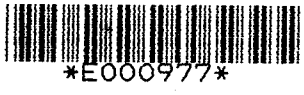
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III. ACTIVITIES AND ACCOMPLISHMENTS - NARRATIVE

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A. General

There was a marked expansion in the level of RMP activities over the 3-year period of 1970 to 1972. This was a direct result of the significant increase in the availability of grant funds in 1972 as compared to the previous years and thus in the awards to the 56 Regions.

In fiscal year 1970, awards to the 56 RMPs totaled $78.2 million, while in fiscal year 1971 they totaled $70.3 million. Funding totaled $111 million in fiscal year 1972, an increase of $40 million or over 50 percent. The expansion in operational activities was even more dramatic. At the end of fiscal year 1971 (June 30, 1971) roughly 600 operational projects were receiving support through the 56 Regions. One year later (June 30, 1972), just over 1,000 operational projects were in progress.

In addition to this expansion in the level of RMP-initiated activities, there has been increased attention given to the relationship between activities relating to particular categorical diseases, and those relating to more comprehensive problems in the health delivery system. Fiscal year 1972 saw an acceleration of the longer-term trend of broadening the categorical emphasis of Regional Medical Programs, so that the program might promote the integration of such categorical activities into the broader health care framework, rather than allowing such efforts to fragment the delivery system. Not only is it possible to improve comprehensive care through the input of such categorical efforts, but frequently the effectiveness of particular disease efforts is improved by increasing public access to those efforts. This often requires collaborative work

which ties the primary and ambulatory care networks through which people enter the health care system, to the more specialized care related to heart disease, cancer, and other specific diseases.

Thus RMP support in FY 72 included a range of efforts to improve care in terms of not only single disease entities, but also in terms of a variety of multicategorical programs and others truly comprehensive in nature.

Among operational activities addressed to individual disease problems, there have been some significant shifts over the past few years. The major result of these shifts is that there is now a far greater balance among the several categorical diseases specified in title IX (i.e., heart disease, cancer, stroke, kidney disease, and other related diseases).

The shifts in funding from FY71 to FY72 are shown in the summary table below:

	FY 71		FY 72		
	No. of Projects	Amount	No. of Projects	Amount	Net Change
Heart and Hypertension	156	$11.7M	124	$7.4M	-$4.3M
Cancer	89	6.2M	98	6.5M	+ .3M
Stroke	65	5.5M	57	4.2M	- 1.3M
Kidney	22	1.5M	74	6.2M	+ 4.7M
Other (e.g. Diabetes, Pulmonary Disease)	41	3.5M	77	5.2M	+ 1.7M

The fourfold increase in the funding of operational projects concerned with kidney disease largely reflects the response of the RMPs to the Congressional priority on end-stage renal disease programs. The significant decrease, nearly 40 percent in the funding of operational projects focused exclusively on heart disease is directly related to the gradual disengagement of RMPs from coronary care demonstration and training activities.

This had, until recently, constituted the single largest discrete area of RMP activity.

That task, the making of high quality coronary care far more readily accessible to the entire population, is not finished. Considerable progress has been made, however, and Regional Medical Programs have contributed to that progress.

Two points highlight that contribution. In the 3 year period, 1966-69, over 7,000 nurses had received coronary care training as a result of the efforts of the 56 RMPs; and by the end of fiscal year 1972 that figure well may have risen to 10-12,000. That such specialized facilities and services are more widely available in illustrated by the fact that the Maine RMP's five-year Coronary Care Project has assisted 48 of that State's 59 community hospitals in their development of coronary care capabilities. Prior to the initiation of this project there were only four hospitals in Maine with CCUs. Similarly, 250 of Arkansas' 1,700 physicians, most of them from rural areas where there are few cardiologists, have been trained in the care and treatment of acute heart disease in CCU settings as a result of Arkansas RMP funding.

As trained personnel have become available, the hospitals in that state have added intensive care units. In 1966 there were three such units; by 1971, 40 were operational with another 50 hospitals planning them.

