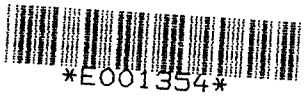
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ON REGIONAL MEDICAL PROGRAMS

August 1971

A SPECIAL REPORT TO THE NATIONAL ADVISORY COUNCIL
REGIONAL MEDICAL PROGRAMS SERVICE

The Fact Book was prepared by
the Office of Planning and Evaluation
with graphic assistance from the Office
of Communications and Public Information,
Regional Medical Programs Service.

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FACT BOOK ON REGIONAL MEDICAL PROGRAMS

A Special Report

to the National Advisory Council

of the Regional Medical Programs Service

August 1971

DEPARTMENT OF HEALTH EDUCATION AND WELFARE
Health Services and Mental Health Administration
Regional Medical Programs Service

PREFACE

"The American people have always shown a unique capacity to move toward common goals in varied ways... Our efforts to reform health care in America will be effective if they build on this strength."

President's Health Message
February 18, 1971

Regional Medical Programs are a pluralistic approach to dealing with our health problems. The Programs have developed a coalition of almost 15,000 health providers and interested consumers to plan and implement activities tailored to local needs and resources.

This Fact Book presents, in abbreviated fashion, how RMPs have organized this effort and the progress they have made. It is hoped that this publication will serve as a ready reference source for those interested in Regional Medical Program activities.

Harold Margulies

Harold Margulies, M.D.
Director
Regional Medical Programs Service

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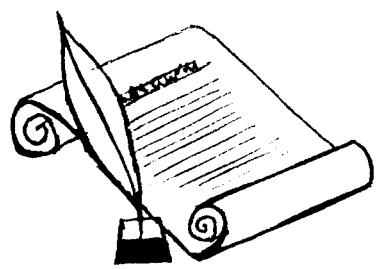


SECTION I

PURPOSE AND HISTORY OF REGIONAL MEDICAL PROGRAMS

This section highlights the purpose, legislative, administrative, and budgetary history of Regional Medical Programs.

PURPOSE OF REGIONAL MEDICAL PROGRAMS

The Regional Medical Programs seek to strengthen and improve the Nation's personal health care system in order to bring about more accessible, efficient, and high quality health care to the American public. To accomplish these ends, the RMPs promote and demonstrate among providers new techniques and innovative delivery patterns; support training which results in more effective utilization of health manpower; and encourage the regionalization of health facilities, manpower, and other resources.

The RMPs develop their programs through a consortium of providers who come together to plan and implement activities to meet health needs which cannot be met by individual practitioners, health professionals, hospitals, and other institutions acting alone. The RMP provides a framework 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.

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 nature and character of Regional Medical Programs. Though RMP continues to have a categorical emphasis, to be effective that emphasis frequently must be subsumed within or made subservient to broader and more comprehensive approaches. RMP must relate primary care to specialized care, affect manpower distribution and utilization, and generally improve the system for delivering comprehensive care.

Even in its more specific mission and objectives, RMP cannot function in isolation. 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, can the RMPs achieve their goals.

HIGHLIGHTS OF

LEGISLATIVE AND ADMINISTRATIVE HISTORY

OF REGIONAL MEDICAL PROGRAMS

1964 DECEMBER The Report of the President's Commission on Heart Disease, Cancer and Stroke presented 35 recommendations including development of regional complexes of medical facilities and resources.

1965 JANUARY Companion administration bills--S.596 and H.R. 3140--were introduced in the Senate by Senator Lister Hill (Ala.), and in the House by Representative Oren Harris (Ark.), giving concrete legislative form to presidential proposals.

OCTOBER P.L. 89-239, the Heart Disease, Cancer and Stroke Amendments of 1965, was signed. The Commission concepts of "regional medical complexes" and "coordinated arrangements" were replaced by "regional medical programs" and "cooperative arrangements," thus emphasizing voluntary linkages.

DECEMBER National Advisory Council on Regional Medical Programs met for the first time to advise on initial plans and policies.

1966 FEBRUARY Dr. Robert Q. Marston appointed first Director of the Division of Regional Medical Programs and Assoc. Director of NIH.

APRIL First planning grants approved by National Advisory Council.

1967 FEBRUARY First operational grants approved by National Advisory Council.

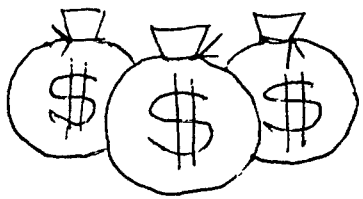
JUNE The Surgeon General submitted the Report on Regional Medical Programs to the President and the Congress, summarizing progress made and recommending its extension.

1968 MARCH Companion bills to extend Regional Medical Programs were introduced in the House by Harley O. Staggers (W.Va.) (H.R. 15758) and in the Senate by Senator Lister Hill (Ala.) (S. 3094).

OCTOBER P.L. 90-574, extending the Regional Medical Programs for two years,was signed. Changes were: include territories outside of the 50 States; permit funding of interregional activities; permit dentists to refer patients; and permit participation of Federal hospitals.

1970 JAN.-OCT. Bills extending RMP introduced; hearings held.

OCTOBER P.L. 91-515 was signed into law. New provisions: emphasis on primary care and regionalization of health care resources; added prevention and rehabilitation; added kidney disease; added authority for new construction; required review of RMP applications by Areawide Comprehensive Planning agencies; emphasized health services delivery and manpower utilization.

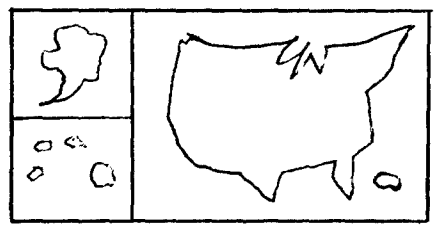


APPROPRIATIONS AND BUDGETARY HISTORY

(Dollars in Thousands)

	Fiscal year 1966	Fiscal year 1967	Fiscal year 1968	Fiscal year 1969	Fiscal year 1970	Fiscal year 1971
Authorization	$50,000	$90,000	$200,000	$65,000	$120,000	$125,000
Amount appropriated for grants	24,000	43,000	53,900	56,200	73,500	89,500
*Amount actually available for grants	24,000	43,934	48,900	72,365	78,500	70,298
Amount actually awarded for grants	2,066	27,052	43,635	72,365	78,202	70,298

* Includes unspent funds carried forward from previous year minus amounts held in reserve by the Office of Management and Budget.

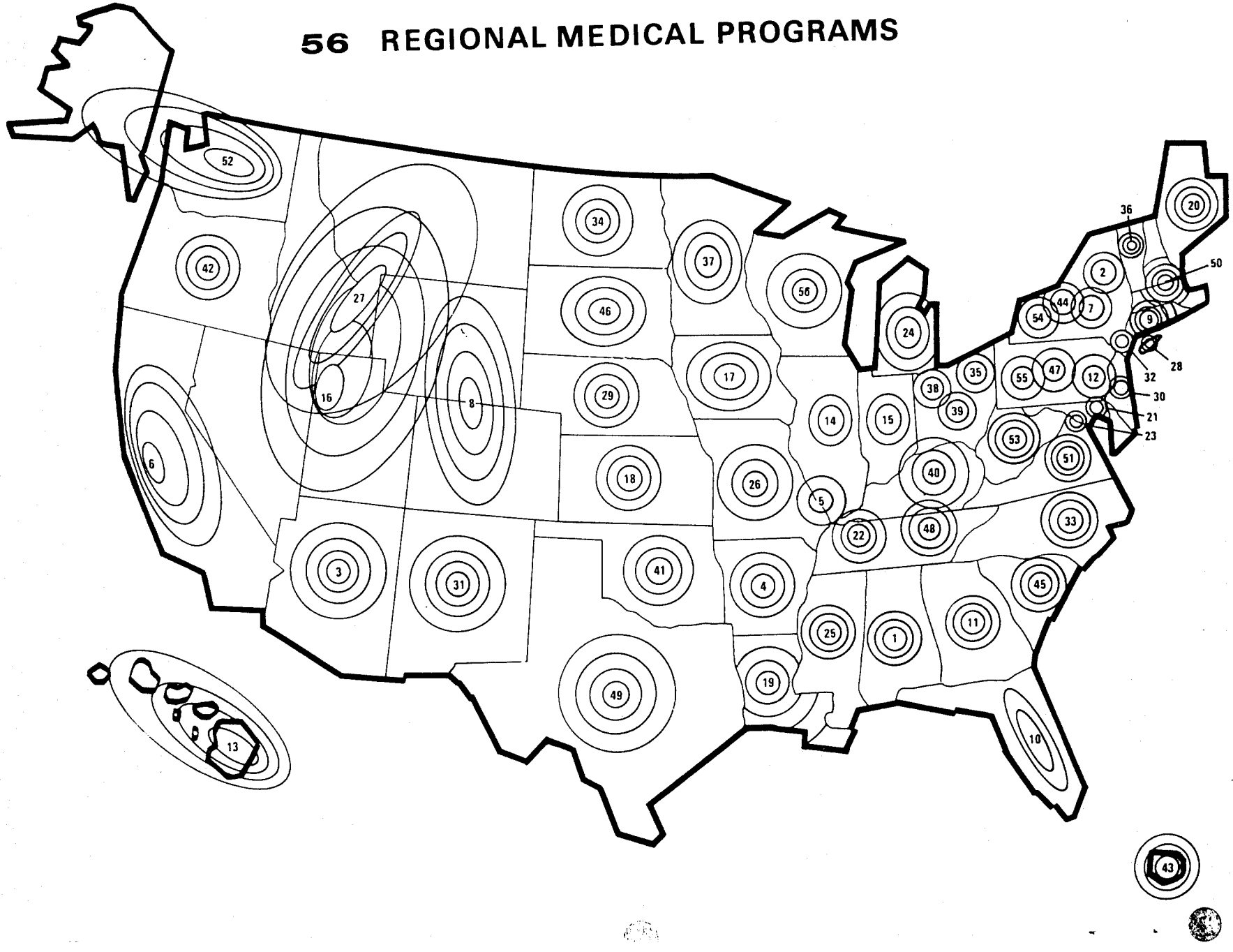


SECTION II

WHAT ARE THE CHARACTERISTICS OF REGIONAL MEDICAL PROGRAMS?

This section provides a brief overview of the 56 Regional Medical Programs, including their geographic boundaries, population ranges, land size, operational status, and ranges of current funding levels.

56 REGIONAL MEDICAL PROGRAMS



THE 56 REGIONAL MEDICAL PROGRAMS BY GEOGRAPHIC AREA COVERED

1. ALABAMA REGION - Covering the entire State of Alabama.

2. ALBANY REGION - Including 21 Northeastern New York counties centered around Albany and contiguous portions of Southern Vermont and Berkshire County in Western Massachusetts.

3. ARIZONA REGION - Covering the entire State of Arizona.

4. ARKANSAS REGION - Covering the entire State of Arkansas.

5. BI-STATE REGION - Including Southern Illinois counties and Eastern Missouri centered around St. Louis metropolitan area.

6. CALIFORNIA REGION - Covering the entire State of California and interface with Reno-Sparks and Clark County (Las Vegas), Nevada.

7. CENTRAL NEW YORK REGION - Including 15 Central New York counties centered around Syracuse, New York and Bradford and Susquehanna counties in Pennsylvania.

8. COLORADO-WYOMING REGION - Covering the entire States of Colorado and Wyoming.

9. CONNECTICUT REGION - Covering the entire State of Connecticut.

10. FLORIDA REGION - Covering the entire State of Florida.

11. GEORGIA REGION - Covering the entire State of Georgia.

12. GREATER DELAWARE VALLEY REGION - Including Southeastern Pennsylvania, (Philadelphia-Camden), Northeastern Pennsylvania (Wilkes Barre-Scranton) and the southern part of New Jersey, and the entire State of Delaware.

13. HAWAII REGION - Including the entire State of Hawaii, plus American Samoa, Guam, and the Trust Territory of the Pacific Islands (Micronesia).

