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RMP Workshop: Responsibilities in Health Planning

Regional Medical Program for Western New York

- New Goals and Objectives
- RMP Mission Statement
- Putting It All Together

western union

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WORKSHOP WESTERN NEW YORK REGIONAL MEDICAL PROGRAM, ATTN JOHN R F

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HOLIDAY INN FREDONIA NY

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ALTHOUGH I CANNOT BE WITH YOU MAY I TAKE THIS OPPORTUNITY TO COMMEND

YOUR WORKSHOP AS A TRUE RESPONSE TO THE NEW DIRECTION IN WHICH RMP

IS MOVING. AS YOU RE-EXAMINE THE GOALS AND OBJECTIVES OF THE WESTERN

NEW YORK REGIONAL MEDICAL PROGRAM I AM SURE IT WILL GIVE RISE TO A

CLEAR UNDERSTANDING AND COOPERATIVE EFFORT TO MEET THE HEALTH NEEDS

OF YOUR AREA AND TO ALIGN YOUR ACTIVITIES WITH THE NATIONAL PRIORITI

FOR RMP WITH BEST WISHES FOR THE SUCCESS OF YOUR WORKSHOP I AM

SINCERELY YOURS

HAROLD MARGULIES MD DIRECTOR REGIONAL MEDICAL PROGRAMS SERVICE.

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NOTE: On March 1, 1972, the name of the program was changed from Regional Medical Program for Western New York to Lakes Area Regional Medical Program, Inc.

1. Foreword

The following document gives a description of the organization and purposes of the Regional Medical Program for Western New York (RMP/WNY) Workshop held September 23-24, 1971, at the Holiday Inn in Fredonia, New York. The theme of the conference was "Responsibilities in Health Planning." About 50 health professionals affiliated with the RMP/WNY from throughout the Western New York-Pennsylvania region, including members of the Health Organization of Western New York, Inc. (H.O.W.N.Y.) Board of Directors, participated. At the Workshop, the mission of the RMP was reviewed, the framework for decisions established for the future, and priorities set. Participants considered the new concepts of the RMP mission and discussed the needs of our own region in the light of this understanding.

This conference provided a forum for the critical review of the Program's newly proposed goals and objectives. The Board of Directors of H.O.W.N.Y., Inc. adopted the new goals and objectives on October 14, 1971. H.O.W.N.Y. serves as the Regional Advisory Group (RAG) to the Regional Medical Program for Western New York.

Our sincere thanks are due to all those who participated in this extremely successful Workshop.

John R. F. Ingall, M.D.
Executive Director
Regional Medical Program
for Western New York

Dr. Ingall

2. Why a Workshop?

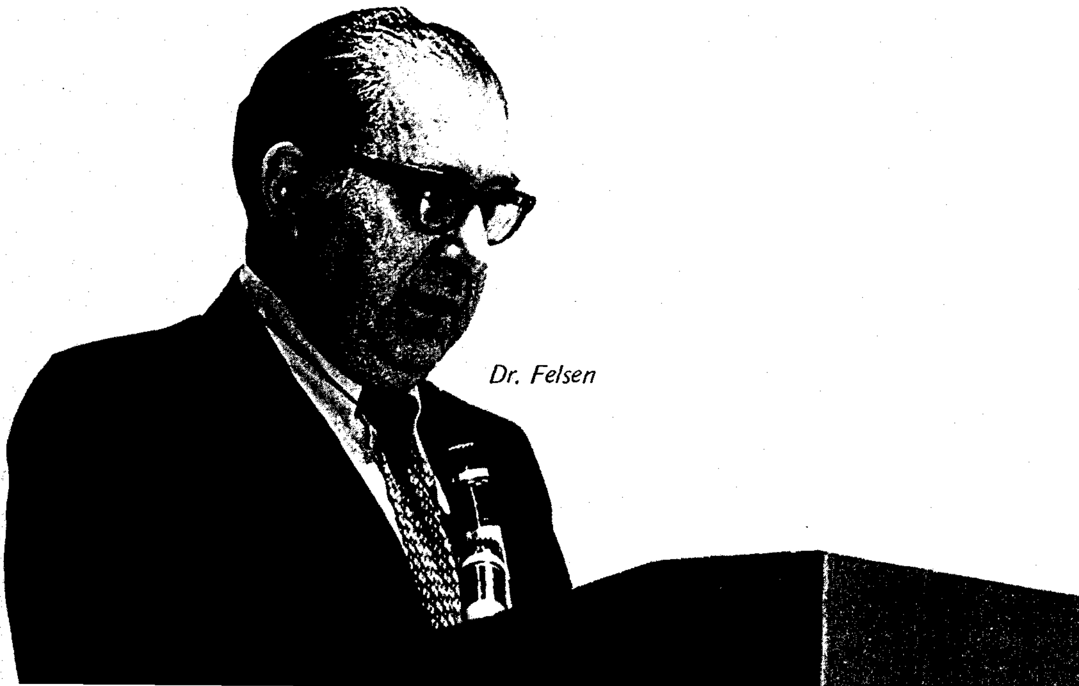
Regional Medical Programs across the nation are currently pursuing new directions. Locally, areas of emphasis encouraged by the original legislation (P.L. 89-239) are being reconsidered in order to align future activities with national priorities in meeting the health care needs of the region.

These proposed changes were thoroughly discussed with members of the Regional Advisory Group, the RMP staff, and other interested health professionals from throughout the region at a two-day conference held in Fredonia, New York, away from the distractions of the central office.

We originally achieved our identity upon the categorical labels of Heart Disease, Cancer, Stroke, and Related Diseases. The need to *subsume* these categories in broader policies was seen as a major change in our program emphasis.