RMP efforts in support of multi-categorical and comprehensive programs increased markedly in FY72 over previous years. Funding for such projects rose from $16.8 million in FY71 to $46.7 million in FY 72. Multi-categorical efforts are aimed at improving the utilization of resources which

might potentially be used for a single disease focus, but which can serve to include a variety of diseases with some redirection of effort. Particularly in areas of training and some patient care demonstrations, resources can be used most efficiently by broadening the focus to include more than a single disease focus. The following types of activity point out how these types of activities can serve to cover a variety of disease entities:

- North Carolina is involved in developing a model system which rapidly screens adults to detect signs of diseases of the circulatory system, involves a minimum of medical manpower, and incorporates referral to physicians and follow-up procedures which can considerably reduce the incidence of disabling and fatal events. Funded under a grant from the North Carolina RMP, the North Carolina and Forsyth County Heart Association are conducting a pilot screening project with three population types: low-income urban residents, rural residents, and employees in industry. Tests are designed to detect possible hypertension, heart disease, impending stroke, diabetes, and anemia. The program is utilizing about 150 volunteers and two nurse coordinators, as well as a small administrative staff. Volunteer groups of physicians and allied health personnel are securing the cooperation of the medical community in accepting referrals and providing for follow-up of the medically indigent.

- The need for additional training for personnel serving the 12,000 nursing home beds (93 percent occupancy) in Arkansas is indicated by the fact that the patients are cared for by 4,000 aides, 265 LPNs and only 125 full-time registered nurses. The nurses have been active in

a series of workshops held in central locations by the Arkansas League for Nursing. The workshops, however, did not reach aides and LPNs. A training program sponsored by the Arkansas League for Nursing and the RMP is attempting to change this by on-site workshops designed for the LPNs and aides. The ultimate goal is to improve the care and facilitate the rehabilitation of heart, cancer, and stroke patients in the State's nursing homes through one and two-day annual workshops in each of the sub-regional communities throughout the State.

RMP is also making increasing efforts to develop projects of a comprehensive nature which deal with major pieces of the health care system. Many of these attempt to improve accessibility and availability to various components of the health care system, both at the level of ambulatory care and more specialized care. Others deal with efforts aimed at quality assurance and assessment. The expanding range of activities which RMPs have become engaged with in responding to local needs and problems include the following:

- Emergency Medical Services was highlighted as a national health priority in the President's Health Message in January 1972. By the end of fiscal year 1972, less than 6 months later, 36 RMPs had responded to the priority with over 50 EMS proposals. As a result, additional funds of $8.4 million were awarded to 28 Regions for new EMS operational projects in fiscal year 1972.

- Regional Blood Banks - The country's first statewide Regional Blood Freezing Program was among the projects initiated with support from the New Jersey RMP last year. That program will double the supply

of frozen blood in New Jersey in one year, blood needed as replacement for cancer and surgical patients, individuals on hemodialysis, and rare-blood types. It also seeks to organize a system for rapid delivery of blood and improvement of donor programs throughout the State.

One other general development has been clearly discerned in the last few years, although it is still of modest proportions. That relates to growing inter-regional cooperation and activities. A few examples in the way of illustration:

- Cooperative development and funding of operational projects by adjoining Regions as reflected by a recently initiated rural health clinic effort jointly funded by the Tennessee Mid-South and Ohio Valley RMPs. As a result, residents of three Appalachian communities in eastern Tennessee and Kentucky will have full-time health care available. The RMP funds will allow daily operation of several clinics, each staffed by a nurse practitioner, a health aide, driver, and an outreach worker. The area served has no resident physicians and over 57 percent of people living there have annual incomes of $3,000 or less.

- The development by the 14 Southeastern RMPs just about one year ago of a Committee on Quality of Care Assessment. That Committee and its supporting staff resources are drawn from the Regions. It has as one of its principal purposes, the constitution of an inter-regional resource to provide technical assistance, consultation and guidance relative to the development and implementation of mechanisms for quality of care assurance and monitoring to any group or

organization (e.g., local medical society, HMO, community hospital) requesting such. Its activities, which are now supplemented by a small contract from RMPS, included a two-day Conference on Quality of Care Assessment held in Atlanta this June aimed at providing an opportunity to the state medical society members and staffs of the 14 RMPs in the Southeast to improve their knowledge and skills in assessing the quality of medical care.

- Elements of the end-stage kidney disease programs of the New Jersey, Nassau-Suffolk, and Metropolitan New York RMPs would be integrated by a pending proposal. The Community Blood Center of Greater New York, acting on behalf of these three Regions, is the applicant.