14. ILLINOIS REGION - Covering the entire State of Illinois.

15. INDIANA REGION - Covering the entire State of Indiana.

16. INTERMOUNTAIN REGION - Including the entire State of Utah, and portions of Wyoming, Nevada, Montana, Idaho and Colorado.

17. IOWA REGION - Covering the entire State of Iowa.

18. KANSAS REGION - Covering the entire State of Kansas.

19. LOUISIANA REGION - Covering the entire State of Louisiana.

20. MAINE REGION - Covering the entire State of Maine.

21. MARYLAND REGION - Including most of the State of Maryland, (except Montgomery and Prince Georges Counties) and York County in Pennsylvania.

22. MEMPHIS REGION - Including Western Tennessee centered around Memphis, Northern Mississippi, Eastern Arkansas and portions of Southwestern Kentucky, and three counties in Southwestern Missouri.

23. METROPOLITAN WASHINGTON, D.C. REGION - Including the District of Columbia and contiguous counties in Maryland and Virginia.

24. MICHIGAN REGION - Covering the entire State of Michigan.

25. MISSISSIPPI REGION - Covering the entire State of Mississippi.

26. MISSOURI REGION - Including the State of Missouri, exclusive of the Metropolitan St. Louis area.

27. MOUNTAIN STATES REGION - Including the States of Idaho, Montana, Nevada and Wyoming.

28. NASSAU-SUFFOLK REGION - Including the counties of Nassau and Suffolk (Long Island) of the State of New York.

29. NEBRASKA REGION - Covering the entire State of Nebraska.

30. NEW JERSEY REGION - Covering the entire State of New Jersey.

31. NEW MEXICO REGION - Covering the entire State of New Mexico.

32. NEW YORK METROPOLITAN REGION - Including New York City and Westchester, Rockland, Orange and Putnam Counties, New York.

33. NORTH CAROLINA REGION - Covering the entire State of North Carolina.

34. NORTH DAKOTA REGION - Covering the entire State of North Dakota.

35. NORTHEAST OHIO REGION - Including 12 counties in Northeast Ohio, centered around Cleveland.

36. NORTHERN NEW ENGLAND REGION - Including the entire State of Vermont and three contiguous counties in Northeastern New York.

37. NORTHLANDS REGION - Covering the entire State of Minnesota.

38. NORTHWESTERN OHIO REGION - Including 20 counties in Northwestern Ohio, centered around Toledo.

39. OHIO STATE REGION - Including 61 counties in central and southern two-thirds of the State of Ohio, excluding Metropolitan Cincinnati areas and Dayton.

40. OHIO VALLEY REGION - Including the greater part of Kentucky (101 of 120 counties), Southwest Ohio, (Cincinnati-Dayton and adjacent areas), contiguous parts of Indiana (21 counties) and West Virginia (2 counties).

41. OKLAHOMA REGION - Covering the entire State of Oklahoma.

42. OREGON REGION - Covering the entire State of Oregon.

43. PUERTO RICO REGION - Covering Commonwealth of Puerto Rico, and the Virgin Islands.

44. ROCHESTER REGION - Including 10 counties centered around Rochester, New York and interface with 3 Northeast Pennsylvania border counties.

45. SOUTH CAROLINA REGION - Covering the entire State of South Carolina.

46. SOUTH DAKOTA REGION - Covering the entire State of South Dakota.

47. SUSQUEHANNA VALLEY REGION - Including 27 counties in Central Pennsylvania, centered around the Harrisburg-Hershey areas.

48. TENNESSEE MID-SOUTH REGION - Including 84 of 94 counties covering the central and eastern sections of Tennessee, Southwestern Kentucky and 3 contiguous Alabama counties.

49. TEXAS REGION - Covering the entire State of Texas.

50. TRI-STATE REGION - Covering the entire States of Massachusetts, New Hampshire and Rhode Island.

51. VIRGINIA REGION - Covering the State of Virginia, except for the Northern counties and cities of Alexandria, Arlington and Falls Church.

52. WASHINGTON/ALASKA REGION - Covering the entire States of Washington and Alaska.

53. WEST VIRGINIA REGION- Covering the State of West Virginia.

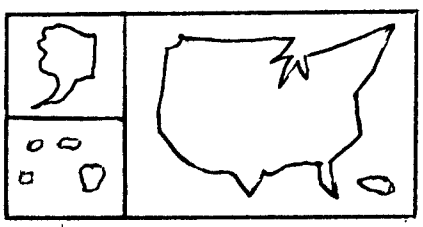
54. WESTERN NEW YORK REGION - Including 7 Western New York counties centered around Buffalo, and the counties of Erie and McKean, Pennsylvania.

55. WESTERN PENNSYLVANIA REGION - Including 28 counties in Western Pennsylvania, centered around Pittsburgh.

56. WISCONSIN REGION - Covering the entire State of Wisconsin.

DEMOGRAPHIC FACTS

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



* LARGEST REGION

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

* SMALLEST REGION

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

* GEOGRAPHIC BOUNDARIES: Number of Regions which

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

* POPULATION: Number of Regions which have

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

CHARACTERISTICS

* FUNDING LEVELS: Regions vary from

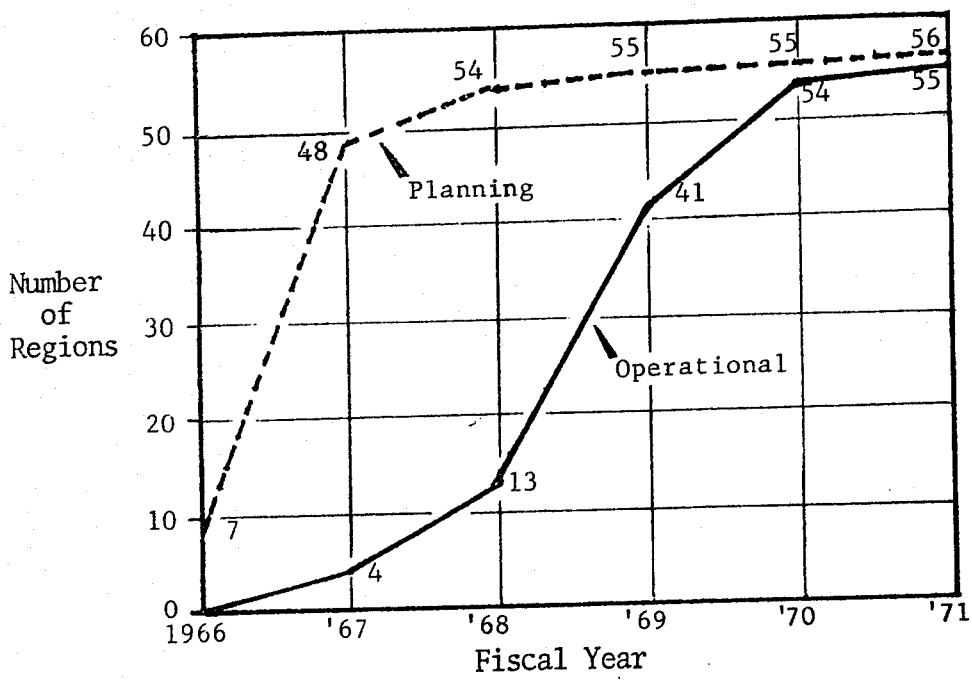
  . Highest: California ($8.3 million)
  . Lowest: North Dakota ($309,000)

* FUNDING LEVEL RANGES: Regions with

. Less than $500,000	5
. $500,000 to $999,000	16
. $1 million to $1.4	15
. $1.5 million to $1.9	10
. $2 million to $2.4	6
. More than $2.5 million	4

* MEDIAN LEVEL: $1.2 million

WHEN REGIONS RECEIVED INITIAL PLANNING AND OPERATIONAL GRANTS



Highlights:

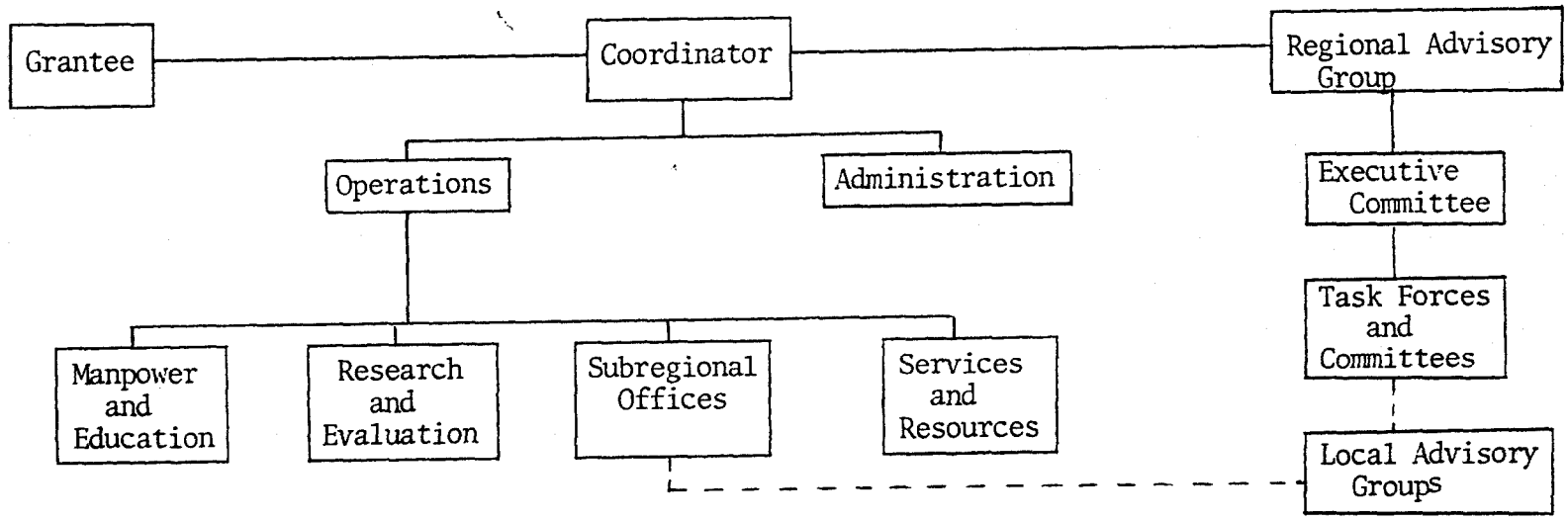
. To date, only one RMP has not yet received its first operational grant -- South Dakota. This is because it received its first planning grant in FY '71.
. By the end of FY '67, 48 of the current 56 RMPs had received their initial planning grant.
. On the other hand, it was not until the end of FY '69 that most (41) Regions received their first operational grants.

SECTION III

HOW ARE REGIONAL MEDICAL PROGRAMS ORGANIZED?

This section highlights the organizational structure of the RMPs, including the composition and function of Regional Advisory Groups, task forces, committees and staffs. Summarized also are overall changes which have occurred in these groups over the past five years, and minority representation.

EXAMPLE OF THE ORGANIZATIONAL STRUCTURE OF A REGIONAL MEDICAL PROGRAM



ORGANIZATION

GRANTEES AND COORDINATING HEADQUARTERS

* PURPOSE: Each Regional Medical Program is fiscally administered by a grantee which may be a public or private non-profit institution, agency or corporation. The grantee is responsible for fiscal control and fund accounting procedures to assure proper disbursement of and accounting for such RMP funds. A coordinating headquarters may be described as being responsible for the implementation, administration and coordination of a Regional Medical Program. As such, it is involved in the development of regional objectives as well as review, guidance and evaluation of the ongoing planning and operating functions.

Grantee and Coordinating Headquarters, Fiscal Year 1971

Grantee	56	Coordinating Headquarters	56
Universities	34		31
Public	(27)		(25)
Private	(7)		(6)
Other	22		25
New Agency/ Corporations	(15)		(18)
Existing Corporations	(3)		(3)
Medical Societies	(4)		(4)

Comment:

. In some RMPs, the grantee differs from the coordinating headquarters. For example in the North Carolina RMP, the grantee is Duke University, but the coordinating headquarters is the non-incorporated agency--the North Carolina Association for Regional Medical Programs.