By participating in RMP planning, those at the Workshop gained the understanding needed to implement proposed changes. An outcome of the workshop was a statement of goals and objectives upon which the Regional Medical Program for Western New York could act over the next three years. Guidance was sought in the RMP Mission Statement, which serves as a basis for interpreting the law, and in the National Review Criteria, which serve as a guide to local management.

The conference was an educational exercise that resulted in better understanding of the Regional Medical Program. This understanding is the basis upon which beneficial changes in our operation can be implemented.



Dr. Felsen

3. How the Workshop was organized

The groundwork for the September workshop was laid the previous summer, when RMP staff met with each member of the Regional Advisory Group (RAG) and with members of the county committees. These personal meetings brought awareness of the new purposes and directions of RMP to RAG members. They provided an opportunity for discussions of health care problems in our region and of new approaches to solve these problems. Important insights brought back by staff members helped shape the workshop agenda.

Committees of the core staff of RMP/WNY and of the Regional Advisory Group considered the issues to be discussed and developed an appropriate agenda. They cooperated in the preliminary planning necessary for a successful workshop. A set of suggested goals and objectives was prepared that would stimulate comment. The agenda provided topics to be considered and a general time-frame, but left enough flexibility to take advantage of spontaneous discussion.

It was decided to divide the participants into three groups for discussion of the proposed goals and objectives. The group leaders were: Edward F. Marra, M.D., Chairman of the Department of Preventive Medicine, School of Medicine, State University of New York at Buffalo; Herbert E. Joyce, M.D., Past President, H.O.W.N.Y., Inc., general practitioner; and Alan Drinnan, M.D., D.D.S., Professor, Chairman of the Department of Oral Medicine, School of Dentistry, State University of New York at Buffalo.. The sessions were vigorous, lasting well into the night.

On the second morning, group leaders presented to the workshop the results of the three evening sessions. A concensus was reached by the workshop on substantive issues; the three group leaders formed a committee to reconcile small points of difference among the reports and developed a final statement of goals and objectives. These were accepted as modified by the RMP/WNY Regional Advisory Group on October 14, 1971. In the final session of the workshop, an executive committee selected the proposals most pertinent to the goals and objectives that had been developed. Request for funding these selected projects was included in RMP/WNY's triennial grant application.

The Agenda

Thursday, September 23

12:00	Lunch
1:00	Welcome: Irwin Felsen, M.D., President, H.O.W.N.Y., Inc.
1:30	John R. F. Ingall, M.D., Executive Director, Regional Medical Program for Western New York
2:00	RMP Mission Statement
2:30	Discussion of RMP Mission Statement: Dr. Felsen
3:00	RMP National Review Criteria
3:30	Discussion of RMP National Review Criteria: Dr. Ingall
5:00	Executive Session
6:00	Hospitality Hour
7:00	Dinner
8:30	Group Discussions

Friday, September 24

8:00	Breakfast
9:00	Summary Report of Three Group Sessions
10:30	Executive Committee Meeting
12:00	Adjournment

From left to right, Miss Kellberg, Dr. Felsen, Mrs. Hoff

4. Introductory Address

Irwin Felsen, M.D., President,
Health Organization of Western New York, Inc.

Dr. Felsen

Some days ago Dr. John Ingall, our director, in a personal conversation, asked me to put down on paper my ideas and feelings about the RMP. The timing could not be more appropriate because I vividly recalled the lessons reflected from my heritage at this time of Rosh Hashana, the New Year. Our teachers exhorted us: "Repent and examine your consciences. Seek new directions through examination of your heritage. Seek interaction with others rather than thinking only of yourself." And so, with much thought, I express myself on the subject of RMP, thusly:

It is a recurring paradox of our present world with its overwhelming scientific, economic, and social complexities, that so many responses to human problems are so easily simplified. We tend to complicate the simple and to make the complex simplistic. The dangers of over-simplification extend into so many areas today, that one can be isolated briefly here—Man's misuse of his most singular gift of language. Bureaucratic language, like jargon as a whole, is immoral because it is deceptive and avoids the complexities of the real world which it attempts to explain. Political language is largely the defense of the indefensible—and every issue, insofar as it involves any attempt to be persuasive or convincing, is a political issue. The decay of language into vague, trite, insincere expression is directly related to political confusion on every level. The uncertainty of our times is not made easier by pompous, round-about and distorted phrasing. The solution is that the re-ordering of Society can begin at the verbal level if we will return to concreteness of expression. But Washington, of course, is merely one obvious realm in which the immoral and inhuman use of language to obscure rather than to express the truth is apparent. We are constantly fed confusing clarifications.

Double Talk Obscures

Double talk seems to be the lingua franca of social scientists, lawyers, university administrators and Madison Avenue. Among many intellectuals, labored obscurantism is rapidly becoming pandemic. The art of non-communication, deftly wielded, quickly changes the trivial or obvious into something seemingly significant, occult, and worthy of a research grant.