B. Availability and Accessibility of Care

Regional Medical Programs are supporting a wide variety of activities aimed at increasing the availability and accessibility of health care, particularly in the target disease areas. They address such problems as the acute lack of health manpower in rural and inner-city areas; the poor utilization of physicians and allied health manpower in most medical trade areas; and the uneven availability and accessibility of health services, again most scarce in rural and inner-city areas.

Special efforts to improve availability and accessibility are being made in terms of minority and inner-city populations and in rural areas.

Minority and Inner-City Populations: In fiscal year 1972 activities directed at special target populations such as Blacks, Spanish-Americans, and Indians more than doubled, from 46 projects and $5.4 million to 147 projects with $17 million in RMP funding. Some examples are as follows:

* More than 5,000 black children in 20 Grand Rapids, Michigan schools have been screened in a massive, free program of testing for the crippling, fatal disease, sickle-cell anemia, a hereditary condition which primarily attacks black people. The tests uncovered 309 carriers of the trait.

  Begun 16 months ago, the tests are part of demonstration programs, funded by a grant from the Michigan RMP. The project also provides follow-up screening for relatives of carriers, as well as genetic counseling for affected families. The total program

is designed to build a prototype model whereby the new low-cost test and follow-up procedures can be made available to all black people within a community.

* The people of some three communities in Northern New Mexico have set up clinics designed to bring medical care directly to the poor of remote mountain villages as well as in the cities. Special courses in emergency medical care provided by the New Mexico RMP train community members to be self-reliant in treating illnesses and accidents. The New Mexico RMP's "Operation Home Run" in Santa Fe has provided surplus medical equipment to La Clinica de la Gente, the first full-time outpatient clinic of its kind in that city.

* A Hospital-Based Family Health Care Service at Middlesex General Hospital in New Brunswick, New Jersey is providing health care to 4,000 of the city's poor. The project was initiated last year with a $143,000 grant from the New Jersey RMP.

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

* Continual electronic heart monitoring services comparable to those available in large urban hospitals have been introduced to Oklahoma's small community and rural hospitals as a result of a statewide Coronary Care Monitoring Network for Rural Areas initiated by the Oklahoma RMP. To date, 43 monitor-equipped beds in 29 small community hospitals have been linked by special telephone lines to 10 central monitoring hospitals. Specially trained nurses in the central monitoring units help monitor remote patients, and when an abnormality is detected, confer with local staffs by telephone "hotlines." The importance of immediate coronary care stems from the fact that most heart attack victims who die, do so within the first few hours.

* Under the sponsorship of the Lakes Area RMP in Western New York, the Rural Externship Program has become an effective means of directing health manpower toward delivery of primary care in underserved rural areas. The program places teams of health science students from a variety of disciplines in a number of rural health care settings for a period of eight weeks during the summer. By so doing, the project provides rural communities and community hospitals with access to health science students, while at the same time providing a means for attracting such students to medical careers in rural communities. The program also provides health science students with a first-hand exposure to primary care, and to health care settings not currently utilized in their formal clinical curricula.

* The Memphis RMP is experimenting with a mobile multiphasic screening unit in Northeastern Mississippi. A minimum of 11,000 persons annually receive up to fifteen different multiphasic screening tests and general health education. TVA is providing technical assistance and computer interpretation of ECG's and the Mississippi State Board of Health laboratory also provides assistance to the projects.

In addition, many Regions have assisted rural communities in which no physician is present to substitute other types of health care service. An empty doctor's clinic in Rochell, Georgia, for example, has been staffed by nurses with the help of the Georgia RMP in an experiment to provide health care. The clinic is being developed into a new Health Access Station. The Maine RMP is directing a program which will link the Stonington Island Medical Center, where there is no doctor, to Blue Hill Hospital via two-way television. And in Darrington, Washington, two registered nurses will staff a long-empty clinic, built to attract a doctor. When no doctor was found, the citizens appealed to the Washington/Alaska RMP, which has now helped finance and staff the facility to provide emergency care, health screening and counseling.

C. Improved Utilization of Health Manpower

As a minimum an estimated $17 million, or over 20 percent of operational funds awarded in fiscal year 1972 were being directed toward manpower development and utilization activities. (This does not include any continuing education, for which an additional $12 million was awarded.) An increasing emphasis of these activities is the improved utilization and increased productivity of existing health manpower, especially nursing and allied health personnel.