ORGANIZATION

REGIONAL ADVISORY GROUPS

* PURPOSE: Regional Advisory Groups reflect a broad spectrum of health interests and institutions, including private practitioners, community hospitals, allied health personnel, and consumer representation. They have as their primary function overall program guidance - that is, determination of the overall scope, nature and direction of the program. Each Regional Advisory Group must determine policies, establish criteria and priorities, allocate RMP grant funds accordingly and review operational projects.

* SIZE:

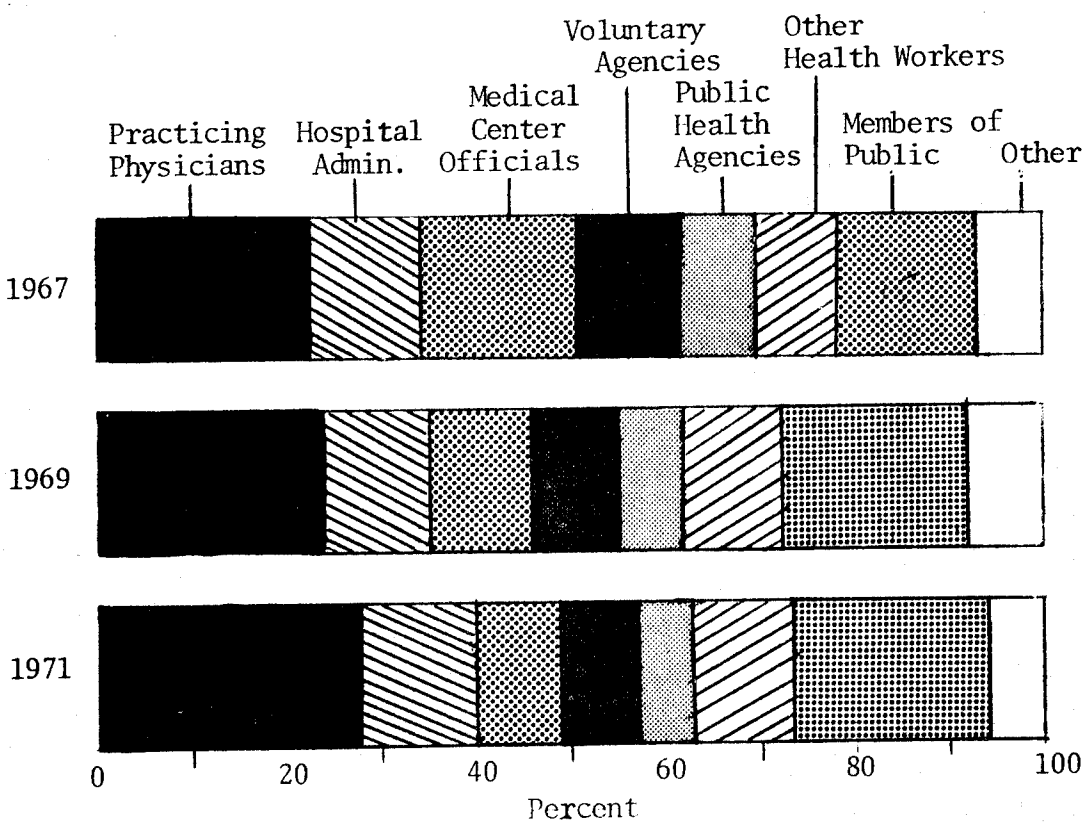
. 1967	1,600	total membership
	30	average group size
. 1969	2,500	total membership
	45	average group size
. 1970	2,700	total membership
	48	average group size
. 1971	2,743	total membership
	49	average group size

Ranges in Size of RAGs--1971

10- 19 members:	3 RAGs
20- 29 members:	11 RAGs
30- 59 members:	34 RAGs
60- 99 members:	5 RAGs
100-199 members:	2 RAGs
over 200 members:	1 RAG

ORGANIZATION

Composition of Regional Advisory Groups
Fiscal Years 1967, 1969, 1971



Highlights:

- Practicing physician representation has increased considerably from 23% to 28%.
- Medical center officials have decreased markedly, from 16% to 8%.
- Voluntary agencies and public health representation has decreased.
- Increase in members of the public from 15% to 21% reflects more consumer involvement in RMPs.

ORGANIZATION

EXECUTIVE COMMITTEES

* PURPOSE: Executive Committees are appointed by the Regional Advisory Group to provide advice and counsel to the RAG and serve as the day-to-day advisor to the RMP coordinator and core staff. They also act in the stead of the RAGs except on final project or policy decisions.

* COMPOSITION:

Comparison of Membership for 1969 and 1971

Professional Category	Number (1969)	Number (1971)	Percent (1969)	Percent (1971)
Physicians	284	266	67%	58%
Nurses	18	16	4%	4%
Allied Health	56	50	13%	11%
Other	67	127	16%	27%
TOTAL	425	459	100%	100%

Highlights:

- The decline in the actual number and percentage of physician membership has been countered by an increase in "Other," from 67 to 127, or 16% to 27%.
- The increase in "Other" reflects more hospital and nursing home administrators, members of the public and others.
- Nursing representation has remained stable.

ORGANIZATION

TASK FORCES AND COMMITTEES

* PURPOSE: Task Forces and Committees have major responsibilities for project development and/or review of projects. Nearly all of them assist in the establishment of objectives and priorities for program activities. They perform a great deal of the coordination and liaison in fostering cooperative arrangements among institutions, organization and various interest groups.

* NUMBER AND SIZE:

  . 1969: 492 Committees in 54 Regions: 5320 Total membership
  . 1971: 410 Committees in 55 Regions: 6379 Total membership

* COMPOSITION:

Comparison of 1969 and 1971

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

Highlights:

. Total membership has increased 20%

. Physicians show a 6% decline while "other" category, which includes members of the public, hospital administrators and others, has increased 6%.

ORGANIZATION

Comparison of Task Forces and Committees 1969 and 1971

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

Highlights:

- Number of Task Forces and Committees has declined from 492 to 410 or about 20%.
- Categorical Disease Committees have decreased while planning/evaluation, continuing education and manpower committees have increased.
- The significant increase of manpower committees clearly indicates that RMPs are departing from traditional approaches and are now concerned with the development of approaches to overcome the existing health manpower crisis.
- The significant number of other committees include health maintenance organizations, experimental health delivery systems, finance, legislation committees, etc.
- 39 Regions have Heart committees; 36 Regions have Cancer committees; 35 Regions have Stroke committees.

ORGANIZATION

LOCAL AND AREA ADVISORY GROUPS

* PURPOSE: Assist in project development and implementation to meet community needs and to strengthen relationships among local institutions, organizations and with the medical center. They are generally organized on the basis of population or medical trade areas. Some are organized according to hospital areas and to local medical schools. Some local area and advisory groups do cooperative planning and coordination with Comprehensive Health Planning 314 "b" agencies. They are often the site for coordination of efforts between RMP regions where they intersect locally.

* COMPOSITION:

Comparison of 1969 and 1971

By Profession	Percent 1969	1971
Physicians	41%	42%
Nurses	9%	11%
Allied Health	19%	15%
Other	31%	31%
TOTAL PEOPLE	4,843	6,047

Highlights

- Total membership has increased from 4,843 to 6,047 or about 25%.
- Nursing representation has increased slightly which has been offset by a slight decrease in allied health representation.
- "Other" which includes hospital administration, nursing home administrators, and members of the public has remained unchanged.

ORGANIZATION

CORE STAFF

* FUNCTIONS: The people who serve on the core staffs provide services in the following areas...

- Project Development, Review and Management - Staff members assist organizational sponsors in developing and conducting educational and patient service activities, process grant requests, support technical review groups, and monitor discrete projects.

- Professional Consultation, Community Relations and Liaison - Staff provides consultation (unrelated to specific projects) to hospitals, Model Cities agencies, community colleges and other agencies; facilitates the development of cooperative relationships among medical schools, professional societies and other groups; develops or works with community or sub-regional groups to identify health needs and plan programs.

- Program Direction and Administration - Provide overall direction and coordination of the program, policy development, evaluation, financial management, communication and information activities, routine statistical reporting, and project coordination.

- Planning Studies and Inventories - Conducts ad hoc or periodic studies designed to help determine objectives, needs, and priorities. These include manpower distribution studies, incidence of disease studies, etc.

- Feasibility Studies - Conduct activities being tested for a specific trial period to determine if larger scale, long term or permanent operations are desirable.

- Central Regional Services - Provides a centralized service such as selected library services, data banks, dial access, systems, etc.

- Other - This section includes any other core staff activities not previously mentioned, such as helping to develop health maintenance organizations, conducting conferences and seminars, etc.

ORGANIZATION

CORE STAFF

* DISTRIBUTION OF CORE STAFF EFFORT BY FUNCTION

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

---

* COMPOSITION:

Professional Breakdown (1969 and 1971)
(Full-time Equivalent, FTE)

	June 1969		June 1971	
	No. FTE	Percent	No. FTE	Percent
Physicians	226	15%	230	14%
Registered Nurses	53	3%	66	4%
Allied Health	45	3%	33	2%
Social Scientists -- Planners & Evaluators	120	8%	164	10%
Business & Public Administration	60	4%	82	5%
Other Professional/ Technical	528	34%	540	33%
Secretarial & Clerical	514	33%	525	32%
TOTAL	1,546	100%	1,640	100%

Highlights:

- The number of full-time equivalent core staff members has increased by 6% over the past two years.
- The professional make-up of core staff has remained fairly constant with the most significant change being in the social scientists category (8% - 10% in 1971).

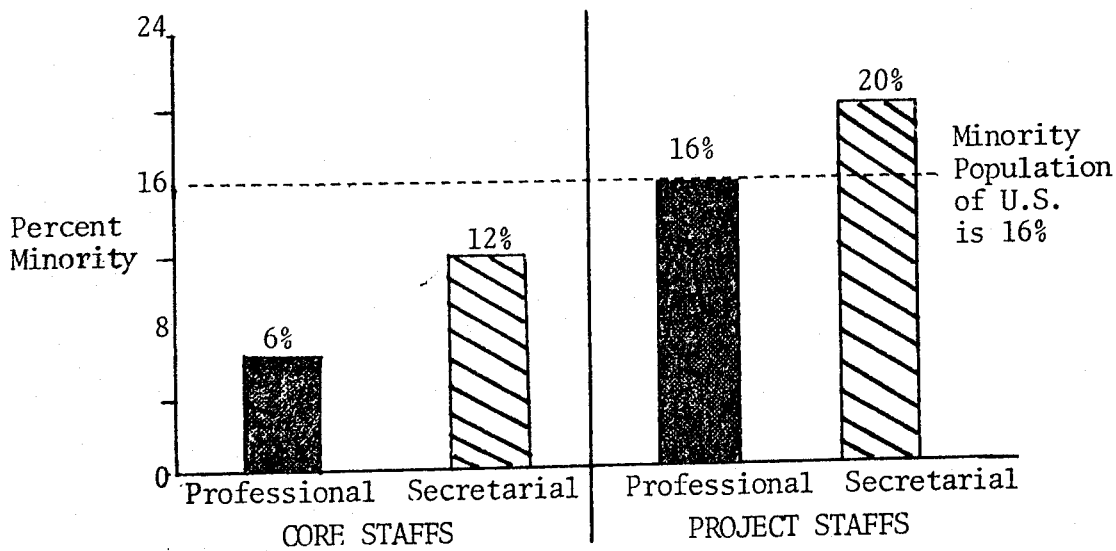
MINORITY REPRESENTATION

Appropriate participation of minority groups at all levels of RMP planning, decision-making and implementation is requisite to responsive relevant program development. Data below reflects minority representation on core and project staffs, RAGs, and committees.