Caution as well as dishonesty motivate much of our jargon and euphemistic language. (Why say spit when we can say expectorate?) Those of us involved in this workshop recognize that the best we can do for the membership is to force them beyond caution, to take a stand on issues, to risk an opinion on what they read and hear (and also to learn about themselves in the process). If we need a rationale for a workshop of this kind it is that man learns about himself by seeing how he interprets other things. I trust all of you will be fully critical and perceptive, and make meaningful choices. Express yourselves clearly and honestly that we might be better able to bring order to the complexity of the health care system. The outlook is not all dark.

continued

Program Benefits Questioned

Recently, at one of our Board meetings, as well as on the Senate floor, hard questions were raised about the usefulness and efficiency of HEW's programs. Former HEW Secretary Abraham Ribicoff, now a Democratic Senator from Connecticut, told the Senate, and I quote: "What disturbs me—with each passing year I am more and more disturbed—is whether or not the bills and the programs we pass here are really accomplishing the objectives we think they are. I think one of the tragedies is our failure to ever repeal a law that has been passed. Instead we continue to pass more and more such laws." Much of the blame for the undoubted waste and inefficiency at HEW (and elsewhere in government for that matter) must be laid at Congress' doorstep. Hundreds of millions of dollars are spent every year by HEW for what may be called "planning and conferring" programs whose ultimate benefit to the consumer is questionable. When cost conscious administrators suggest paring such activities they are greeted with congres-
Ribicoff noted that some $31 billion will be spent this year at all levels of government on poverty programs. And yet, it is questionable whether any of these programs have removed a single person from poverty. "It might be intriguing for senators to contemplate that if we eliminated all these programs and bureaucracies, and divided the $31 billion among the people who are under the poverty line, every family of four would receive a total of $4,800, almost $1,000 over the poverty line. We would eliminate poverty completely in America. Perhaps the time has come for all of us to start taking a very hard look at these programs instead of automatically continuing them. But with each passing year, I am more and more convinced that it is incumbent upon us in the Senate to be more critical of the actual performance of many of the programs we pass."

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Caution Urged

And so at a time when Congressmen are starting to try to outbid each other on massive new programs for national health care, we should raise some cautionary flags about the kind of programs that are really needed and can do the most good. The nation doesn't know yet why the existing huge outlays on medical care do not produce better results. And it could use more evidence before rushing into a radical restructuring of the entire medical care system. Who determines eligibility or necessity for medical care? What are our health problems? Do we suffer from too few doctors or is the problem one of maldistribution both geographically and in terms of specialties? Poverty itself causes much physical and emotional illness. Is poor health in the slums a medical problem or, rather, a sociological one? Does not this problem involve better housing, jobs, education, example, and habit? A thousand of the best doctors in the world could march into the slums of any big city with the best intentions and without any discernible improvement. There are no easy solutions until we begin to solve the problems of the community. We must not ignore all the complex social forces at work. Too much of our money gets swallowed up in terms of just keeping alive ideas that are no longer truly pioneering and ought to be shifted to private expenditure. We need a greater role for consumer involvement in the delivery of health care. We need in our health agencies a conception of how other program sectors outside of the medical service area relate importantly to health.

RMP Key Program

Now, there should be many ways in which the present medical care system can be intelligently and humanely improved, and these needed and useful improvements can be made within the context of a continued pluralistic system. We need not assume that our proposals and recommendations at this workshop will introduce a Utopia. However, I am convinced that the RMP may be the key Federal program around which all these problems will pivot. We must also get accustomed to the idea that RMP depends on other structures and is not standing by itself. And we should resist being pulled into areas where our competence is limited. We have an opportunity to make RMP and H.O.W.N.Y. the key program for moving intelligently and successfully to improve the health care system.

This is a conference in the sense of setting goals and priorities. Where are we going and how do we get there? We must be both pragmatic and visionary as well as innovative and experimental. Though this is not a sensitivity training program, I ask of you to participate as equals. Let us not act without conviction.□

5. Executive Director's Address

John R.F. Ingall, M.D.
Regional Medical Program for Western New York

Dr. Ingall

Ladies and Gentlemen:

I would like to endorse Dr. Felsen's welcome. I would also like to take this opportunity to stress that the staff of the RMP/WNY have provided for you as clearly as possible some indications on the way we should look to making future decisions. I might add that if the arguments and intramural lobbying are a capsule of things to come, we are heading for a very active session.

In earlier discussions we have had a number of concerns presented to us, namely, the multitude of Federal programs that have health components and difficulty of coordinating these. An even greater and more nebulous issue has been forcefully brought to my attention, namely, the concern by the physician that in treating the medical manifestations of the social ills, he will be considered as culpable for those ills. Perhaps he is, but only in part. I am quite sure that the voices of my colleagues, raised in concern, bespeak a genuine desire to work for solutions.

We cannot today venture into the aforementioned. We are convened to make decisions on the goals, objectives, and priorities of this WNY/RMP. These must reflect your constructive suggestions and give guidance to the Board of Directors of H.O.W.N.Y. who, as you know, are the final decision-making body of the RMP/WNY.

The Agenda Committee of the Board has been responsible for the sequence that will follow and it is hoped that digression from the program will be limited to the break time and cocktail hour.

We have a great deal of serious business before us, to reiterate Dr. Felsen's comment. My job today is to give you some of the legislative background to the RMP. In my view, ability to look back and see change is a prelude to looking forward and effecting change. Furthermore, a program like ours which started off with a label of "another source of funds" or "money for heart, stroke and cancer" has changed. I am sure many of you will remember how we started. We had to identify, and rapidly, the needs in our Western New York area. We did not have a systematic means of doing so. What we did was called consensus planning. Furthermore, we had to develop a mechanism of project review, regional involvement and decision-making; staff competence and the concept of an integrated total program.

Re-examine Objectives

You are here today because facets of our total program are being discussed. We are reviewing our objectives, namely, where we are going, and we have to decide on restating these clearly and succinctly. Furthermore, we are also deciding on how we reach these objectives, the tactic, and the priorities we see in doing this. In somewhat school-boy language, our health objectives, i.e., what we are going to do, and secondly, and most important, our program objectives, namely, how we are setting about doing this, have to be refined and reappraised.

continued

Now having decided on where we are going and how we are going to get there, we have to decide on a flexible mechanism of priorities. We can all respond to setting our priorities as of this date. What is vital in conducting our program in the future is that the priority mechanism has the ability to reflect change. For example, our priorities for RMP may be influenced and recast by the achievements of other programs. In effect, what I am saying is a clear priority today may no longer be so in a year's time. It is the mechanism for reflecting this in our program upon which we need your informed participation and guidance.