The central focus of RMP activities in the health manpower area is on developing programs that more closely relate education to the health service delivery needs of an area. The definition of such health service needs must involve participation of a wide range of health service and education institutions, such as community colleges and hospitals as well as health professionals and consumers. A community-based identification of health services needs must, moreover, precede any determination of the numbers and types of health personnel needed and how they should be trained.

In RMP's approach to resolving manpower problems, the emphasis is on assisting communities to identify their needs and to link and relate total health resources in such a way as to ensure a better balance between the quality and quantity of manpower available and locally determined needs for service.

RMP support for manpower development and utilization is generally divided into three categories:

1. Training existing health personnel in new skills aimed at enabling the person trained to assume new responsibilities in his already chosen career field. The emphasis is on increasing the productivity of personnel and includes expanding the functions of registered nurses and career mobility for licensed practical nurses;

2. Activities directed toward the training and development of new categories of personnel, the establishment of training programs for new categories of personnel such as physicians' assistants, nurse practitioners, and community health workers. The primary objective here is to expand the manpower health pool through the development of these new categories of health and allied health professionals who can become part of an expanded health services delivery team;

3. Continuing education activities aimed at maintaining or improving the levels of practice of health professionals. An effort is being made toward relating career (or continuing) education more closely to deficiencies identified as a result of quality of care monitoring.

Activity in the second area, the development of new kinds of health manpower, has increased markedly in the past year as RMPs have

sought to promote the concept of the health delivery team approach. Projects dealing with new categories of personnel increased from 16 and slightly less than $1 million in fiscal year 1971 to some 55 projects and $3.5 million in fiscal year 1972.

The Family Nurse Practitioner, for example, will play an increasingly vital role in helping solve the health manpower shortage in North Carolina, especially in communities beset by physician shortages. In a health center or clinic, a physician's office, or patient's home, this new breed of nurse may be the first person the patient sees.

She takes a health history, does the physical exam, uses her own judgment to start preventive screening or diagnostic procedures. She coordinates health care needs, makes proper referrals, provides health instruction, counseling, and guidance. A pilot project was held last year for seven carefully selected nurses. Six are now the core of a two-county Comprehensive Health Service Program with a central clinic at North Carolina Memorial Hospital and two rural satellite clinics. In these rural areas, the Family Nurse Practitioner is part of a health team which also includes physicians and community health workers. This year, through support from the National Center for Health Services Research and Development, the University of North Carolina, and a $70,000 grant from the North Carolina RMP, twelve more Family Nurse Practitioners are being trained.

Similar activities are taking place in a number of other Regions:

* In Syracuse, New York, the Central New York RMP has provided a grant to a community hospital to conduct a seven-month course for registered nurses designed to increase the availability of health care services to areas with inadequate physician coverage by teaching nurses how to render primary patient care.

* Pediatric nurse practitioner and nurse clinician programs are being started with RMP financial and other assistance in a number of places such as California and Kansas where it was determined after a survey that most physicians preferred to hire nurses retrained for expanded assistant roles rather than ex-medical corpsmen or newly trained personnel.

* Part of the stroke program of the Puerto Rico RMP trains high school graduates to become "Assistentes de Salud Familiar." Their mission is to help the patient maintain good health, and bring together the patient and the community in cooperation with health professionals.

D. Regionalization and Kidney Disease Programs

Working relationships and linkages among community hospitals and between such hospitals and medical centers, with their more specialized resources is an important way of overcoming the maldistribution of certain resources and services.

Kidney disease and heart disease are special categories in which the development of integrated regional systems can prevent the duplication which has so frequently wasted our limited resources. In the field of kidney disease, for example, RMP is in the process of developing regional/national networks of dialysis and transplant centers, so as to maximize access to life-saving services enhancing quality and efficiency.

Between FY 71 and FY 72 there was a fourfold increase in the funding of operational projects concerned with kidney disease. By the end of FY 72, 29 Regional Medical Programs were supporting end-stage renal activities at a funding level of approximately $6 million, in contrast to a level of $1.5 million in FY 71. (This does not include over $2 million on contract activities, primarily related to home dialysis training, also being supported directly by RMPS).