* MINORITIES:

Defined as Blacks, Spanish surname, American Indians, Orientals, and Others (Asian Indians, Polynesians, etc.), with the preponderance being in the first four categories. According to the 1970 Census, 12% of the total U.S. population is classified as Black or Other. However, the Other category does not include Spanish surname. Therefore, by extrapolating from the 1969 Census data on persons of Spanish origin, one arrives at an estimated 16% of the population being minorities as defined above.

Minority Representation on Core and Project Staffs (Full-Time Equivalents), 1971

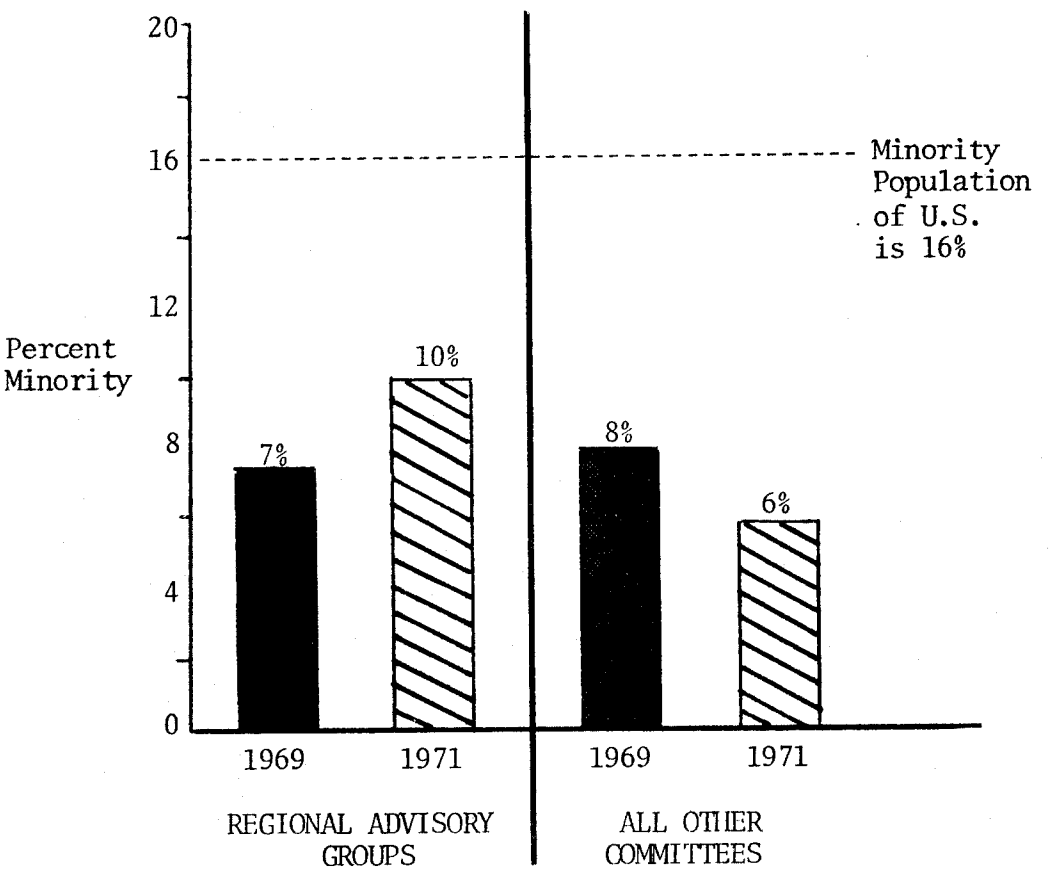


Highlights:

- Only 9% of the total 1,640 FTE core staff are minorities; 17% of the 2,440 FTE project staff are minorities.

- In terms of actual people (i.e., full and part-time personnel) the percentage of minorities is less in all categories, ranging from 1% fewer core professionals to 3% fewer project professionals. In other words, minorities are more likely to be full-time personnel.

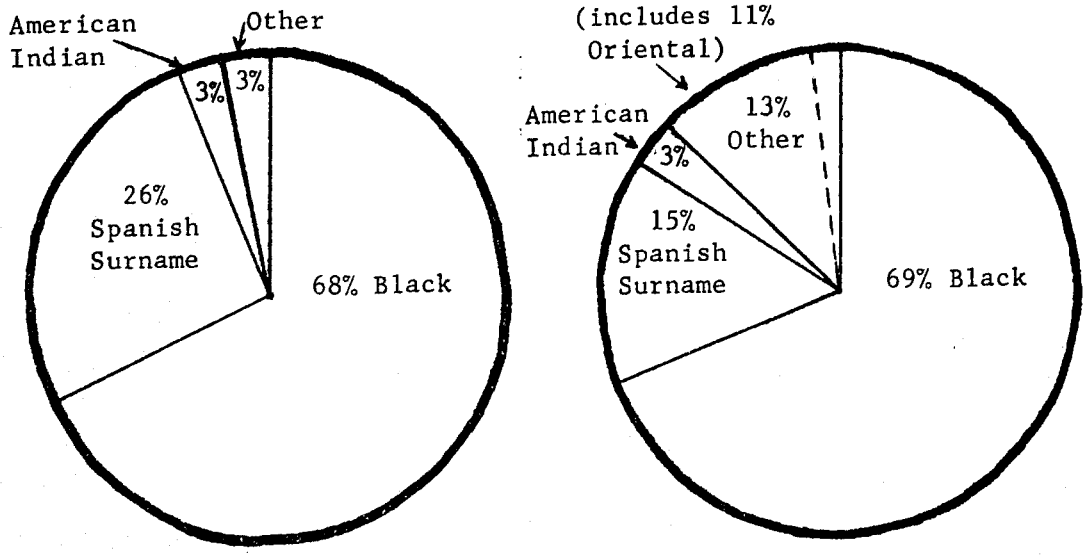
Minority Representation on Regional Advisory Groups and Other Committees of Regional Medical Programs
1969 and 1971



Highlights:

- The minority representation on RAGs has increased by 3% to 10% of the 2,700 membership, but is still 6% shy of being representative of the nation.
- On the other hand, minority percentage on Other Committees has decreased by 2%, to a low of 6% of the total 12,000 membership.

Comparative Distribution of Estimated National Minorities and RMP Minorities, 1971



Estimated National Distribution

RMP Distribution

Highlight: The comparative distribution is relatively consistent (surprisingly so in the case of Blacks) with one exception -- the Spanish surnames are under-represented.

Female Participation in Regional Medical Programs (Full-Time Equivalents) 1971

HIGHLIGHTS:

- There are over 6,000 females involved in Regional Medical Programs.
- A majority (54%) of the professional project personnel are women.
- Only 14% of Regional Advisory Group members are females.
- 31% of professional core staff personnel are women.
- 98% of core and project secretarial staffs are females.

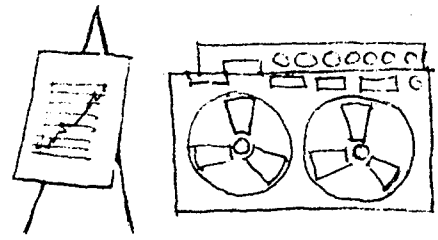
SECTION IV

WHAT DO REGIONAL MEDICAL PROGRAMS DO? --

PROGRAM ACTIVITIES

This section outlines the kinds of activities carried out by the Programs, including how and what they *PLAN*, *IMPLEMENT*, and *EVALUATE*. It describes areas of special emphasis and new program developments as well as the relationship of the RMPs to health and health-related agencies and programs, particularly to other federally-supported programs.

PROGRAM ACTIVITIES



PROGRAM PLANNING

* ASSESSMENT OF NEEDS AND RESOURCES: The initial step in planning for Regional Medical Programs is the identification of regional health needs and resources. For most RMPs, this is a two-pronged approach: one , the development of health committees and task forces to assist in identifying, in a consensus manner, what the needs are, and where they exist. The other is the collection of pertinent data to determine the extent of the problems and the resources available for use in their solutions. During 1970 and 1971 the RMPs carried out nearly 400 such data collection activities in the following areas:

Area of 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

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* SETTING OF PROGRAM PRIORITIES: Another step in planning is setting Program Priorities -- those locally identified health needs which Regional Medical Programs have determined to be of the greatest urgency locally. The setting of priorities (usually done by the Regional Advisory Group) ideally enables the RMP to review activity proposals and allocate funds in accordance with the Region's most pressing needs. To date 45 of the 56 Regions have formally set priorities. Of the 45 RMPs, about 5 named priorities so broad they might easily be mistaken for goals; another 30 presented listings which, while they included some specific areas of need, were for the most part a vast expanse of comprehensive issues ranging from "organization and delivery of care" to "heart disease, cancer, and stroke"; only about 10 Regions reported definitive, specific priority areas.

PROGRAM ACTIVITIES...*PLANNING PRIORITIES*

The priorities which have been set by the 45 RMPs relate generally to three broad areas: *health care organization and systems*, *health professionals*, and *patient services and target groups*.

Highlights:

- Virtually all of the 45 Regions named education or manpower as a major regional need.
- One-third identified disease prevention and early detection.
- 20 identified health care for the poor.
- 7 specified urban health, while 10 named rural health.

Summary of Priorities

Health Care Organization and Systems

- 16 RMPs named organization and delivery of care; 5 of these specified new and innovative models for organization and delivery.*
- 12 RMPs named availability, accessibility, and quality of care.
- 10 RMPs named health needs and resources assessment.
- 6 RMPs named coordination of existing resources and distribution of services.*
- 5 RMPs named ambulatory care.*
- 5 RMPs named efficiency of health care organization and systems; 4 of these specified health care costs and financing.
- 3 RMPs named specialized and long-term care.

Health Professionals

- 33 RMPs named continuing education and training.*
- 29 RMPs named manpower development, utilization, and distribution.*
- 4 RMPs named increasing provider efficiency.*

* These have also been named as HSMHA priorities for RMP.

- 2 RMPs named communication and coordination among provider groups.
- 2 RMPs named education and career mobility for allied health personnel.

Patient Services and Target Populations

- 20 RMPs named health care delivery for disadvantaged groups*; 7 of these specified urban populations; 10 specified rural populations; 2 named particular minority groups.
- 14 RMPs named disease prevention and early detection.*
- 11 RMPs named public information and education.
- 5 RMPs named rehabilitation.
- 3 RMPs named consumer participation in health planning.
- 3 RMPs named infant and child health.*
- 2 RMPs named health care for migrant workers.
- 2 RMPs named emergency services.

* These have also been named as HSMHA priorities for RMP.

PROGRAM ACTIVITIES

PROGRAM IMPLEMENTATION

Program implementation follows planning efforts. Once the needs have been identified and the goals and priorities have been set, activities to meet these needs are designed and conducted. These activities may be described in a number of ways, including (1) functional emphasis or primary purpose, e.g., education, patient care, etc., (2) health care emphasis, e.g., prevention, rehabilitation, and (3) disease emphasis. The following sections highlight what the RMPs are doing in terms of these three areas including areas of high priority and special emphasis, such as special manpower programs, programs for urban and rural poor, and others.

* FUNCTIONAL EMPHASIS: What the RMPs do to implement their programs is in five major functional areas:

  General continuing education--those activities concerned with maintaining or improving the level of practice of health personnel through improved skills or increased knowledge. This includes such activities as seminars and conferences for physicians, nurse training in patient management, dial-access, consultation, etc.