Categorical Emphasis

Now to the legislation. The original law, P.L. 89-239 was one which was highly categorical in nature, and by categorical I mean that it defined certain disease areas in which we should make some of our prime efforts. It was clearly interpreted as a means to translate or transfer the results of clinically applicable scientific progress for the benefit of the patient. It was interpreted very dominantly as the hand maiden to continuing medical education and in some areas this remains the view. Dr. Robert Marston, to the best of my recall, coined the phrase *"science to service"* as a simple description of the RMP. What better method to transfer this than continuing medical education? We responded to the categorical emphasis and the need for transmission of usable measures, discoveries, or concepts to the patient. Initial projects were the Telephone Lecture Network and the Coronary Care Program. We used as our motto "communication means cooperation means science to service." Communication is essential if we are to obtain cooperation and cooperation is the essential precursor for applying science to service. I think communication still has a major role to play in the conduct of our program. Today I trust we will communicate and reach understanding even if we do not reach agreement. It is no good my talking if you don't hear and if you do hear, you may not understand. If you do not understand you cannot respond, at least, not in the terms of what has been presented. I suppose the people are very often vociferous because of their ability to be so in the absence of hearing. We meet this in the medical school occasionally.

Early Projects

Under the old legislation we have developed projects which have been successful. The early projects were not necessarily related, but sincere attempts were made to relate them using the guidelines then at our disposal.

As the projects became greater in number, so did the staff, and indeed, their competence. It's gratifying to look back on a small closet, 6 by 12 with two occupants. In effect, the projects that we had, and have had over the years, were the stepping stones to a program. Under the continuation resolution in Washington and the extension of the RMP law, we now see ourselves evolving as a total program, and not just a series of successful, isolated grants: a program that can not only define a need but promote mechanisms to satisfy that need.

Total Program

The total program is the mechanism whereby we use the information that we have mustered in the past few years and will continue to use in the future. We will use this information, this data, to state our objectives and, indeed, decide upon priorities.

continued

Now this, with your help of course, is what we are about today. I hope as a result of this workshop, we shall do three basic things:

1) agree upon our goals and objectives;

2) agree upon our priorities;

3) gain an insight that will enable H.O.W.N.Y., the RAG to this RMP, to make basic decisions upon our currently approved but unfunded projects, and to decide on how they fit into our revised criteria. This is especially true in relationship to a number of projects approved a year ago which may receive a totally different ranking in relationship to the decisions to be made here over the next 24 hours.

RAG Decision

The decision is, of course, the responsibility of the RAG, namely, H.O.W.N.Y., who are the prime authorities as to our needs in this Western New York area. There are many authorities as to our needs and many of them are here. It is important that our projects within the total program are not what the nebulous Washington says we should have, but what we say we should have! This does not, of course, mean an absolutely free hand. We have the law to refer to, the interpretation of our program in relationship to this law, and the Mission Statement—something we will come to later on this afternoon.

I think I should reiterate that the decisions are the final responsibility of the Board members and the material here in front of you is intended to help guide those decisions.

RMP Impact

Now the new law is not so important as the manner of its implementation—how it is to be effected. It is a modification of the old; it specifies kidney disease, it specifies participation of the Veterans Administration, and the review and comment required from the Comprehensive Health Planning Council. I'll come back to this briefly later. What I would like to mention to you now is some of the discussion that has been going on at the executive level and in the two Houses of Congress. At the hearings in Washington the case for RMP was made with considerable impact. This was equally so at the Committee on Interstate and Foreign Commerce of the 91st Congress. The full Senate Appropriations Sub-Committee requested an increase of $40 million over the House appropriation and it has become patently obvious that both the Senate and the House of Representatives saw the RMP as a vital and viable component throughout the country. It was "a viable link between the Federal mechanism and the private and voluntary agencies." This was very encouraging because, as you know, many of us were wearing drab clothes with the feeling that RMP was moribund. The House Appropriations Sub-Committee agreed to $102.8 million for RMP to which should be added a $34.5 million carry-over which adds up to $137.3 million. This is not bad, of course, in a year when we anticipated approval of only $70 million. In addition to this, and in order that there would be no mistake with regards to both Houses of Congress in their support, an extra $10 million supplement was added to the carry-over which brings us to a figure of $147.3 million.

continued

The Mission Statement to which Dr. Felsen will refer gives clear indication as to the way in which we should implement our program. The National Criteria, which we shall also run through this afternoon, gives further indication as to the interpretation of the law.

The word *"subsume"* by the way, seems to be a Washington vogue word. It is passed across my desk so often that I relish using it. I think it safe to re-emphasize that projects which are presented to the RMP or, indeed, which we seek, must relate to established needs and clearly fit the program which we have defined today. The impact that these decisions may have on the delivery process, may subsume all the categories in which the RMP attained its identity. I have now used my word!

Focus on Patient

A nurse does not have to tend exclusively cancer or coronary patients, and transplantation may properly be the province of a transplant surgeon rather than the anatomical subcategory from whence he emerges. New concepts that embrace the patient as a total component rather than the disease as an incident in his history would appear to be the way that things are going. *At no point in our thinking must the population to be helped, be they the providers, or through them, the patients, be forgotten.* We will still remain a patient-oriented program.