The focus of the RMP effort is on the development and implementation of regionalized, end-stage kidney disease programs. This was reflected at the national level by the development of a long-range, "life plan" approach for dealing with the major problem represented by the 8-10,000 new patients afflicted with end-stage kidney disease every year.

The principal aim of the "life plan" approach is the efficient linkage, and orderly growth of scarce resources throughout the United States. The program

guidelines developed by RMPS and approved by the National Advisory Council seek to exploit the opportunities for regionalization of end-stage kidney disease programs without sacrificing quality and accountability. These guidelines require that in order to be eligible for grant support, RMP-proposed activities should include the following components:

1. Assurance of early identification of patients approaching renal failure
2. Rapid referral of such patients
3. Early classification of these patients regarding tissue-typing
4. Availability of the coordinated dialysis-transplantation facilities to assure treatment alternatives to both the patient and the physician
5. Effective cadaver kidney procurement and preservation operations, coupled with rapid kidney donor-recipient matching.

The advantages of such an approach include the fact that patients would have access to conservative treatment before kidney function stops, an optimal organ in terms of tissue-typing would probably be found while the patient is still alive, and that almost all patients would be carrying out dialysis outside of the hospital.

Kidney disease is one area in which the need to develop a strategy of sharing scarce and costly resources is clearly indicated. The cost of treatment has been the major obstacle to saving patients with end-stage kidney disease. Because of the technical complexity of treatment with an artificial kidney, this treatment usually had been provided in a medical center. While the cost of dialysis in the center was close to $20,000 a year, the advent of dialysis in the home, reduced this type of treatment to approximately $10,000 a year. Because of these reduced costs, more patients were being saved during their most productive years, and being at

home, a larger percentage of them were able to carry out a large proportion of their normal activities.

As the practicality of dialysis in the home and the feasibility of transplantation as the eventual treatment of choice became apparent, RMPs increasingly were in a position in fiscal year 1972 to launch regionalized programs optimally addressed to the particular needs and resources found in their areas. For example:

* A grant received by the Arkansas RMP in July 1971 permitted the expansion of kidney transplant facilities at the University of Arkansas Medical Center and the provision of facilities at Arkansas Baptist Medical Center for the training of patients to perform their own dialysis in their homes. Since then, 15 patients have received transplants, and 26 patients have been or are being trained for home dialysis. All but one of the proposed sub-regional nephrology centers in the larger community hospitals around the State are now in operation; providing back-up dialysis. A tissue-typing laboratory, with trained staff, and an Organ Procurement and Distribution Section has been established at UAMC. Modern equipment makes it possible for the first time to retrieve kidneys from anywhere in the State. This region participates in an inter-regional organ-sharing program whereby kidneys, which cannot be used at the point where they are received, are shipped from city-to-city and/or state-to-state, wherever they might be utilized.

* In Los Angeles, since Harbor General Hospital's participation in the California Regional Kidney Disease Program beginning in September 1971, the number of cadaver kidneys produced has tripled. This increase is

attributed to both a $40,000 grant from the California RMP and the formation of the Greater Los Angeles Belzer Preservation Service, a cooperative community effort affiliated with four medical schools including UCLA. Harbor General Hospital's Department of Renal Transplantation used to work in a "crisis" atmosphere associated largely with the maximum six hours in which a kidney would be safely preserved by freezing methods. With the acquisition of two Belzer Preservation units, one of them RMP-financed, that time has been extended to 48 and sometimes as long as 72 hours. It has also relieved much of the stress connected with harvesting the organ, finding a suitable recipient and successfully transplanting the kidney at Harbor General or one of the other nine kidney transplant centers to which Harbor General supplied cadaver kidneys. In part because of this support, monitoring can be done with more precision, there is more time for tissue-typing to match the donor and recipient, and for the first time more than one donor can be serviced at once.

E. Quality of Care

The primary focus of RMP concerns with quality of care has generally been on the individual patient encounter, improving the quality of services provided through such individual encounters. The past year or two have witnessed a new concern by RMPs, concern with mechanisms for assessing and assuring the quality of care actually delivered.