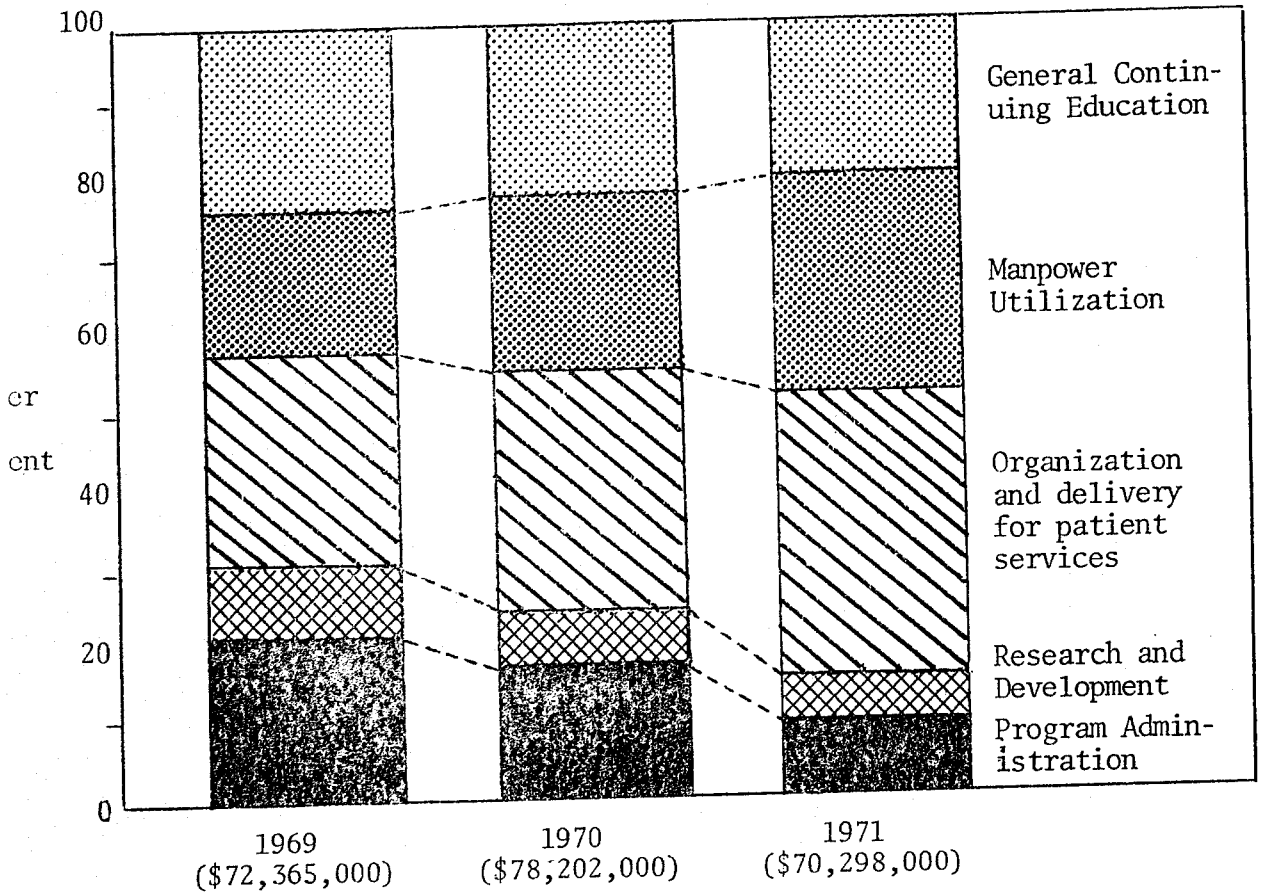
  Manpower utilization and training--activities aimed at improving the distribution, development and utilization of health personnel. This function includes training in new skills, training new categories of personnel, curriculum development, and other areas.

  Organization and delivery for patient services--these activities relate directly to patient care delivery through demonstrations of new techniques, development and demonstration of organizational models for delivery, and improving coordination of patient services.

  Research and development--activities which emphasize the testing or investigation of prototypes for new systems, processes, techniques, etc.

  Program coordination and administration--overall RMP direction and coordination, including policy development, evaluation activities, program coordination, community liaison, and interrelationships of health institutions providing multiple levels of care.

Functional Emphasis, 1969-71



Highlights

- Research and development activities have taken on less significance due, in part, to the fact that the new emphasis is on methods for the actual delivery of patient care.

- RMPs are still devoting a large portion of their resources to patient care, but the emphasis within this category has shifted to the newer concepts of organization and systems for the delivery of patient services particularly for primary care.

- Since 1969, manpower activities and studies have shown a steady increase, with a proportionate decrease in general continuing education activities. The trend in Regional Medical Programs today is toward activities concerned with better utilization of personnel and improving manpower distribution rather than only education to increase medical knowledge and expertise.

PROGRAM ACTIVITIES ... *IMPLEMENTATION*

* HEALTH CARE EMPHASIS: RMPs are supporting training, delivery, and coordination of:

  Screening and early detection programs such as cervical cancer, new stroke detection techniques;

  Demonstration treatment and diagnostic services programs such as in kidney dialysis and laboratory services;

  Stroke and other more comprehensive rehabilitation programs, often using the health team approach; and

  Demonstration comprehensive care programs, such as complete hypertension management.

  All such activities are coordinated with other support services to promote continuous, comprehensive care.

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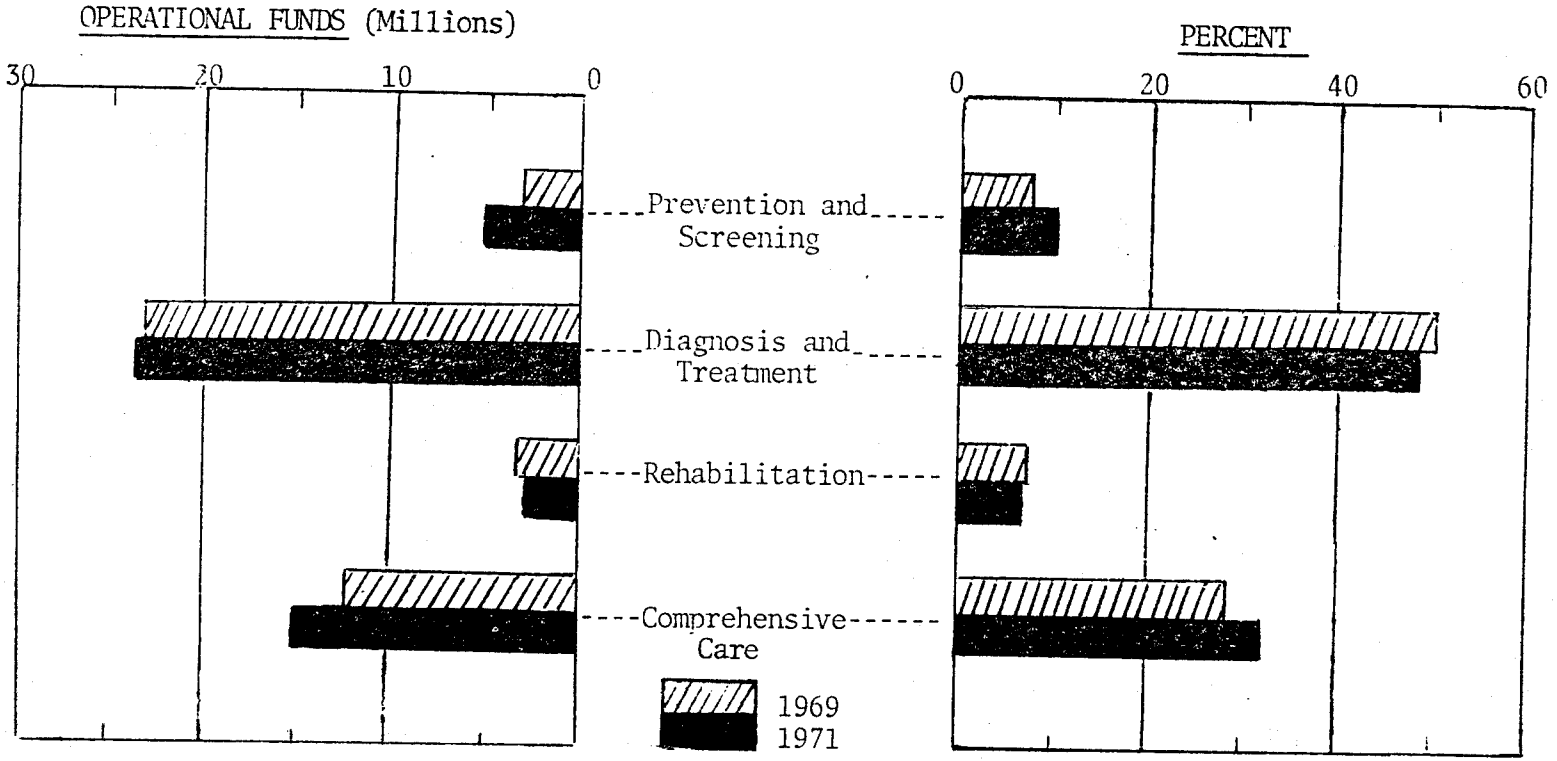
* DISEASE EMPHASIS: The disease focus of program activities has shifted since the first few years of RMP implementation. Most Programs are moving in favor of a broader approach to health problems and are supporting less heart disease and more cancer and kidney disease:

Disease Category	Comparison Percent of Funds	
	1968	1971
Heart disease	35%	26%
Cancer	9%	13%
Stroke	12%	12%
Kidney disease	--	4%
Related diseases	8%	6%
Multicategorical and non-specific	36%	38%

Health Care Emphasis Comparison 1969-1971



Highlights

- The funding emphasis on prevention and early detection activities has increased by 3% over the two-year period. This is in line with national and regional priorities.
- Comprehensive programs have also gained significance; the proportion of dollars in this activity has increased by about 4%.
- Activities concerned with diagnosis and treatment are still the largest portion of the health care picture, but have shown a steady decrease during this period.

EXAMPLES OF HEALTH CARE ACTIVITIES

- To improve manpower utilization and capability and to coordinate the delivery of health services:

  Confederation of Coronary Care Units -- California: This activity covers 11 counties in northwestern California with a population of over 3 million. Sponsored by the University of California, San Francisco Medical Center, the activity assists hospitals in designing coronary care units; provides the necessary training for their operation; and coordinates the delivery of coronary services. The program is multifaceted, including components of data collection systems, coronary care nurse training, advanced cardiac nurse training, coronary care teaching for nurse educators and practitioners, electronics consultation, one-week physician preceptorships, physician consultation, and a library for unit directors.

- To improve the organization for delivering services and upgrading quality:

  "Acute Stroke Management Demonstration Project in a Community Hospital" -- South Carolina: This project involves a coordinated team approach to stroke management, and attempts to encourage additional stroke programs in the Region. The stroke team consists of stroke nurses, a speech therapist, a discharge planner, and a public health nurse, coordinated by the two physicians who direct the project.

- To expand manpower availability and utilization in ghetto areas:

  Model City Health Manpower Education and Recruitment Program -- Kansas: This activity raises the level of knowledge and understanding among Kansas City, Kansas model neighborhood residents about good health practices, and provides a means of their entry into health professions as health aides. At the same time, it helps to ease the health manpower shortage and access problems prevalent in the area. Under supervision of a health coordinator, health aides are involved in classroom instruction on community health, practicum activities, and participate in supervised activities involving communication with and teaching of other residents in need of education or services.

AREAS OF SPECIAL EMPHASIS

The problems of accessible, available, high quality health services, particularly in deprived urban and rural areas, are of increasing concern to the RMPs and they are addressing these problems through a variety of avenues, including:

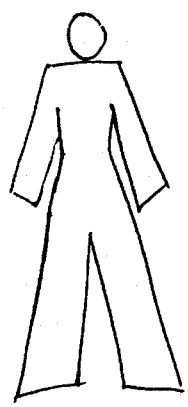
(a) Programs to improve manpower distribution, utilization and development

(b) More emphasis on ambulatory care programs, including activities linked to neighborhood health centers, out-patient clinics, home health programs and the like; and

(c) Training and other programs to increase the availability and utilization of health services by ghetto and rural residents and to heighten their involvement in the delivery of services.

* HEALTH MANPOWER

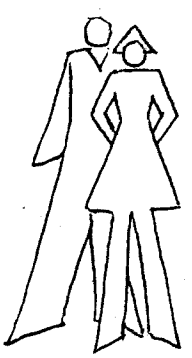
Approximately one-third of RMP funds support activities to improve health manpower utilization and development. These include training programs (1) to expand the duties of existing health personnel; (2) to develop new health manpower personnel; (3) to study distribution and utilization; and programs to retrain and improve manpower availability.



