is the requirement or need for Regions to establish a priority ordering or ranking system (in general) for all project applications for which support is requested. Since such ordering or ranking would by definition reflect the relative position of projects in relation to stated goals and priorities of the program, the system itself should incorporate regional needs and program objectives, priorities, and policies.

The specifics of such a project ordering or ranking system, however, are left to each Region to determine. Thus, it might provide for either an interval (e.g., 1-2-3-4-5) or ordinal (e.g., high-medium-low priority) ranking of projects, or some other suitable means for reflecting priorities.

The application of the system must be the responsibility of the Regional Advisory Group. Final determination must be made by it as to the relative or comparative priority ordering or ranking of approved projects and their eventual funding. It is anticipated that regional funding decisions (e.g., whether to fund, level of funding) generally would be guided by each Region's own project priorities.

7. Feedback: Each Region must have a formal feedback mechanism. Applicants and prospective project directors, whose proposals have been disapproved, should be given specific reasons why they have been disallowed in terms of technical adequacy and/or regional priorities.

Applicants generally should not have to wait more than four months between the time the application is entered into the RMP review process and RAG notification of its action. If a project is approved

with conditions, or has been modified as a result of the regional review, there should be evidence of acceptance of such conditions and/or modifications by the applicant organization and/or project director.

8. Appeal Procedure: A formal appeal mechanism must exist in any Region where a proposal may be disapproved by a body other than the Regional Advisory Group (e.g., an executive or steering committee, the board of trustees of a new corporation) without reference to the RAG in order to provide applicants with the option of appealing such adverse actions to the Advisory Group itself.

The levels of review, prior to RAG action, should be clearly outlined, including the method of appointing the membership of these groups and be made available at the time of site-visit or management assessment-visit. Copies of this procedure should also be made known to all applicants.

B. Scope

The regional review process must not only meet the minimum requirements or standards set for above, it also must encompass or embrace all operational proposals or projects, for project review and funding authority to be decentralized to the regional level. In addition, it should provide for general Regional Advisory Group consideration of and concurrence in the overall core activity, funding, and staffing as proposed. If there are major discrete components of core that share many characteristics of operational projects (e.g., disease registeries, library services, pilot or experimental training programs for new kinds of health personnel) it would be desirable if these were subject to the same kind of review process, including review for technical adequacy, as those clearly identified as operational proposals.

An exception to the decentralization of technical project review and funding authority to Regions are major kidney or renal disease projects -- for example, proposals for integrated dialysis-transplantation centers or programs or major constituent elements thereof such as tissue typing or organ procurement. All such proposed projects must continue to be submitted to RMPS for review at the national level of the adequacy of the local technical review accorded the proposal. This is in keeping with the recent action of the National Advisory Council based on the recommendations of the Ad Hoc Review Committee on Kidney Disease Grant Applications convened in January, 1971.

C. Documentation

The following documentation reflective of a Region's review process and structure must either be routinely submitted to RMPS as specified elsewhere (e.g., application) and/or be available for its review and examination:

- The review criteria and program priorities currently employed in determining the technical adequacy of proposals and their priority rankings respectively.
- The standard application form or format, and instructions being used.
- The comments submitted by areawide CHP (or "B") agencies.
- The current membership of technical review committees.
- The procedures or practices governing appointment to and the operations of these committees.
- The minutes, reports, or summaries of technical review committee and RAG meetings covering their deliberations and actions on proposals, including eventual funding determinations.
- Where appropriate, the established appeal procedure; and RAG minutes reflecting any appeal actions.
- Any other written materials, including general application review procedures, pertaining to the review of proposals, either generally or specifically, at the regional or local level.

D. Implementation

In this transition from national to regional review of projects, the assumption is being made that the review processes of all Regional Medical Programs presently meet the requirements set forth herein, or can be made to do so with certain minimum adaptations.

This assumption will be verified between now and December 31, 1972. In many cases this will necessitate a special staff visit to assess the regional review process subsequent to submission and examination of the documentation enumerated above in Part C. In some instances,

however, this assessment of the regional review process will be undertaken in conjunction with regular management assessment visits scheduled over the next twelve months.

It is anticipated that the verification process will find that most Regions do meet the requirements. For those Regions, if any, in which the assessment indicates this not to be the case, RMPS staff is prepared to provide such consultation and assistance as will permit or assist those individual Regional Medical Programs to meet the minimum standards prescribed.

Any Regional Medical Program which is not in substantial compliance with these minimum standards governing regional review processes by December 31, 1972, will forfeit its project review and funding authority. In addition, regions that are not in substantial compliance will not be eligible for a developmental component. Furthermore, non-compliance with these standards after December 31, 1972, will be brought to the attention of the National Advisory Council.