Now, I've touched on the legislation in general terms because I am convinced that the interpretation of the legislation is much more exciting than those familiar with the original document would ever have conceived. During the coming year I think we can anticipate – I am sure we can *anticipate, – an expanding role for the RMP.* Local autonomy in decision-making is but one step in this direction. The equity of our investment and furthermore the visibility of *it in times of restricted funds,* should be very seriously considered. We have got to decide how to widen our portfolio, how not to put too many eggs in one basket or, for those of you who have investment interest, too much money in a doubtful issue.

continued

Dr. Fischman Dr. Drinnan

Attack Identifiable Problems

Finally, I would like to just make a comment from Dr. Merlin DuVal who, some of you will be aware, has taken over the role of Assistant Secretary for Health and Scientific Affairs. He, of course, is now the person to whom Secretary Elliott Richardson looks to for a great number of decisions. And he has said recently, "In the area of social progress as in the practice of medicine, we have witnessed the development of an incredible interdependence among parts of the public body, and we have learned the treatment of one segment without the consideration of the whole can result in great harm. This kind of recognition produces growing impatience with pie-in-the-sky solutions which some have offered as therapy for the afflictions suffered by our health care mechanism." He goes on to say that we should tackle our ailments constructively, restricting ourselves for an increasingly positive attack on problems that we have successfully identified thus far. Now, Miss Elsa Kellberg will give you an idea of what resources we have used in our local diagnosis and Mrs. Patricia Hoff will present for your consideration and discussion, our goals and our objectives. This evening you will find yourselves divided into three groups to discuss these objectives and our own proposals.

I think it very important to make this point at this time—that none of the deficits we see or that we define are pointed out in an accusatory fashion; they are part of our local diagnosis. We don't want you to misconstrue this any more than we would scold someone for having a hot appendix or chide someone for manifesting the measles.

I hope you will provide us with the guidance we need to capitalize on the expertise of those present. This certainly is going to influence the Board members of H.O.W.N.Y. in its decisions and they, of course, will give us the instructions on how to implement these decisions.

Finally, you've all seen the RMP change and in my view change is healthy. The capacity to encourage it is even healthier. Money (and this is the first time I dare mention it) is a matter that will inevitably raise its head. Money is restricted and I feel it should be plain to all those present that the money available has got to be used in a manner that will really give us the best possible return for our investment and the best possible way of giving identity to this RMP for the benefit of the community in the Western New York area.☐

6. RMP Mission Statement

(This statement was used as the basis of discussion for the Workshop)

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 individual practitioners, health professionals, hospitals and other institutions acting alone. It also is a structure deliberately designed to take into account local resources, patterns of practice and referrals, and needs. As such it is a potentially important force for bringing about and assisting with changes in the provision of personal health services and care.

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

continued

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.

continued

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 critera 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.

continued

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.□

7. National Review Criteria

1. GOALS, OBJECTIVES, AND PRIORITIES
   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
   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
   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?

continued

4. MINORITY INTERESTS

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

1. COORDINATOR

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?

2. CORE STAFF

a. Does core staff reflect a broad range of professional and discipline competence and possess adequate administrative and management capability?

b. Are most core staff essentially full-time?

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

continued

3. REGIONAL ADVISORY GROUP

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

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

c. Are meetings well attended?

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

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

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

g. Is that committee also fairly representative?

4. GRANTEE ORGANIZATION

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

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

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

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?

continued

8. MANAGEMENT

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

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

1. ACTION PLAN

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

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

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

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

d. Is better care to more people likely to result?

e. Are they likely to moderate the costs of care?

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

3. UTILIZATION MANPOWER AND FACILITIES

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

b. Is it 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

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

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

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

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

continued

6. REGIONALIZATION

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

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?

Dr. Vance

JOHN R.F. INGALL, M.D., F.R.C.S., F.A.C.S.

Medical Director

PAIN THERAPY CENTER™ OF SOUTHEASTERN MICHIGAN

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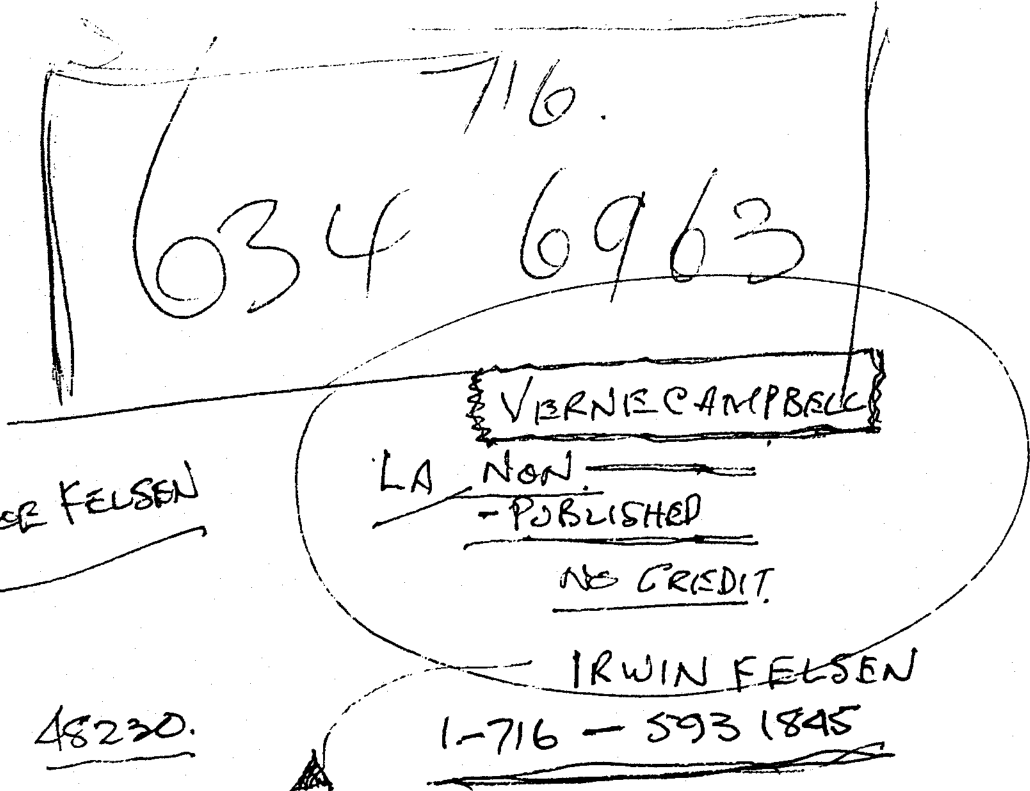
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8. RMP-WNY Goals and Objectives 1972-1975