In particular, regions have:	Number of Regions
. Established Health Manpower as Priority	29
. Established Health Manpower Committees	27
. Designated Core Staff Member for Manpower	17
. Designated Core Staff Representative on CHP or State Manpower Council	12

Regions have also coordinated:	Number of Regions
. Health Manpower Inventories or Feasibility Studies	17
. Health Manpower Legislation	10
. Physician Assistant/Nurse Practitioner Development	29
. Health Manpower Recruitment and Retraining	23

Examples of Manpower Activities



- Several RMPs are helping to train nurse practitioners, particularly in pediatrics. One region sponsored a feasibility study to train 6 RNs in an 18-week pediatric nurse course and all are now working with private physicians or home health agencies.
- Other RMPs are helping to train radiation/ nuclear medicine technicians in cooperation with local hospitals and community colleges.
- Curriculum development is another area -- one RMP helped develop the curriculum for a network of 17 rural junior colleges all linked to a central training institute.

* AMBULATORY AND OUT-OF-HOSPITAL CARE

Approximately one-fifth of RMP funds are estimated to support activities related to ambulatory care and other out-of-hospital services. These include training, health delivery, and planning activities linked to neighborhood health centers; home health services; and in a few instances extended and long-term care services.

In particular:

- Five regions have singled out ambulatory care as a priority.
- Ambulatory care activities are estimated to have doubled over the past year. Currently over $8 million is supporting more than 50 activities.
- Almost half these activities contribute to providing comprehensive health services. For example, in one region a hypertension screening program has extensive referral services and is tied to major hospitals and home health services.
- About ten of the activities are linked to the services of a neighborhood health center, and include such activities as multiphasic screening and early screening for cancer and stroke.
- Home health activities have also doubled and now $1.5 million is supporting activities related to extended care and nursing home services.

* URBAN AND RURAL HEALTH CARE

About 17 percent of RMP funds now support special programs for the urban and rural poor, reflecting increased efforts in this area.

In particular:

- Almost 10% of the funds are for inner city residents and include over 30 activities totaling about $4.5 million.
- Poor rural residents are the targets of over 50 activities totaling about $3.2 million.
- Over half of the inner-city activities relate to patient services, and include such activities as comprehensive stroke programs; improving the co-ordination of existing services involving multiple

levels of care, e.g., screening, acute hospital care, home health and rehabilitation services; and improved hospital-based primary care. The other half is for various types of training and planning efforts.

- Several inner city programs involve training community residents to enter jobs with career mobility.

- Many of the rural programs include training activities to experiment with expanding the amount and level of services which allied health personnel can deliver; they also include programs which coordinate existing services for broadened outreach.

RECENT DEVELOPMENTS

The success of Regional Medical Programs stem from their capability to be flexible and responsive to changing health needs and problems. It is this characteristic which has enabled RMPs to shift from a categorical approach, i.e., reducing the ill effects of heart disease, cancer, stroke, kidney and related diseases to the development of diversified systems of health delivery tailored to local needs. Regions are presently stimulating and fostering planning for such delivery systems.

* HEALTH MAINTENANCE ORGANIZATIONS: The Regional Medical Programs are involved in the newly emerging Health Maintenance Organization program in a variety of ways. Foremost among these is providing assistance to help HMO's in the developmental stage and in improving and maintaining quality of care.

  A Health Maintenance Organization is based on the following four provisions:

  - It is an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of ....
  - an agreed upon set of comprehensive health maintenance and treatment services for ...
  - a voluntarily enrolled group of persons in a geographic area and ...
  - is reimbursed through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

  Fifty-two of the 56 Regional Medical Programs (one RMP was non-reporting and three indicated that they had such contacts but desired not to be specific) reported a total of 177 specific contacts with individuals and/or groups interested in possibly establishing HMO's. In addition approximately 75% of the RMP's have sponsored or conducted seminars, panels or discussion sessions regarding HMO's for the Regional (or Area) Advisory Group, its executive

or steering committee, for RMP core staff, practicing physicians and others.

The institutions, individuals and groups contacted have been rather diverse as the table below reflects:

RMP Contacts Regarding HMO's

Kind of Institution	No. Contacted
Medical Schools	20
Hospitals	29
Clinics	22
Medical societies (state & local)	17
Individual physicians	18
Existing group practices	11
Planning groups (CHP & other)	32
Neighborhood health centers & other Federally-sponsored programs	12
Private insurance carriers	4
Labor unions	2
Other	10
	177

* EXPERIMENTAL HEALTH SERVICES PLANNING AND DELIVERY SYSTEMS: The Experimental Health Services Planning and Delivery Systems Program is a new effort of the Health Services and Mental Health Administration, with the National Center for Health Services Research and Development as the lead agency. It seeks to create a management capacity and function to rationalize and systematize health services in those communities which have come together and voluntarily agreed to participate.

Sixteen communities or sites have been selected for participation. The degree of RMP involvement depends on the site, but in many of these, the Regional Medical Program was a moving force in putting together the application and is actively involved in setting up an Experimental Delivery System, such as in Vermont and the Mountain States.

The sites selected represent a range of experimental situations, including three States, four rural areas, three large cities, three moderate-sized cities, one sub-city, and two counties.

* AREA HEALTH EDUCATION CENTERS: The President's Health Message in February, 1971, and subsequent proposed legislation call for the development and support of Area Health Education Centers to meet identified health manpower needs in underserved areas. These Area Health Education Centers, in part, would be related to health science centers; their educational programs would be assisted by the health science faculty, and some patient care functions would rely on health science center personnel. The area centers would work with the community and neighborhood facilities, including the private practitioner.

Hospital and other health service organization and educational institutional linkages will be established to provide both academic education and clinical training. Allied health profession education will be strengthened through the development and expansion of curricula in comprehensive and community colleges along with increased emphasis on interdisciplinary learning to enhance the team concept on the delivery of comprehensive health services.

RMP Involvement

- Despite the fact that there are no fully developed Area Health Education Centers operating, many of the components of such a center can be found within some of the educational programs presently being supported by the Regional Medical Programs.

Approximately one-third of the Regional Medical Programs are currently involved in activities related to Area Health Education Centers, such as:

- Assisting in conducting negotiating conferences of multiple interest for Area Health Education Centers.
- Providing demographic and health data for Center development.
- Providing "agency" linkages for curriculum development.
- Developing criteria for selection of communities to be included in Center.

- Analyzing provider needs and attitudes toward Area Health Education Centers.

- Assisting in development of expanded roles for existing health professionals.

Examples of selected Regional Medical Programs' activities are as follows:

- The Kansas Regional Medical Program has developed a prototype area health education center in the rural Great Bend area. The program has established linkages between the existing educational system with the smaller peripheral and regional community hospitals in an attempt to meet the needs of the area's health service workers.

- The Maine Regional Medical Program has directed considerable effort toward the development of a health/science education center with a medical school component, using a remote teaching faculty from nearby universities, community hospitals and medical schools in Massachusetts, Vermont and New Hampshire.

- The Western New York Regional Medical Program has effected the institutional arrangements that have permitted residents and interns from the Upstate New York Medical Center at Buffalo to train at community hospitals across the state line in Pennsylvania. These community hospitals are seen as prototype area centers.

WHO THE RMPs WORK WITH

Regional Medical Programs have close-working relationships with the broad spectrum of public and private health and health-related planning, service, and education organizations, and with professional societies and associations. These include hospitals, medical schools, state and local health departments, medical societies, and the like. These relationships are integral and requisite to the efforts of the RMPs to influence and contribute to high quality, comprehensive health care. Of particular interest are the other federally-supported programs with which the RMPs work.

* RELATIONSHIPS WITH OTHER FEDERALLY-SUPPORTED PROGRAMS: Included in this category are such programs as: Model Cities, Comprehensive Health Planning, (both "a" and "b" agencies) and Appalachia Health, to name a few. Specific examples of how RMPs interrelate with these programs are:

Model Cities

RMPs provide: 1) technical expertise to the Model Cities programs; 2) support specialized service programs; and 3) participate in joint planning activities.

- Approximately 26 of the 147 Model Cities programs in the United States have active relationships with the RMPs.
- One-fourth of the RMPs (15) support a total of 20 operational activities in Model Cities areas.
- Very few RMPs have Model Cities agencies represented on their Regional Advisory Groups or other planning committees.
- Example: The New Jersey RMP (1) has detailed staff to serve as health planners for the Model Cities agencies; (2) established an urban health task force; (3) supported a heart screening survey in Newark; (4) is assisting a new hospital-based family health care service in New Brunswick; and (5) helped support a citizens health survey in Hoboken.

Comprehensive Health Planning

Cooperation between RMP and CHP is being fostered through emphasis on their complementary roles. CHP agencies provide an expression of the consumer's viewpoint, while RMPs express the provider's view of needs. Current RMP legislation requires that the Regional Advisory Groups include representation from health planning agencies. Similarly, CHP legislation requires RMP represenation on both "a" and "b" agency Councils.

* RELATIONSHIPS WITH CHP "a" AGENCIES: All 56 RMPs fall within the boundaries of at least one of the 56 CHP statewide agencies. Relationships between RMP and CHP "a" agencies include:

A. Interlocking Board and Committee Memberships

- RMP's relate to 51 of the CHP State Agencies through various types of interlocking memberships.
- A total of 48 RMPs have RAG and/or Core staff as members of CHP Agency Boards; 42 CHP "a" Agencies have Board or staff on RAGs.
- A total of 23 RMPs reported RAG or Core staff on CHP "a" committees; 14 CHP "a" agencies have Board or staff personnel on RMP committees.

B. Data Collection, Processing or Analysis

- 43 CHP "a" agencies cooperate with RMP's on joint studies or surveys; data banks, systems, or centers; health information committees; and exchange of services in data collection, compilation or analysis.

C. Cooperative Mechanisms for Review of Grant Applications

- In 46 RMPs the CHP "a" agency has an opportunity to review all or part of RMP proposals and applications.
- In another 4 cases, RMPs' proposals are either sent directly to CHP "b" agencies or channeled through "a" agencies for "b" review.

D. Other Joint or Cooperative Activities

- Additional cooperation includes the development of, support or other assistance to "b" agencies.
- Joint sponsorship or planning of conferences and workshops, consultation, shared staff, and joint projects development.

* RELATIONSHIPS WITH CHP "b" AGENCIES: Forty-eight of the 56 RMPs have at least one of the funded areawide CHP "b" agencies within their Regions.

A. Interlocking Board Relationships

- Forty-four RMPs are represented on the CHP Areawide Advisory Groups.
- Thirty-three RMP RAGs include CHP "b" representation.

B. Cooperative Efforts Relating to Data Collection, Processing or Analysis

- Of the 48 RMPs having a recognized "b" agency within their region, 46 have some data sharing with at least one areawide agency.

- Data activities include: joint preparation of directories of services and facilities; joint surveys of manpower needs; and assisting in the development of data for Experimental Health Services Planning and Delivery Systems and HMO applications.

- RMPs have assisted new areawide agencies in collecting, processing and analyzing data, especially for their organizational application.

C. Staff Sharing and Staff Contacts

- All 48 RMPs having an Areawide agency within their region have regular meetings with CHP representatives.

- Thirteen RMPs reported sharing staff on a full-time basis.

- In many RMPs a core staff member has been used as a special consultant by the Areawide Agency in such areas as manpower development and data collection.

D. Cooperative Mechanism for Review

- Forty-three of the RMPs reported that they have established a cooperative mechanism for the review of grant applications and activity proposals; the remaining 11 RMPs either have no areawide agency or are now establishing review mechanisms.

E. Other Joint or Cooperative Activities and Relationships

- Some RMPs and CHPs have merged Program Committees.

- RMP local advisory groups coincide with the areawide CHP agency boundaries in many areas.

Appalachia Health

The Appalachian Commission was established to improve the health, economic and social conditions of those residing in the Appalachian region of the country. The area covered is from Virginia to Alabama. This area of the country has rather pronounced health problems; therefore, a logical as well as needed set of cooperative arrangements have been developed between Regional Medical Programs and the Appalachian Programs.