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

Some of these efforts have clearly demonstrated that early, continuing care can pay dividends. In North Carolina, a Comprehensive Stroke Program was initiated which included among its range of activities the publication of guidelines for community stroke programs, educational activities such as training programs for nurses, annual stroke workshops, and stroke consultation services for physicians through the cooperation of the neurological staffs of the three medical centers. A family-patient education unit was also designed to help patients and their families learn

to cope with the long-term effects of stroke disability. Operating in 19 counties, this program funded by the North Carolina RMP has resulted in a decrease in mortality; fewer in-hospital complications; shorter hospital stay; and a reduction in hospital charges.

That improvement in the quality of care can reduce mortality has also been shown in New York, where the New York RMP, in cooperation with Harlem Hospital, has undertaken a program for stroke management in this inner-city area. Coupling a comprehensive prevention and treatment program with a detection and information effort in the community, the project's preliminary mortality rate of those brought to the hospital suffering from stroke has dropped from 48% to 27% in the nine months since the project's inception.

Some of the RMP-supported efforts to improve quality involve greater use of technological innovations, which can often increase the productivity of available manpower at the same time. To assure safe, precise and effective radiation doses for their patients, for example, 21 hospitals in New Jersey have formed the first statewide network linked by teletype to the Dose Distribution Computation Service at New York's Memorial Hospital for Cancer and Allied Diseases. Data on patients is forwarded by teletype to Memorial Hospital's computer which analyzes the information and relays a treatment plan back to the originating

hospital. This plan assures the best distribution of radiation during treatment so that the cancer site receives the maximum doses while adjacent healthy tissues receive only a minimum amount of radiation. Sponsored by the New Jersey RMP, it is expected this will upgrade the treatment of 8,000 of New Jersey's 25,000 new cancer patients annually.

2. Quality Assessment: During 1972 there has been an increasing emphasis on developing practicable methods for assessing the quality of medical care in various types of delivery systems. Three particular areas of effort are: (1) the development of standards and guidelines for high quality care in particular disease areas; (2) contracts with major medical societies to identify criteria for good medical practice; and (3) surveys to identify hospitals which make available the most advanced techniques for treating heart disease, cancer, stroke and kidney disease. In terms of setting standards for high quality care, the best example is the contract with the Inter-Society Commission for Heart Disease Resources, an organization brought into being to implement a contract between RMPS and the American Heart Association. The purpose of the contract and the Commission was to establish guidelines for the prevention, treatment and rehabilitation of patients with cardiovascular diseases. These guidelines have been disseminated around the country and are being used in varying degrees for planning, evaluation, and quality of care standard setting and performance review mechanisms.

The Northern New England RMP, among others, for example, is making an effort to utilize the standards of care developed by the ICHD studies. Its Regional Disease Management Committee on Coronary Care, in cooperation with the Vermont Heart Association, has developed task forces formed around the ICHD reports. These task forces were given the specific tasks of: (1) reviewing the ICHD reports; (2) reviewing the status of services in Vermont; and (3) recommending ways and specific disease control projects to upgrade Vermont programs to achieve state-of-the-art status. Made up of representatives of community hospital coronary care programs, this approach has established the quality control function clearly in the hands of those involved most immediately in the delivery of care.

RMPS is also interested in developing methods of monitoring the quality of care of health delivery systems, as well as individual diseases. It has been determined that although considerable study has been done with regard to inpatient medical care quality assessment, the care delivered in other sites has rarely been measured satisfactorily. This is particularly true of ambulatory medical care which, in fact, is the type of medical care received by 96 percent of the patient population today. One effort to be undertaken in fiscal year 1973 will be aimed at providing a full range of quality assessment in the three most common forms of ambulatory care delivery systems, namely

individual private practice, hospital outpatient clinics, and prepaid group health practice. It is hoped that this effort will produce quality assessment parameters which can be applied to other types of health delivery systems and geographic areas.

Monitoring of the quality of health care by internal audit and external review is receiving increasing attention at both the national and community levels. It is important to raise the level of health care provider understanding and experience of the objectives and techniques of quality monitoring as rapidly as possible. RMPs hope to be able to serve as technical resources to providers of health care and as channels for provider feedback to HS on theories and practice of quality control.

Thus RMPS plans development this year of an inter-regional program for development of quality of care consultative services. A National Meeting of RMP Coordinators on Quality of Care was held in January 1973, to develop a common frame of reference and policy for implementing a quality of care program. This will be followed by inter-regional sectional meetings to apply these policies to their own particular regional problems. This will enable the majority of RMP's to gain capability for technical assistance on monitoring the quality of health care by the end of 1973.