Goal #1. *To stimulate and promote preventive services in health maintenance.*

Objectives

1. To continue defining the need for additional or new preventive services in each sub-regional area, based on a data profile of resources and services, an assessment of the community's characteristics and health problems, and on the acceptability of the service to the community.
2. To encourage delivery of preventive services through sources of primary care with emphasis on the role of allied health personnel.
3. To encourage coordination among government, voluntary, and private agencies to (a) maximize the impact of preventive services and (b) assist public health agencies in responding to community needs.
4. To encourage expanded programs in health education.

Goal #2. *To develop and improve primary care services.*

Objectives

1. To continue defining the need for additional altered or new primary care services in each sub-regional area, based on a data profile of resources and services, an assessment of community characteristics and health problems, and on the receptability of the pattern of services to the community.
2. To maximize the role of existing health personnel in delivering primary health care by (a) improving distribution of health personnel, (b) encouraging the expansion of ambulatory care within or associated with community hospitals, (c) using interdisciplinary approach to delivery of primary care, (d) encouraging the development and evaluation of innovative methods of health care delivery, and (e) promoting improved referral patterns to assure continuity of care.
3. To encourage general and family practice and other forms of primary health care.
4. To stimulate development of already defined new roles of health personnel.
5. To seek feasible solutions to the problems of distance and lack of transportation as barriers to utilization of primary care, preventive and rehabilitation services.
6. To promote consumer education regarding availability and utilization of existing health services.

continued

Goal #3. *To encourage the development, expansion and integration of rehabilitation services into the continuum of medical services.*

Objectives

1. To continue defining the need for additional altered or new rehabilitation services in each sub-regional area, based on a data profile of resources and services, an assessment of the community's characteristics and health problems, and on the acceptability of the patterns of service to the community.
2. To promote the continued development of a variety of facilities and programs to assure placement of patients at the appropriate level of care.

Dr. Thorsell *Dr. Klein*

SOLVING HEALTH PROBLEMS

The new goals and objectives of the Regional Medical Program for Western New York (RMP/WNY) will be a framework for future program decisions. They will allow RMP/WNY to play a more deliberate role in fostering needed improvements in health care, guiding data-gathering and research activities, and providing clear indication to staff and potential authors of the kinds of proposals and undertakings RMP/WNY will develop and support.

Our health activities goals and objectives are based on the most pressing needs of our region as indicated in the health data at our disposal. This includes such sources as staff interviews with members of the RMP/WNY Board of Directors, interviews with leaders in the health care system conducted by the Information Support System, the new RMP legislation and mission, and the regional plan of the Comprehensive Health Planning Council of Western New York, Inc.

The most important health problems in the region involve (1) the availability and accessibility of health services, (2) the organization of the health care system—problems indicating inadequate communication, coordination, and continuity among various levels of health care, and (3) manpower—problems related to the shortages or maldistribution of health personnel and deficiencies in training and continuing education. We seek to alleviate these health problems in the context of three broad goals, which cover the spectrum of health care services and indicate the importance we place on continuity and coordination of health care services among various health disciplines and between components of the health system. We are concerned with the quality, quantity, accessability, availability, acceptability, and continuity of care as well as the economy and efficiency of resources with which that care is provided.

First, to stimulate and promote preventive services in health maintenance. The field of prevention includes efforts to limit the progression of disease at any stage, reduce the likelihood of its recurrence, and to maintain health.

Secondly, to develop and improve primary care services. The concern is for augmenting availability and distribution of first-stage medical care, especially in underserved rural and inner city areas.

Thirdly, to encourage the development, expansion, and integration of rehabilitation services into the continuum of medical services. The field of rehabilitation includes efforts to reduce the debilitating consequences of illness and facilitate the return to more normal patterns of living. Our third goal suggests the development of effective home care and social services, patient education, and the extension of physical and occupational therapy services out into the community under the direction of the primary physician. RMP's role is to stimulate the rational definition of need, to develop strategies and plans appropriate for meeting these needs, and to assist in the implementation and evaluation of resulting activities.

Objective #1 is identical for each goal, and shows our intent to respond to documented local needs. To attain a high level of health care throughout the region requires, as a first step, the identification of those areas which suffer the greatest deficits. At this stage of our program, we expect to invest our major resources in the areas of greatest need, with upgrading of existing services as a secondary consideration.