Examples of cooperative arrangements:

- The Tennessee Mid-South RMP has helped plan for a comprehensive health care program in an isolated community in eastern Tennessee and Kentucky in cooperation with the Ohio Valley Regional Medical Program and the Appalachian Regional Commission. Through RMP support it has been possible to link three isolated rural clinics in a mountain valley of East Tennessee for the first time by telephone so that the clinic nurses can communicate with one another and with the physicians on whom they depend for consultation and support.

- The Alabama RMP has worked with the Appalachian program in a project involving Alabama's 17 junior colleges and the Regional Technical Institute, University of Alabama, in an attempt to meet the needs of health service workers for the State's community hospitals and health-related facilities.

PROGRAM ACTIVITIES...*IMPLEMENTATION*

Veterans Administration Hospitals

A total of 83 (out of 131) Veterans Administration hospitals are presently involved in activities in 42 RMPs. The breakdown by planning and operational activities is as follows:

Number of VA Hospitals Represented:	
On Regional Advisory Groups	25
On Local Advisory Groups	13
On Task Forces and Committees	33
TOTAL (discounting overlaps)	55
Number Participating in Operational Activities	38
GRAND TOTAL (discounting overlaps)	83

Examples of Veterans Administration hospitals' involvement:

- The VA hospital in Tuscaloosa, Alabama, is sponsoring a training program in "reality orientation technique," which is designed to improve the care and rehabilitation of older patients with cerebrovascular disease and stroke. The training is directed toward a broad spectrum of health service personnel with special attention to lower echelon personnel in nursing homes.

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

* NON-FEDERAL HEALTH ORGANIZATIONS -- PARTICIPATION IN RMP PLANNING AND DECISION-MAKING

Representatives of about 6,800 health and other institutions and organizations have been or are actively involved in the planning and decision-making processes of the regions. Types and numbers of institutions represented are presented in the following table:

Kind of Participant Institution or Organization	Number Represented
Educational Institutions, including Medical Schools	638
Medical Societies, State and Local	761
Nursing, Dental and Other Health Professions Groups	546
Voluntary Health Agencies	721
Health Planning and Related Agencies	790
Hospitals, Nursing Homes and Other Care Institutions	4,110
Others, (largely non-health)	642
TOTAL	8,208

PROGRAM EVALUATION

Along with planning and implementation, evaluation is a key activity used by the Regional Medical Programs both as a means for measuring impact and progress and as a management tool for decision-making and future planning. Evaluation within Regional Medical Programs has only recently taken on significance. In the first three years of RMP, evaluation received little or no attention at the local level. For example, findings from a study conducted in the summer of 1969 illustrate that: 1) only 7% of the activity proposals reviewed nationally included an evaluation protocol within the project design; 2) only 30% of the funded Programs had an Evaluation Director on core staff; and 3) no Regions had even begun the development of a total program evaluation design.

As of June 1971, however, significant changes in evaluation have taken place:

- 20 additional RMPs have hired Evaluation Directors - fifty Regions now employ 53 Directors or co-Directors: over one-third of these have backgrounds in the social sciences; about 13% in education; 10% in business administration or economics; 10% in statistics; 10% in medicine; 8% in public health or epidemiology; and the remainder in fields such as operations research, basic science, and community planning.

- It is estimated that about 7-10% of the core budget is allocated for evaluation activities.

- Several RMPs are developing information systems for use in regional decision-making.

- About one-fourth of the RMPs have developed active evaluation programs for use in decision-making. Some Regional Advisory Groups of these RMPs make extensive use of evaluation findings in their determination of the future direction of projects and Program. Many RAGs now site visit ongoing projects.

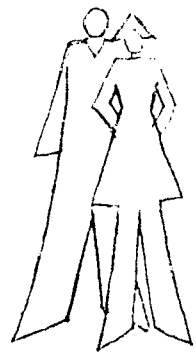
- Program evaluation, though actually being implemented in only a few RMPs, is in the developmental stages in many Regions.

SECTION V

WHAT PROGRESS HAVE THE RMPs MADE?

This section describes RMP progress toward improving manpower resources through education and training. It also describes the extent of hospital participation as an index of the regionalization of health services. Lastly, the section describes the extent and character of the phasing-out of RMP support for specific projects and the reinvestment of these funds by the RMPs into other worthy activities.

IMPROVING MANPOWER RESOURCES THROUGH EDUCATION AND TRAINING



RMP-supported training, education, and manpower programs are designed to improve, update, and expand the knowledge and skills of health professionals so that more and better health care may be delivered in a more widely-distributed and efficient manner. Over 250,000 health professionals have been trained by RMP to date.

Percentage and Number of Health Professionals Trained
Fiscal Years 1968-1971

	FY 1968 Percent	FY 1969 Percent	FY 1970 Percent	FY 1971 Percent (as of 4/71)
Physicians	29%	30%	23%	21%
Registered Nurses	64%	45%	25%	25%
Allied Health	6%	12%	29%	15%
Multi-professional	--	13%	23%	39%
TOTAL PEOPLE	2,948	51,726	105,613	97,706

Highlights:

- There has been a considerable increase in the number and proportion of allied health personnel trained.
- The sharp rise in the multi-professional group reflects the trend toward developing training programs which (1) train for the health team approach, and (2) train physicians, nurses, and others under one program.
- Initial training programs were discretely for physicians. Now, a broader array of professionals are being trained.

PROGRAM PROGRESS...*TRAINING*

Percentage and Number of Health Professionals Trained By Disease Category

	FY 1968 Percent	FY 1969 Percent	FY 1970 Percent	FY 1971 Percent (as of 4/71)
Heart	51%	46%	48%	49%
Cancer	7%	4%	7%	7%
Stroke	8%	8%	13%	10%
Related Disease	7%	8%	15%	10%
Multi-categorical	37%	34%	17%	24%
TOTAL PEOPLE	2,948	51,726	105,613	97,706

Highlights:

- More people are still being trained in heart disease than any other area. This includes over 10,000 physicians, nurses, and others trained in coronary care techniques.
- The early increase in related diseases reflects, in part, an emphasis on pediatric pulmonary diseases due to an early Congressional earmarking of funds.

Percentage of Total Professionals Trained By Length of Training (FY 1969-1971)

	FY 1969 Percent	FY 1970 Percent	FY 1971 Percent (as of 4/71)
One day or less	33%	68%	60%
2 - 5 days	44%	23%	27%
2 - 5 weeks	22%	7%	11%
More than 5 weeks	1%	2%	2%
TOTAL PEOPLE	51,726	105,613	97,706

Highlights:

- Most of the training continues to be one-day or less with only a few programs including extensive, continuous training, such as coronary care.

Percentage of Professionals Trained
By Training, FY 1971

	Physicians Percent	Registered Nurses Percent	Allied Health Percent	Multi-Professional Percent
one day or less	60%	44%	75%	64%
2-5 days	31%	24%	16%	31%
2-5 weeks	7%	27%	3%	5%
more than 5 weeks	2%	5%	6%	--
TOTAL PEOPLE	20,944	24,366	14,319	38,077

Highlights:

- RNs are the group receiving the lengthier training, and this has been primarily in coronary care.
- Many of the one-day or less sessions are seminars and conferences.

IMPROVING HEALTH SERVICES THROUGH REGIONALIZATION

Hospital Participation

* REGIONALIZATION AND HOSPITAL PARTICIPATION: Regionalization is one of the major themes of Regional Medical Programs. Working relationships and linkages among community hospitals and between such hospitals and medical centers are among the primary concerns of the program. The linking of less specialized health resources and facilities such as small community hospitals with more specialized ones is a critical way to overcome the maldistribution of certain resources, and increase their availability and accessibility. Therefore, hospital participation is one key to the development of Regional Medical Programs.

Percent of Nation's Hospitals* Participating in RMPs**

	National Total	No. Participating	Percent Participating
FY 1968	5,850	851	15%
FY 1969	5,820	1,638	26
FY 1970	5,853	2,084	36
FY 1971 (est.)	5,880	2,693	46

Highlight: Almost half of the Nation's short-term non-Federal hospitals are now participating in RMPs.

Percent of Nation's Medical School-Affiliated Hospitals* Participating in Regional Medical Programs

	National Total	No. Participating	Percent Participating
FY 1969	436	121	28%
FY 1970	480	241	50
FY 1971 (est.)	490	285	58

Highlight: Almost three-fifths of the Nation's medical school-affiliated hospitals now participate in RMPs.

* short-term, non-Federal hospitals
** participation includes membership in advisory groups and committees and in operational activities.

Hospitals* Participating in Operational Activities Only

	Total	No. Actively Participating and Percent		No. Generally Participating and Percent	
FY 1968	301	60	20%	241	80%
FY 1969	1,246	247	20%	999	80%
FY 1970	1,471	860	58%	611	42%
FY 1971 (est.)	2,079	1,221	59%	858	41%

Comment

- Hospitals actively participate by sponsoring projects or serving as the location for an activity. For example, many hospitals serve as coronary training sites or provide intensive stroke services.
- Other hospital participation may include such activities as sending personnel to be trained.

Distribution by Bed Size of RMP Participating Hospitals*

	Total Participating Hospitals	Less Than 200 Beds	200-399 Beds	400 plus Beds
FY 1968	851	587	153	110
FY 1969	1,638	1,081	327	229
FY 1970	2,084	1,344	467	273
FY 1971 (est.)	2,693	1,750	592	351

Highlights

- About 40% (1,750) of the Nation's smallest hospitals are now participating.
- In contrast, about 85% (351) of the largest hospitals are now participating.

* short-term, non-Federal hospitals

PROGRAM PROGRESS ... *REGIONALIZATION*

* REGIONALIZATION -- GEOGRAPHIC SCOPE OF ACTIVITIES: Geographical coverage of activities offers another insight into the regionalization process of RMPs. The trend during the last several years has been away from program activities concentrated in the medical center and towards those designed to improve and expand community resources and services. The following table shows program funds as distributed by geographical areas (regionwide, subregional, interregional) within the RMPs. An example of a regionwide activity might be a circuit course for nurse training or a coronary care network; a subregional activity might be support of a multiphasic screening clinic in a ghetto area.

Geographic Scope of RMP Activities by Funding Emphasis, 1971

Scope of Activity	% Funds
Regionwide	58%
Regionwide involving central and satellite units.	(13%)
Subregional	40%
Inner city	(7%)
Rural	(9%)
Interregional	2%