F. Program Activities

A significant part of the overall RMP effort has always been so-called program activities. In fiscal year 1972 these accounted for approximately $43 million ($36 million direct costs), or about 39% of the total amount awarded ($111 million) to the 56 RMP's.

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

	% Total
* Program Direction and Administration: Overall direction and coordination, policy development, financial management, project coordination, communication and information activities, program evaluation.	27%
* Project Development, Review and Management: Assistance to local applicants in project design and conduct, processing of individual operational applications, staff support to project review groups, project monitoring and evaluation.	22
* Professional Consultation, Community Relations and Liaison: Staff assistance to other health programs, facilitation of cooperative relationships, development of and assistance to sub-RMP groups, etc.	26

	Est. Amt.	% Total
* Planning Studies and Inventories: Staff time and/or sub-contract costs for studies designed to provide guidelines in development of program objectives, base-line data, etc.	$ 3.7M	11%
* Feasibility Studies: Staff time and/or sub-contract expenditures for activities designed to assess the potential of prototype programs or techniques for larger scale application.	2.7M	7
* Central Regional Services: Centralized services supported on a continuing basis, such as libraries, data banks, etc.	1.8M	5
* Other:	.7M	2

About $22 million, or over one-half of the $43 million for program activities directly contribute to increasing the availability and accessibility of care and enhancing its quality -- every bit as much as RMP-supported operational projects and activities.

The following are examples of the kind of activities that take place within three of these categories:

Planning studies - In 1969 a community health survey in the San Fernando Valley was undertaken by Area IV (UCLA) of the California RMP. An extreme shortage of health manpower was found to exist. As a result representatives from San Fernando Valley State College began meeting with physicians and other providers and the RMP. These

discussions in turn have led to the development of the San Fernando Health Consortium, again with funding help from Area V (USC) as well as IV.

Professional consultation and technical assistance - The Wayne State component of the Michigan RMP has, over the past several years, provided extensive and continuing technical assistance to the Detroit Model Cities Program in developing comprehensive, prepaid health care for approximately 10,000 inner-city residents. Funding for initiation of this program has now been received from HUD and other sources.

Feasibility studies - pilot projects which frequently provide necessary seed money. If the initial results warrant, implementation on a larger scale, either as a RMP-supported operational project or with funds from other sources, can generally proceed.

* A project to screen Pittsburgh students for sickle cell anemia was initiated last year by the Western Pennsylvania RMP. Testing will provide an indication of the problem in school age groups, with the data to be analyzed by the Allegheny County Health Department and the University of Pittsburgh Health Center.

* The American Indian Free Clinic opened this spring in a remodeled wing of the Grace Baptist Church in Compton, California, which is part of the greater Los Angeles area. With seed money from the California RMP, an OEO grant, and much volunteer help, the clinic

handles 35-40 patients every Tuesday and Thursday evening. All equipment for the clinic was donated and almost all the volunteer help are Indians.

Not all RMP program activities can be readily and neatly sorted out in terms of pilot projects, studies, technical assistance, and the like. Because of their organizational make-up and identification with local resources, RMPs often tend to serve a "medical forum" role for providers, consumers, and others. By design or otherwise, they also often serve in a sounding board role. Thus, when issues with potentially major impact on the nation's health care system arise, RMPs are often looked to for information, sometimes guidance. Such was the case with the recent Federal initiative to plan, develop, and organize Health Maintenance Organizations.

During the first six months of fiscal year 1972, over one-half of the RMPs (29) initiated HMO-related activities without any additional grant inducements. Nine provided some financial assistance in preliminary HMO planning and many more supplied technical assistance and advice; for example, the Tennessee Mid-South RMP had staff members actively participating in actuarial and other studies related to organization of specific HMOs. A number engaged in informational and education activities. These ranged from mailing of brochures to convening meetings to the joint sponsorship of several HEW Regional Conferences on HMOs. The Arizona, California,

Colorado/Wyoming, Intermountain and Mountain States RMPs actively assisted with the latter. Twelve RMPs designated a staff person as an HMO resource person or focal point.

These HMO-related activities were undertaken by RMP program staff and with funds budgeted for general program activities (as opposed to those earmarked for specific operational projects). It illustrated both the flexibility in RMP operations that such funds allow and the relative immediacy in response they permit.