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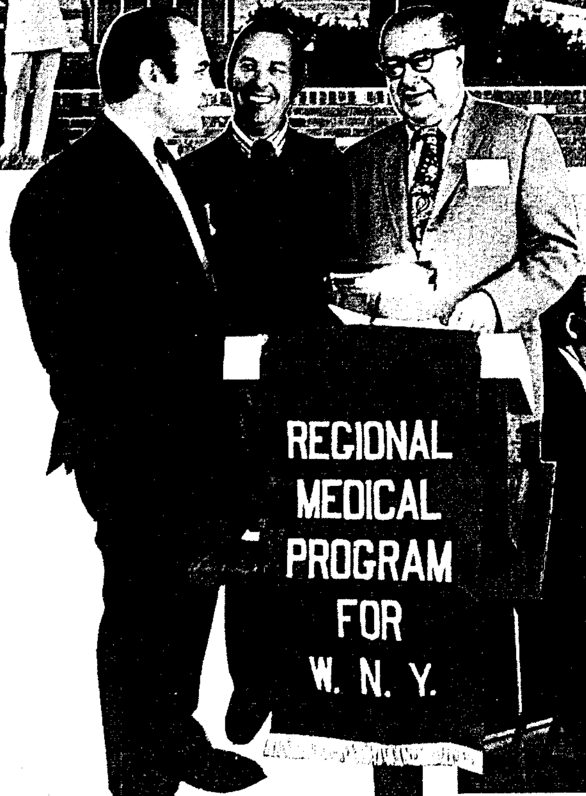
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9. Comments of Workshop Participants

Virginia Barker, Ph.D., Dean, School of Nursing, Alfred University:

"I found it a very stimulating and very interesting meeting, especially in view of the newer thrust of Federal Legislation in powering the Regional Medical Programs to incorporate a broader thrust to their specific activities.

"I found the exchange of ideas among various participants interesting, enlightening and provocative.

"I would be very interested in such a conference in the future which would explore in detail the relationships between RMP and Comprehensive Health Planning. I think there is duplication of effort and membership existing simultaneously with unique programs and problems within each organization. This matter was touched on briefly at the September conference and I believe the interest was there for their exploration of it."

LaVerne E. Campbell, M.D., Regional Health Director, New York State Department of Health, H.O.W.N.Y. Board member:

"The general session in the afternoon of September 23 certainly helped the many people that were in attendance to start to get an appreciation of each other's interest and role in the health affairs of Western New York. In the evening when the Workshop broke up into three separate groups for discussion purposes in anticipation of making recommendations the following day, there was considerable in-depth discussion toward hammering out goals and objectives for the future direction of RMP-WNY.

"I am indeed satisfied that the Workshop was needed and did meet its goal to develop a platform for the future of the Regional Medical Program in this area. Further, I believe that the goals and objectives that were developed and finally approved by the Board of Directors of the Health Organization of Western New York, Inc., have established a workable framework for guiding RMP and the local H.O.W.N.Y. units at this time in view of the changing role for regional medical program services throughtout the country."

Mrs. Margaret D. Connelly, Supervising Nurse, Allegany County Public Health Nursing Service:

"I wish to thank you for the opportunity of attending the Workshop on September 23 - 24, 1971 at the Holiday Inn in Fredonia, New York. I came away feeling more knowledgeable about the Western New York Regional Medical Program. The opportunity of meeting the people concerned with improving health care in this region was certainly appreciated and the obvious enthusiasm of the staff is reflected in the excellent presentation of the goals and objectives.

"If as a result of this Workshop others are planned, I would be interested in participating once more. Your hospitality was most gracious. Again thank you."

Alan J. Drinnan, M.D., D.D.S., Department of Oral Medicine, School of Dentistry, State University of New York at Buffalo:

> "I personally found the meeting to be most worthwhile as it gave me the opportunity, not only to be brought up to date with current thinking regarding Regional Medical Programs, but also to meet other interested people on an informal basis.
>
> "It would be a good idea to hold a workshop of this type occasionally just to keep everybody fully apprised of developments."

Stuart L. Fischman, D.M.D., Associate Professor and Assistant Dean, School of Dentistry, State University of New York at Buffalo:

> "I found the general discussions most useful and the informal evening workshops very helpful. I am certain that I came away from the program with a better understanding of the goals and guidelines of the RMP."

Ernest R. Haynes, M.D., Director, Clinical Professor of Family Practice, State University of New York at Buffalo:

> "I found the recent RMP workshop in Fredonia interesting, informative and valuable.
>
> "I think it wise to take a session like this out of town. I thought the format was good and the staff of RMP are certainly to be congratulated on their homework. I liked the meeting. It began in a broad way and ultimately narrowed through good organization down to essential basic issues.
>
> "I hope there will be further sessions such as this. Perhaps the location of the meetings can be kept away from Buffalo and moved throughout the nine counties covered by the RMP for WNY."

Myroslaw M. Hreshchyshyn, M.D., Department of Gynecology-Obstetrics, School of Medicine, State University of New York at Buffalo:

> "I found that the session I attended was most interesting and educational and I feel that it would be desirable to have similar sessions in the future. To make it more productive I would suggest that the session deal with a specific problem that can be resolved at one session. My own preference would be a session that would deal with identification of needed services that already exist in the community but that have not been made sufficiently available to the medical community and the consumers in this region and how could this be brought about."

Edward F. Marra, M.D., Professor and Chairman, Social and Preventive Medicine, School of Medicine, State University of New York at Buffalo, H.O.W.N.Y. Board member:

> "I think the Fredonia Workshop was constructive principally in that it brought together people of various primary professional interests and set them to work dealing with a task which had to be accomplished in a finite period of time, namely, the goals and objectives of the Regional Medical Program. It is this kind of activity which leads to a true interaction of the various opinion and feeling spectra that exists among the various practitioners. They get to 'know each other' at the emotional, as well as the intellectual levels, and this leads to a binding consensus."