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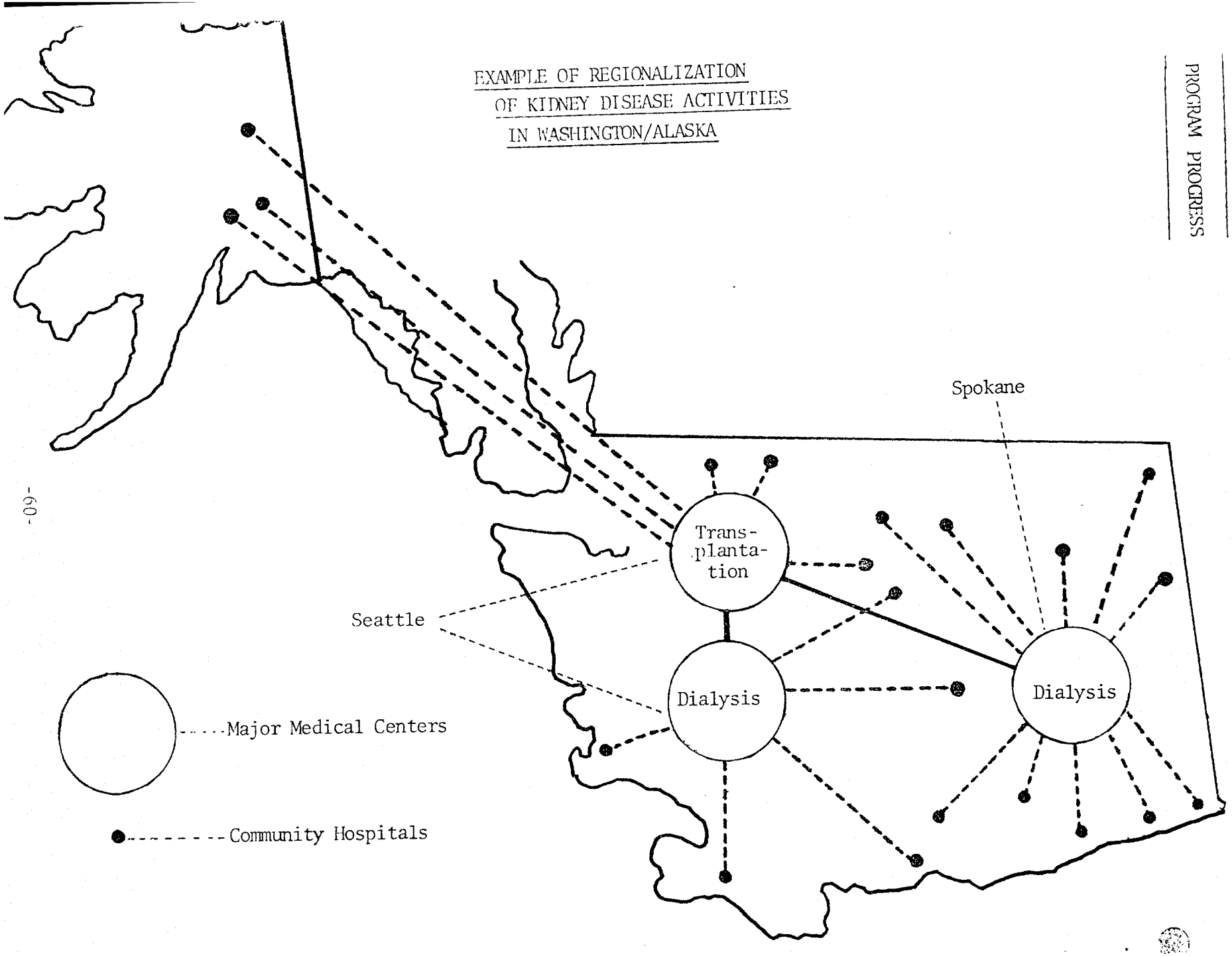
* EXAMPLES OF REGIONALIZING SERVICES AND RESOURCES: Two maps follow which graphically describe:

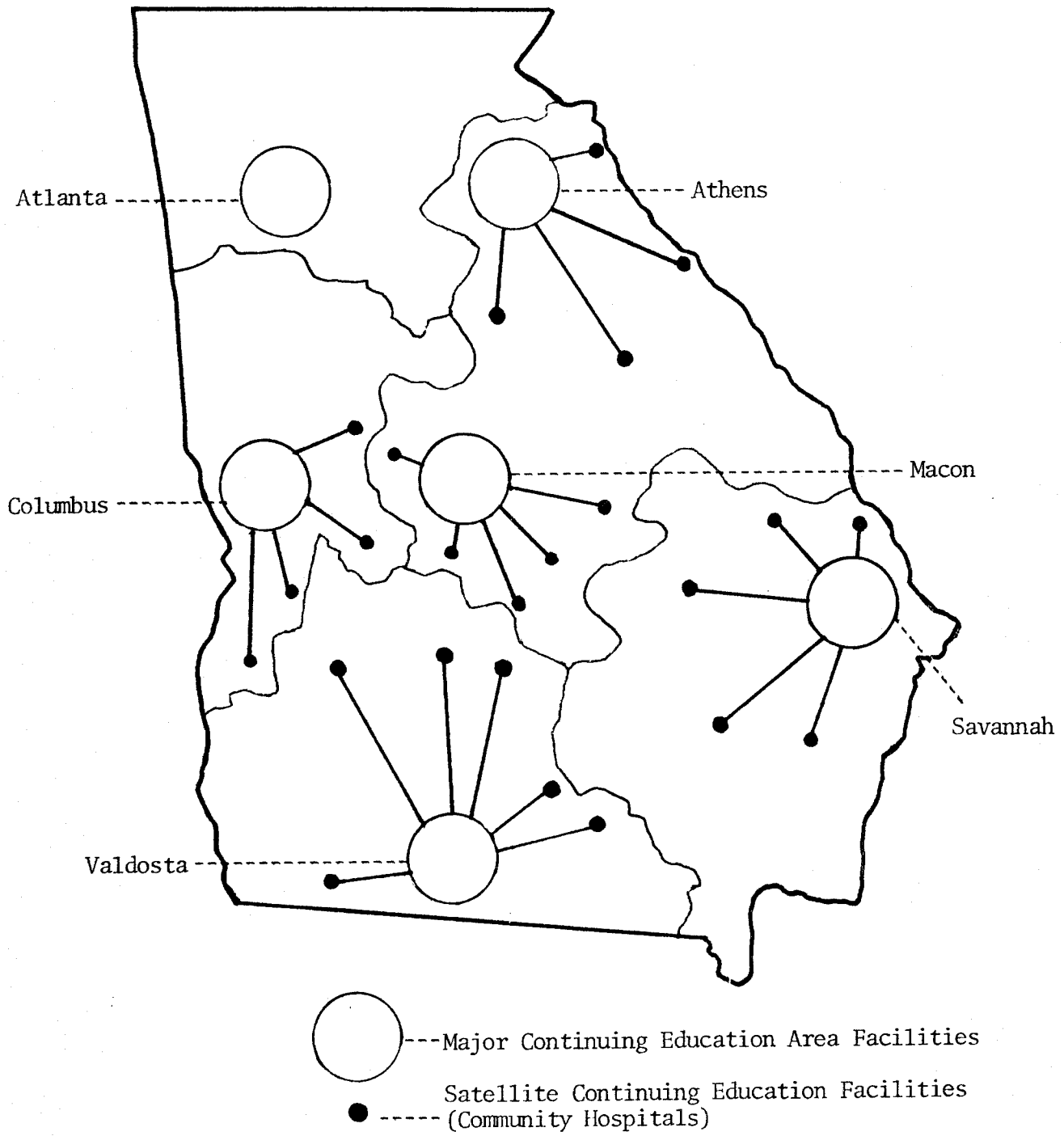
(1) a regionalized kidney program in the Washington/Alaska RMP, which includes a planned, coordinated program for kidney transplantation, dialysis, and education; and

SEE MAPS

(2) an education program in Georgia with major area education centers located in one or a cluster of large hospitals serving satellite hospitals. Each major center is linked to a medical school.


EXAMPLE OF REGIONALIZATION
OF KIDNEY DISEASE ACTIVITIES
IN WASHINGTON/ALASKA
Spokane
Trans-
planta-
tion
Seattle
Dialysis
Dialysis
Major Medical Centers
Community Hospitals

EXAMPLE OF REGIONALIZATION OF CONTINUING EDUCATION ACTIVITIES IN GEORGIA



TURNOVER OF FUNDS TO MEET CHANGING NEEDS

* PURPOSE: The RMPs hope to support demonstration activities for approximately three years, at which time local financing mechanisms should take over the support of the activities. This approach permits the RMP to reinvest its funds in other areas of urgent need and allows RMP to be a meaningful catalyst.

* TERMINATING RMP SUPPORT: During the past six months, support for over 90 activities was withdrawn and reinvested in a comparable number of new activities.

Activities for which RMP Support Terminated
(Jan. 1971-June 1971)

By Disease Emphasis	No. Activities	Amount (in thou)	Percent
Heart	34	$1,088	30%
Cancer	13	454	12%
Stroke	6	164	4%
Related Diseases	8	294	8%
Multicategorical	33	1,426	46%
Total	94	$3,426	100%

Highlights:

- The extensive heart disease cutbacks primarily reflect a decrease of coronary care training activities.
- Multicategorical terminations reflect reductions in audio-visual support services, and some multipurpose continuing education programs, as well as other activities.

PROGRAM PROGRESS ... *TURNOVER OF FUNDS*

By Primary Purpose	No. Activities	Amount in (Thousands)	Percent
General continuing education	24	$1,790	23%
Training Health Professionals in new Skills	32	998	29%
Health Care Delivery	22	823	24%
Health Planning & Coordination	5	348	10%
Research & Development	11	467	14%
Total	94	$3,426	100%

Highlights:

- Many general continuing education for physicians programs have been terminated as well as videotape and TV type activities.
- The 29% reduction in Training Health Professionals reflects primarily the reduction in coronary care training.

* REINVESTMENT OF THE RMP FUNDS: The funds withdrawn from the above set of activities have, in part, been reinvested with a different emphasis:

Highlights:

- About one-fifth of the funds have been put into stroke activities, thereby markedly increasing stroke programs, particularly in ghetto areas.
- Correspondingly, smaller reinvestments have been made in heart, but slightly more in cancer.
- Over two-fifths of the funds have been reinvested in health care delivery activities, thereby markedly increasing efforts in these areas.

A GLOSSARY OF TERMS

AREA HEALTH EDUCATION CENTER

An Area Health Education Center, proposed under pending legislation, would be a satellite of a university health science center for the purpose of increasing opportunities for training, retraining, and continuing education of health professionals in an effort to enhance the delivery of health care in deprived areas.

CATEGORICAL COMMITTEES AND TASK FORCES

Groups of health care providers and other technical experts appointed by either the Program Coordinator or Regional Advisory Group for the purpose of planning, evaluation, and review of projects which emphasize one or more of the following diseases -- heart disease, cancer, stroke, kidney disease, education, and other areas.

CONSUMER

A non-health professional who receives health care and may be engaged in RMP activities.

COORDINATING HEADQUARTERS

The agency responsible for the implementation, administration, and coordination of a Regional Medical Program. It is involved in the development of regional objectives as well as review, guidance, and evaluation of ongoing planning or operational RMP functions.

CORE STAFF

Comprised of professionals and clerical persons whose prime responsibility is program development, coordination and administration; providing consultation or professional services to local institutions and serving as facilitators or conveners of multiple interest groups to solve local health-related problems.

EXECUTIVE COMMITTEE

Executive Committee usually is appointed by the Regional Advisory Group to provide advice and counsel to the RAG and serve as the day-to-day advisor to the RMP Coordinator and core staff.

EXPERIMENTAL HEALTH CARE DELIVERY SYSTEM

An Experimental Health Care Delivery System is a new grant program to create a management capacity to rationalize health services in a community.

GRANTEE

Grantee is a public or non-profit institution, agency, or corporation which is responsible for fiscal control and fund accounting procedures to assure proper disbursement of and accounting for RMP grant funds.

HEALTH MAINTENANCE ORGANIZATION

A prepaid, organized system of health care which includes a consortium of health care providers who come together for the purpose of making available comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons in a specified geographic area.

LOCAL ADVISORY GROUP

A consortium of interested providers and consumers who reside in a geographic subsection of a region and are brought together by the Regional Medical Program to advise it with respect to health care needs, priorities, and plans to be undertaken which should ameliorate many of the existing local health care needs and problems.

OPERATIONAL GRANT

Operational Grant is authorized upon a recommendation of both the Regional Advisory Group and the National Advisory Council on Regional Medical Programs to assist in the establishment and operation of a Regional Medical Program.

PLANNING GRANT

Planning Grant is authorized upon a recommendation of the National Advisory Council on Regional Medical Programs to assist in the planning and development of a Regional Medical Program.

PROJECT

Project is a discrete activity which is undertaken by the Regional Medical Program as an integral facet of its overall operational program. These may include education, training, and patient service demonstration.

PROVIDER

Provider is an individual whose prime function is to make available health care services, e.g., physician, nurse, physical therapist, occupational therapist.

REGIONAL ADVISORY GROUP

Regional Advisory Group is comprised of a broad spectrum of health professionals, institutions, and consumers whose prime function is determination of the overall scope, nature, and direction of Regional Medical Programs.

REGIONALIZATION

Regionalization is the linkage among health care institutions and resources established for the purpose of improving both the quality of and accessibility to health care as well as gaps and duplications in the Region's health care system.

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Health Services and Mental Health Administration