Jean Miller, Project Director, Information Dissemination Service:

"I found it was of value for personnel currently involved in RMP activities as it clarified function and relationships to other agencies, it updated members regarding legislation and objectives, and it provided an opportunity to exchange ideas and problems with participating and cooperative agencies. The material discussed would be of value to those contemplating submitting projects to RMP for approval."

Rita J. Smyth, Ed.D., Assistant to the Dean for Clinical Resources, Assistant Clinical Professor of Pediatrics, School of Medicine, State University of New York at Buffalo:

"The two day RMP workshop in Fredonia was provocative, stimulating and fruitful. It served successfully both as a mechanism to set future goals and objectives for RMP, and as a vehicle for intra agency communications."

John W. Vance, M.D., Director, RMP/WNY Chronic Respiratory Disease Program:

"With respect to this workshop there is no question that it was interesting and informative for me as a project director.

"Especially important was the contact with the various other project directors, as well at the H.O.W.N.Y. Board in open forum to discuss priorities of concern most appropriate for this region.

"As a result of this exposure, I feel I have a much better grasp of the various elements of program, as well as of the attitudes and needs of our community. I feel strongly that such workshops should be scheduled regularly, possibly even twice yearly.

"One addition might be to include someone from RMP headquarters in Washington so that their viewpoint could be obtained, as well as those of the local staff board and project directors."

Participants

Irwin Felsen, M.D. – President, H.O.W.N.Y., Inc.
John R.F. Ingall, M.D. – Executive Director, RMP/WNY
LaVerne Campbell, M.D. – Regional Health Director, N.Y.S. Dept. of Health
Julian Ambrus, M.D. – Roswell Park Memorial Institute
Virginia Barker, Ph.D. – Dean, School of Nursing, Alfred University
Sandy Berlowitz – Scientific Writer, RMP/WNY
Ernst Beutner, Ph.D. – School of Medicine, S.U.N.Y. at Buffalo
Lester H. Block – Legal Counsel, H.O.W.N.Y., Inc.
Catherine Brownlee – Model Cities, Erie, Pa.
Gene Bunnell – Associate for Planning, RMP/WNY
Evan Calkins, M.D. – Chairman, Dept. of Medicine, S.U.N.Y. at Buffalo
Michael Carey – Director, Lake Area Health Education Center, Erie, Pa.
Clifford Carpenter – Director, Comprehensive Health Planning Council of W.N.Y., Inc.

Max Cheplove, M.D. – Erie County Chairman, RMP/WNY

Dennis Chiaramonte – Model Cities, Erie, Pa.

Floyd Cogley, Jr. – Associate for Grant Development, RMP/WNY

Margaret Connelly, R.N. – Allegany County Health Dept.

Alan Drinnan, M.D., D.D.S. – School of Dentistry, S.U.N.Y. at Buffalo

Kenneth Eckhert, M.D. – Dept. of Legal Medicine, S.U.N.Y. at Buffalo

Stuart Fischman, D.M.D. – Assistant Dean, Dept. of Oral Medicine, S.U.N.Y. at Buffalo

John Fortune – Erie County Health Dept.

Elemer Gabrieli, M.D. – Director, Clinical Information Center, S.U.N.Y. at Buffalo

Joseph Gerbasi, M.D. – Assistant Prof of Surgery, S.U.N.Y. at Buffalo

Martin Gerowitz – Comprehensive Health Planning Council of WNY, Inc.

Ivan Harrah – Executive Director, W.N.Y. Hospital Association

Ernest R. Haynes, M.D. – Director, Family Practice Center

Patricia Hoff, R.N. – Director for Nursing Affairs, RMP/WNY

Myroslaw Hreshchyshyn, M.D. – Professor, Gynecology-Obstetrics, S.U.N.Y. at Buffalo

Herbert Joyce, M.D. – Past-President, H.O.W.N.Y., Inc.

Elsa Kellberg – Associate for Evaluation and Research, RMP/WNY

Bert Klein, Pod. D. – Board Member, H.O.W.N.Y., Inc.

Robert Ludwig – Comprehensive Health Planning Council of W.N.Y., Inc.

Edward Marra, M.D. – Chairman, Dept. of Social & Preventive Med., S.U.N.Y. at Buffalo

Ruth McGrorey – Dean, School of Nursing, S.U.N.Y. at Buffalo

Jean Miller – Information Dissemination Service – S.U.N.Y. at Buffalo

James H. Morey – Alternate, H.O.W.N.Y., Inc. Olean, N.Y.

William Mosher, M.D. – Commissioner, Erie County Health Dept.

Joseph Nechasek, Ph.D. – Assistant Dean, School of Health Related Professions-S.U.N.Y. at Buffalo

Mary Northington – Comprehensive Health Planning Council of W.N.Y., Inc.

Gary Reynolds – Administrative Associate for Business & Personnel, RMP/WNY

Joseph Reynolds – Coordinator, Telephone Lecture Network

Rita Smyth – Assistant to the Dean of the Dept. of Pediatrics, S.U.N.Y. at Buffalo

Harry Sultz, D.D.S. – Board Member, H.O.W.N.Y., Inc.

Marion Sumner – Administrative Associate for Business & Personnel, RMP/WNY

Gerald Surette – Administrative Associate for County Committees, RMP/WNY

H. Gregory Thorsell, M.D. – Secretary, H.O.W.N.Y., Inc.

John Vance, M.D. – Director, Chronic Respiratory Disease Program

Gene Wilczewski – Comprehensive Health Planning Council of W.N.Y., Inc.

Anthony Zerbo – Director of Communications, RMP/WNY